Telehealth and COVID-19

Healthcare Business Specialists & inQuiseek LLC

Sponsored by Azalea Health and ChartSpan

March 24, 2020

HBS
Healthcare Business Specialists

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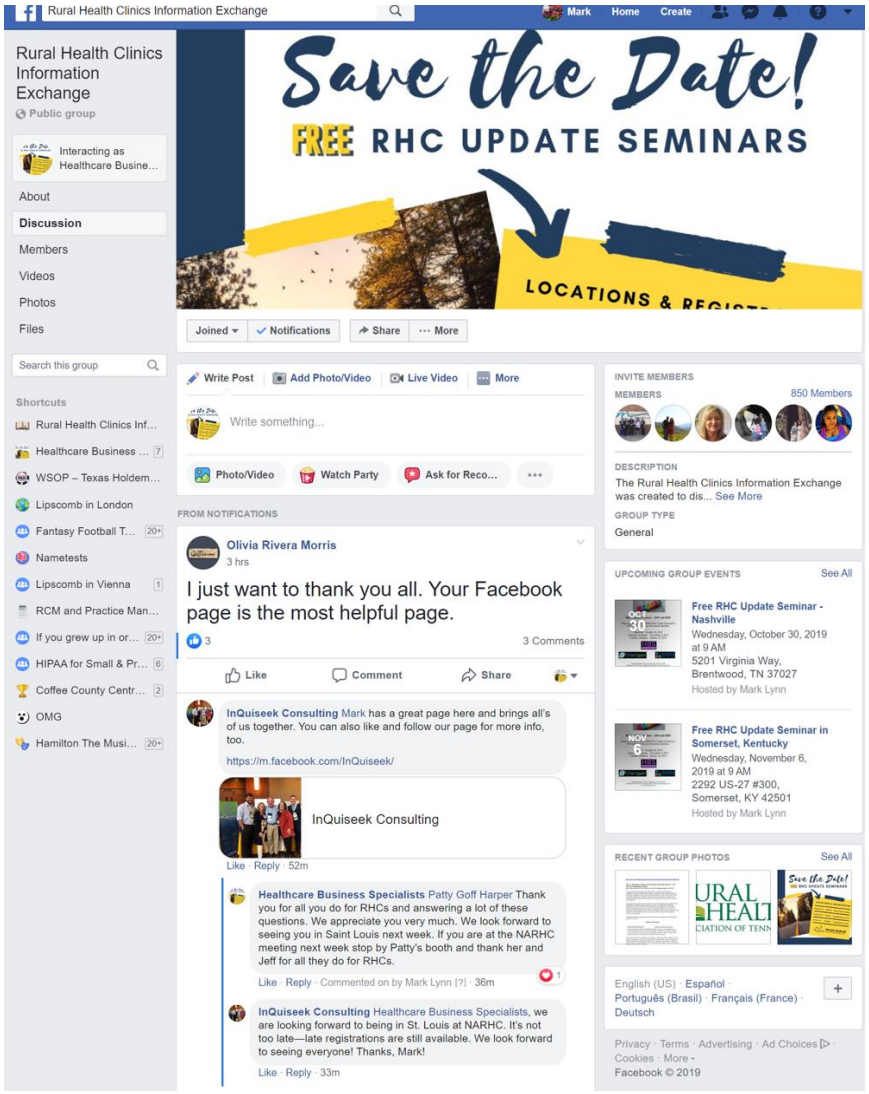
RHC Information Exchange Group on Facebook

- *"A place to share and find information on RHCs."*

RHC Information Exchange Group on Facebook



Join this group to post or ask questions regarding RHCs. Anyone is welcome to post about meetings, seminars, or things of interest to RHCs

https://www.facebook.com/groups/1503414633296362/

HBS

Healthcare Business Specialists

- What does Healthcare Business Specialists do?
- Listing of Services

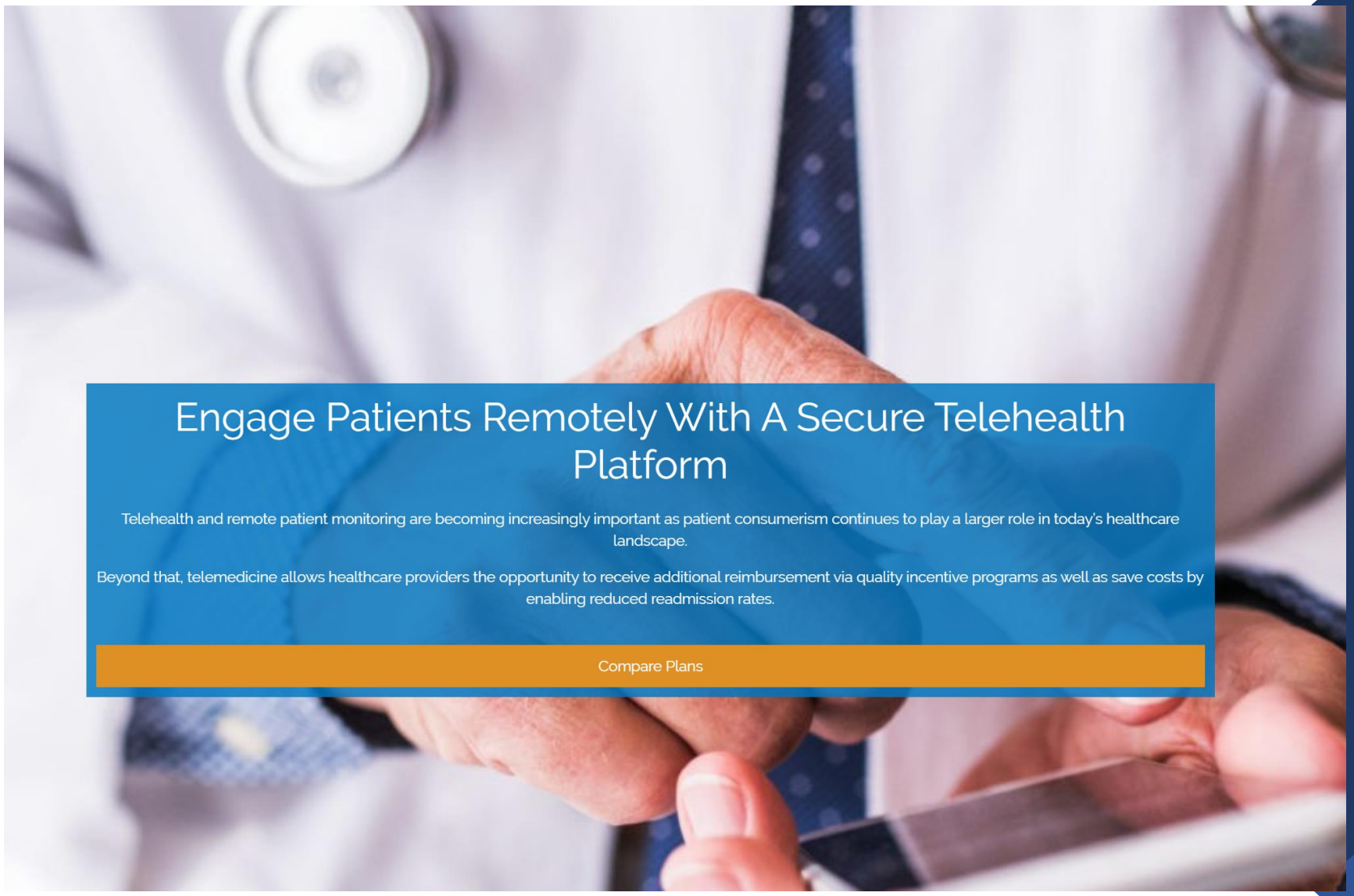
https://tinyurl.com/w63xbp9

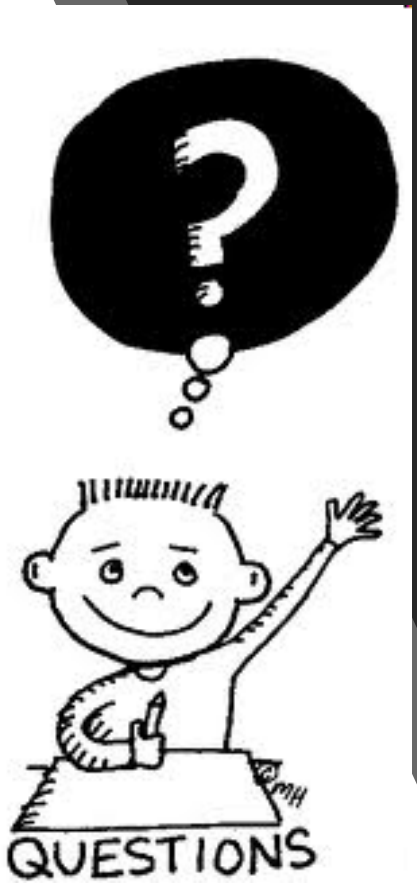
- We prepare Medicare and Medicaid Cost Reports for Rural Health Clinics.
- We prepare Program evaluations of RHCs.
- We help clinics startup as RHCs.
- Emergency Preparedness for RHCs.
- We prepare Tenncare Quarterly Reports
- Our Cost Reporting Brochure can be found at the following link:
- RHC Cost Report Brochure

2020 Dates

Nashville 11/5
Somerset, KY 11/12
Alabama, 11/18

Azalea HEALTH


Engage Patients Remotely With A Secure Telehealth Platform
Telehealth and remote patient monitoring are becoming increasingly important as patient consumerism continues to play a larger role in today's healthcare landscape.
Beyond that, telemedicine allows healthcare providers the opportunity to receive additional reimbursement via quality incentive programs as well as save costs by enabling reduced readmission rates.
Compare Plans



Questions or Comments?

Please type your questions in the Questions area of Go To Webinar. Additionally, we will open up the lines for questions at the end of the webinar.

Agenda

12:00 to 12:05 Mark Lynn - Administrative

12:05 to 12:07 Clark Bishop - Azalea Health - Sponsor's Message

12:07 to 12:17 Introduction of Speakers and Panelists

12:17 to 12:37 Ryan Kelly - Legislative Update and Technology

12:37 to 01:07 Patty Harper and Kate Hill- Logistics, Protocols, Logs, HIPAA, Clinical Issues

01: 07 to 01:27 Charles James- RHC Telehealth Billing

01:27 to 01:30 Mark Lynn Cost Reporting and Telehealth

01:30 to 01:45 Question and answer from the audience - Please type your question in the question panel

MEET OUR SPEAKERS 

Ryan Kelly – Mississippi and Alabama Rural Health Associations

Ryan Kelly, MS, is a Mississippi native and founder/CEO of Horizon Professional Services. In this role, he serves as executive director of the Mississippi Rural Health Association, Mississippi Telehealth Association, and Alabama Rural Health Association, among others. He previously served as Chief Advancement Office for William Carey University and Director of External Relations for The University of Southern Mississippi College of Health.

Kelly earned a bachelor's of science with honors from The University of Southern Mississippi in 2005 and a master's of science with honors from Mississippi College in 2007. He is a graduate of the Area Development Partnership's Leadership Pinebelt, received the Mississippi Top 50 under 40 award in 2016, and received the Mississippi's Top Entrepreneur award in 2019. In addition to professional activities, Kelly also serves as a deacon at Temple Baptist Church,, member of The Gideon's International, board member for Pi Kappa Phi Alumni Association and the United Way of Southeast Mississippi, and many others. His areas of professional interest and expertise include healthcare, education, business, technology, economic development, and politics.

Ryan Kelly
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Patty Harper, RHIA, CHTS-PW, CHTS-IM, CHC®
InQuiseek Consulting
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318-243-2687

Patty Harper is CEO of InQuiseek, LLC, a business and healthcare consulting company based in Louisiana. She has over 21 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. Patty holds a B.S. in Health Information Administration (cum laude) from Louisiana Tech University. She is credentialed through AHIMA as a RHIA, CHTS-IM, and CHTS-PW. Patty successfully completed AHIMA's ICD-10 Academy and has been recognized as an ICD-10 Trainer. She is also Certified in Healthcare Compliance (CHC®) thorough the Compliance Certification Board. Patty is a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other reimbursement-related topics. She has held memberships regional, state and national organizations throughout her healthcare career including NARHC, NRHA, AHIMA, MGMA, and HFMA. Patty currently serves on the Board of NARHC and LRHA.

TheComplianceTeam™ Exemplary Provider® Accreditation

Kate Hill-Kate is a graduate of Einstein Medical Center School of Nursing. As an Army Nurse, Kate served in Viet Nam where she was awarded the Bronze Star for meritorious service. Kate joined The Compliance Team in early 2012 to direct TCT's rural health clinic accreditation program & has fallen in love with Rural. As VP of Clinical Services, she has spearheaded the TCT Rural Health Clinic Accreditation program combining her clinical expertise, business acumen & passion for delivery of the best care possible to every patient. She presently serves on the NARHC Board. Her years of business & nursing experience combined well to contribute meaningfully to the NARHC board. She feels fortunate to have been able to speak at numerous state & national meetings about RHC compliance countrywide which gave her the opportunity to learn firsthand the diverse regional issues clinics are facing. Kate is now also working with clinics in TCT's PCMH program & is seeing that a PCMH accreditation is being increasingly rewarded by payers. Kate also serves on the NRHA Rural congress and is always advocating for Rural Health Clinics. Kate lives in suburban Philadelphia with her husband and near her three granddaughters. She loves teaching Sunday school to the 4s. She's happy to share photos anytime.

Charles James, Jr.-Charles took the position of President & CEO in 2004 after the loss of the company founder, Charles James, Sr. North American celebrates its 25th year in business in 2017. Charles began his career with James Clinic running the IT department. As part of North American, Charles has overseen & helped develop all aspects of the company. Today, North American is a proud gold-certified, Aprima EHR/PRM. In addition, he provides Revenue Cycle Management, RHC certification/cost reporting/Annual Evaluations, Provider Enrollment, and Financial Consulting to all types of healthcare entities.


?
MEET THE
PANELISTS

Elsie Crawford, RN, BSN, MHA, VP of Operations, Wilkens Medical Group / Surveyor, AAAASF, Jellico, TN

Elsie is a certified Medicare RHC surveyor & works for AAAASF doing clinic surveys. She also serves on 3 Boards of Directors: NARHC, KYPCA, & the TN Rural Health Assn. Additionally, she is the VP of Operations & Director of Nursing with Wilkens Medical Group since 1974 where she manages clinics in KY & TN.

Elsie attended Cumberland College & Carson Newman College for BA & Roane State Community College for Nursing.

Elsie has served on the board of The TN College of Applied Science (Nursing Division) since 2004, Board Member of NARHC since 2006, Jellico SDA Church School Board Member (Treasurer) for 9 years & Jellico City Council for 12 years.

Julie Quinn, CPA, VP Cost Reporting & Provider Education
jquinn@hsagroup.net
231-250-0244

Ms. Quinn is a CPA with over 20 years experience in governmental cost reporting, 15 of which she spent in the Medicare Contractor arena. During her years with Medicare, she managed an audit staff responsible for the tentative and final settlement of independent RHC cost reports in 15 states. She served as Compliance Officer for a Medicare Contractor prior to joining Health Services Associates as Vice President of Cost Reporting and Provider Education in 2010. Ms. Quinn has worked with policy personnel at CMS in the development and clarification of CMS policy for specialty providers including Rural Health Clinics. She has worked closely with CMS on interpretation and reporting for HIPAA and privacy issues. She wrote position papers and defended those positions in official intermediary hearings and has worked with congressional offices for issue resolution. In her current role, she assists RHCs with cost reporting, audit resolution, rate setting and various cost issues. Ms. Quinn also works to provide educational opportunities for RHCs across the nation through webinars and presentations at conferences for NARHC, NRHA and state associations.

Tom Terranova - AAAASF

- **Tom Terranova received a BA in Political Science and Government from Loyola University Chicago, an MA in International Relations and Affairs from the University of Chicago, and a JD in International and Comparative Law from Loyola University Chicago School of Law. He is currently pursuing an MBA in International Business from the Quinlan School of Business at Loyola University Chicago.**

ArchProCoding

Association for Rural & Community Health Professional Coding

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Gary Lucas- Gary serves as Senior Adjunct Faculty for the rural health & state/federally-funded medical community. His focus is on helping clients manage the transition to ICD-10 by integrating clinical documentation regulations into the organization's business ops. He prepares a plan unifying its people, processes, & technologies, i.e. EHRs. Gary was previously with The Medical Mgm Institute as Senior Instructor/Director where he taught 1300+ courses on physician medical records documentation, revenue cycle compliance, prof. coding, & medical billing in 46 states. Gary has been an AAPC certified CPC & CPC-Instructor for 12+ years. From 2007- 2012, Gary provided federal healthcare & IT management consulting services with Booz Allen Hamilton to large medical centers, Military Health Systems (US & international), VA Medical Cnts, the CDC, medical device manufacturers, CMS, pharmaceutical companies, & state rural health, primary care, & hospital associations. He earned his M.S. in Health Informatics from the University of Illinois in 2014, preceded by a B.A. from the University of Georgia's Terry College of Business in 1994.

MIDWEST HEALTH CARE

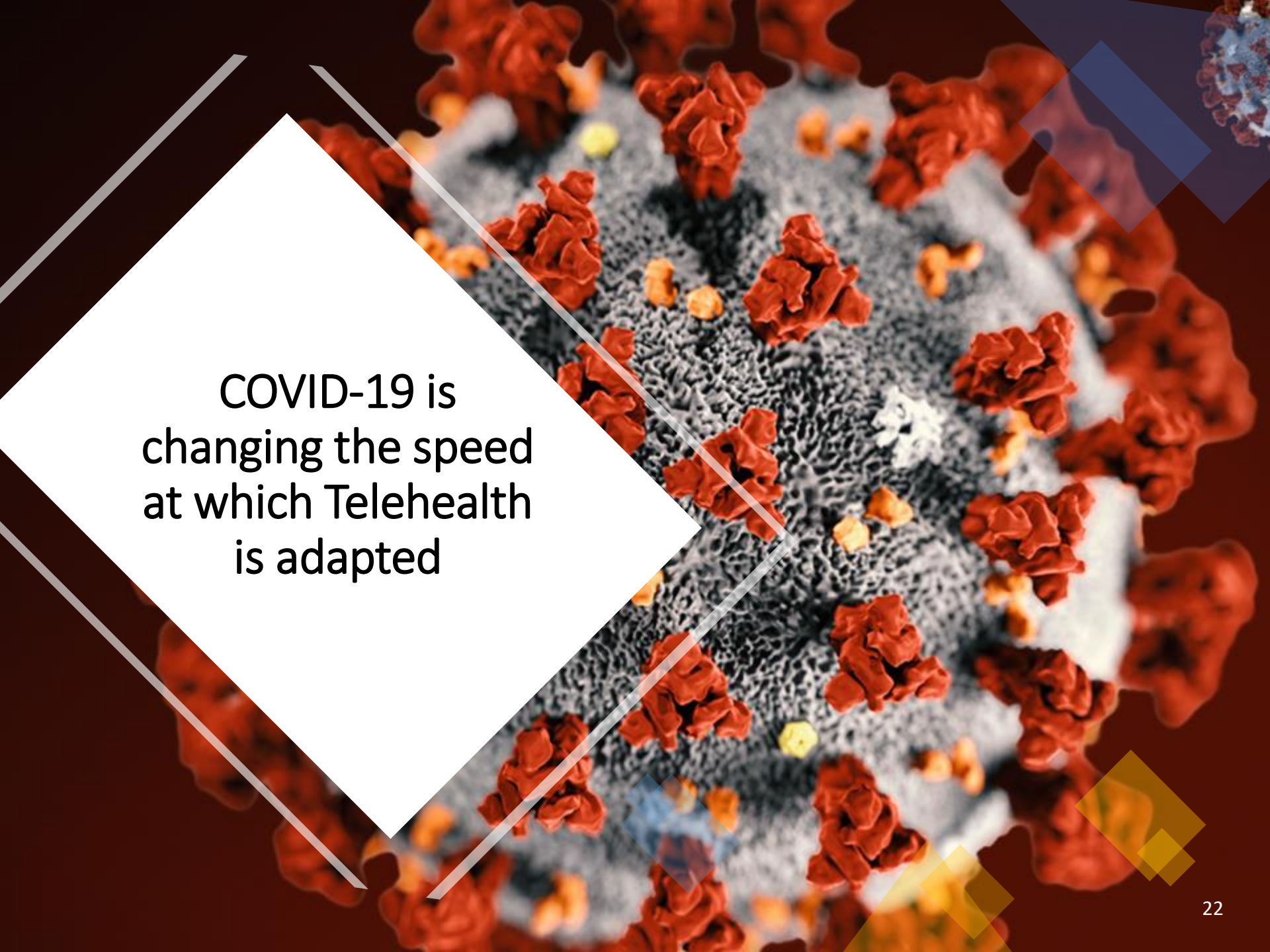
Glen Beussink

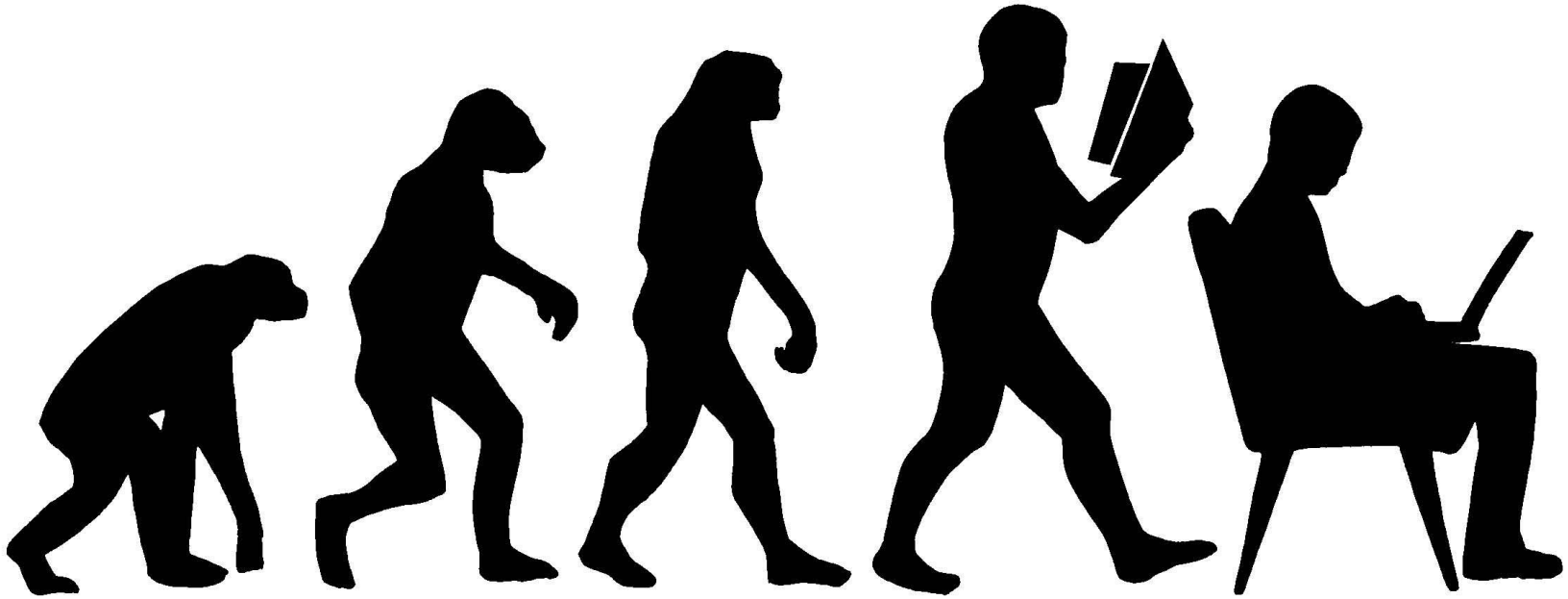
My desire to serve as a NARHC Board Member comes on the desire to help my clients improve their business, but also serve those in need in rural America. I can remember when my grandparents talked about Medicare as a benefit to their family & friends in the mid 60's. Almost immediately in the mid 70's the discussion went to all the doctors leaving the rural areas of SE MO. I have always had a desire to serve those in need & served on many boards, including scouting, schools, state assns & most importantly I am currently developing a school in Haiti, which is now in operation. I want to improve, serve & add value to a growing important part of health care in rural America. Serving is part of me & I would like to serve on the NARHC board. After nearly 20 years in health care, Glen has become a trusted advisor in the RHC business. Glen spent 20 years prior to this in the private sector developing business distribution models. Glen has developed clinics through the Midwest and Southeast. He is a trusted advisor to some of the largest hospital organizations & smallest independent RHCs. His desire of knowledge leads him to hours of reading in the Federal Register. He has presented & attended numerous conferences on the subject of Rural Health Clinics and dedicated his career to clinic conversion and regulation compliance.

Glen Beussink
Director of Clinic Development & Research, Midwest Health Care, Inc., Cape Girardeau, MO 63703
gbeussink@mwhc.net

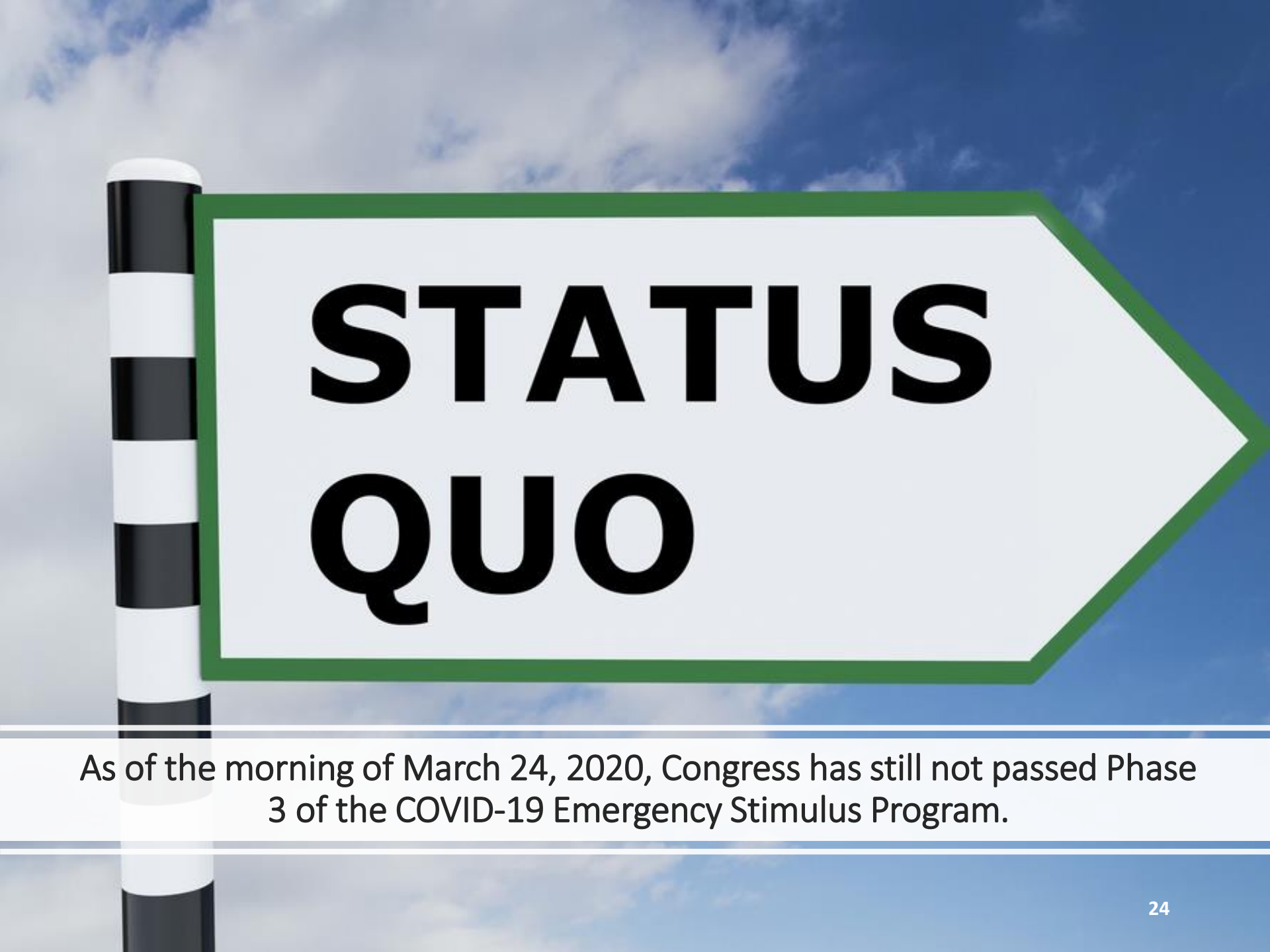
Telehealth is Changing the way healthcare is delivered

COVID-19 is changing the speed at which Telehealth is adapted





The Purpose of this webinar is to help RHCs adapt to change caused by COVID-19 and the need to rapidly adopt Telemedicine by RHCs



As of the morning of March 24, 2020, Congress has still not passed Phase 3 of the COVID-19 Emergency Stimulus Program.

We will be talking mostly about Medicare rules which do not always apply to other payers

Because Medicare does not pay RHCs as Distant Site Providers does that mean an RHC can not provide Telehealth Services?

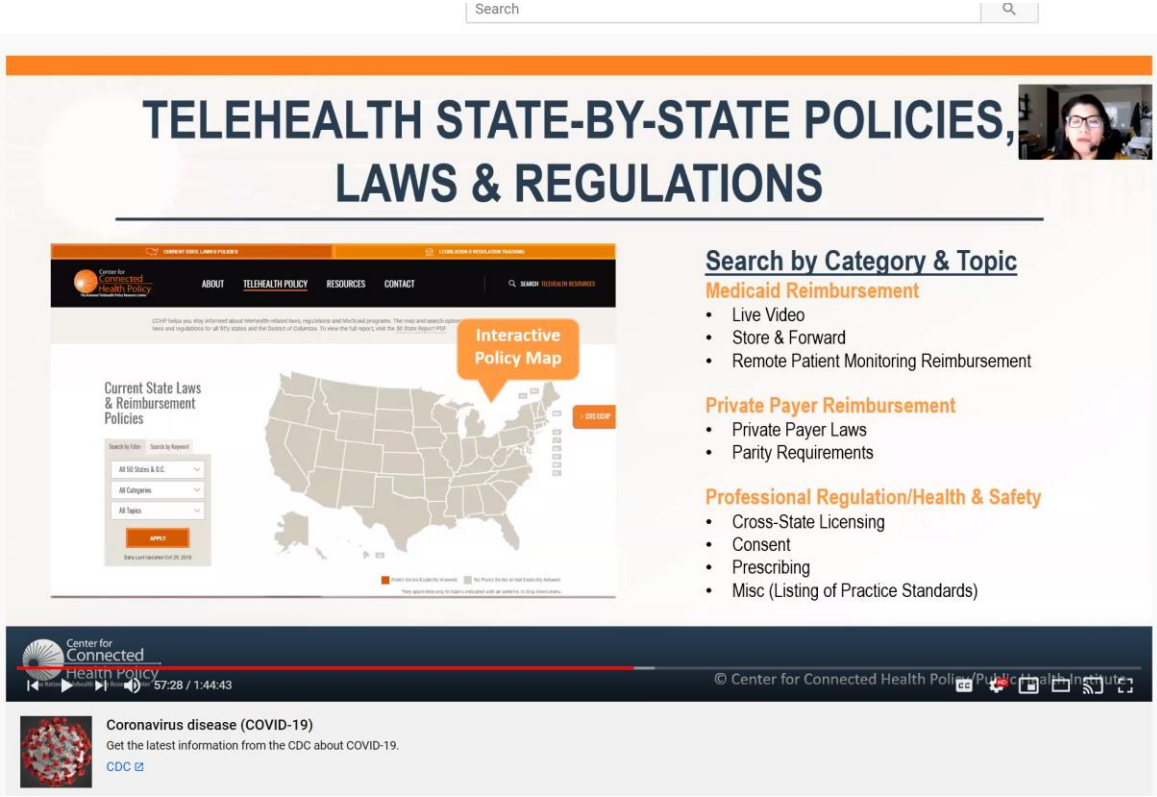
No. RHCs can be a distant site for Medicaid in some states and for most insurance plans. Follow the Golden Rule. "He who has the Gold makes the rules".

https://www.cchpca.org/resources/covid-19-related-state-actions?utm_source=Telehealth+Enthusiasts&utm_campaign=e9dfb9c33f-EMAIL_CAMPAIGN_2020_03_20_01_02&utm_medium=email&utm_term=0_ae00b0e89a-e9dfb9c33f-353242051

How Medicare RHC Regulations have slowed the growth of Telehealth

- The Patient must be located at specific originating sites
- RHCs can not be Distant Sites
- Telehealth costs are currently not used to compute the AIR.

Where can I find more information on Telehealth Policies, Laws, and Regulations (start at the 55th minute)
https://www.cchpca.org/



https://www.youtube.com/watch?v=HtMYM9zdqM0&feature=youtu.be&list=PLJ3YvVX2HpzVXTnfXMUG_dd6RcGWd4Pt7&utm_source=Telehealth+Enthusiasts&utm_campaign=e9dfb9c33f-EMAIL_CAMPAIGN_2020_03_20_01_02&utm_medium=email&utm_term=0_ae00b0e89a-e9dfb9c33f-353242051

Recording

CMS TELEHEALTH POLICY - NOW

PRE-COVID-19	WITH WAIVER INSTITUTED
Geographic Limitation (must take place rural area/non-MSA)	Temporarily waived. All geographic locations now qualify
Specific type of health site (specific list of eligible facilities and narrow exceptions for the home)	Temporarily waived. Other locations can now act as the originating site such as the home.
Eligible Providers (specific list of providers)	No change. FQHCs and RHCs, allied health professionals still cannot act as distant site providers.
Modality – Live Video with Hawaii & Alaska allowed to use Store & Forward	No change. However, some services can be provided via "technology-based communications" that are not considered "telehealth" by Medicare
Services	No change. However, CMS has said that the removal of the location restrictions will apply to delivery of all eligible services that are reimbursed if provided via telehealth, not just those related to treatment of COVID-19
Facility Fee	Any sites that come in under the waiver (ex: hospital in an urban area) are NOT eligible to receive a facility fee.

https://www.cchpca.org/

CMS TELEHEALTH POLICY - NOW

OTHER QUESTIONS	CMS FAQ
HR 6074 said to utilize telehealth to provide services under the waiver, I need a prior existing relationship.	That requirement is still there but CMS has said that HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.
Do co-pays and out-of-pockets still apply?	Still applies, but the OIG is providing health care providers flexibility to reduce or waive fees.
Can smartphones be used?	Under HR 6074, yes.
How much flexibility do I have under HIPAA now? Is Facetime OK?	OCR "will exercise enforcement discretion and waive penalties for HIPAA violations." Keep in mind you may still have state requirements to meet. OCR guidance: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
Licensure	It appears the licensure requirement to be licensed in the state the patient is located in was waived for Medicare reimbursement. Does not impact state law.

CMS FAQ - https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

https://www.cchpca.org/

TECHNOLOGY ENABLED/COMMUNICATIONS-BASED SERVICES

SERVICE	MODALITY	AVAILABLE TO FQHC/RHC
Virtual Check-In Codes G2010, G2012	Live Video, Store-and-Forward or Phone	Yes
Interprofessional Telephone/Internet/EHR Consultations (eConsult) 99446, 99447, 99448, 99449, 99451, 99452	Can be over phone, live video or store-and-forward	No
Remote monitoring services: Chronic Care Management (CCM); Complex Chronic Care Management (Complex CCM); Transitional Care Management (TCM); Remote Physiologic Monitoring (Remote PM); Principle Care Management (PCM)	RPM	CCM, TCM
Online Digital Evaluation (E-*Visit) – G2061-2063 Online medical Evaluations – 99421-99423	Online portal	No

https://www.cchpca.org/

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Newsroom Press Kit Data Contact Blog Podcast Search

Fact sheet

MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET

Mar 17, 2020 | Telehealth

Share

Medicare coverage and payment of virtual services

INTRODUCTION:

Under President Trump's leadership, the Centers for Medicare & Medicaid Services (CMS) has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility. These policy changes build on the regulatory flexibilities granted under the President's emergency declaration. CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. The benefits are part of the broader effort by CMS and the White House Task Force to ensure that all Americans – particularly those at high-risk of complications from the virus that causes the disease COVID-19 – are aware of easy-to-use, accessible benefits that can help keep them healthy while helping to contain the community spread of this virus.

Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health. Innovative uses of this kind of technology in the provision of healthcare is increasing. And with the emergence of the virus causing the disease COVID-19, there is an urgency to expand the use of technology to help people who need routine care, and keep vulnerable beneficiaries and beneficiaries with mild symptoms in their homes while maintaining access to the care they need. Limiting community spread of the virus, as well as limiting the exposure to other patients and staff members will slow viral spread.

EXPANSION OF TELEHEALTH WITH 1135 WAIVER: Under this new waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Related Releases

Trump Administration Releases COVID-19 Checklists and Tools to Accelerate Relief for State Medicaid & CHIP Programs
Mar 22, 2020

President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak
Mar 17, 2020

Telehealth Benefits in Medicare are a Lifeline for Patients During Coronavirus Outbreak
Mar 09, 2020

COVID-19 Response News Alert: CMS Issues Frequently Asked Questions to Assist Medicare Providers
Mar 06, 2020

CMS Selects Applicants for Participation in Innovative Payment Model with New Emergency Treatment and Transport Options
Feb 27, 2020

Contact us

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202-690-6145

KEY TELEHEALTH TAKEAWAYS

- *Effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances.*

- *These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.*

- *Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings. (Does this language override the prohibition of RHCs being distant sites? No, is the answer from CMS, NARHC, NRHA, CCHP)*

Key Telehealth Takeaways (2)

- ***While they must generally travel to or be located in certain types of originating sites such as a physician's office, skilled nursing facility or hospital for the visit, effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home. (No longer restricted to originating sites)***

- ***The Medicare coinsurance and deductible would generally apply to these services. However, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.***

- ***To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency. (New patients are allowed during the duration of the National Emergency.)***

Originating Sites for Telemedicine can now be in urban areas and can be initiated from a patient's home

Telehealth Medicare Fact Sheet

TELEHEALTH SERVICES

Target Audience: Medicare Fee-For-Service Providers

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

Medicare Originating Sites

ORIGINATING SITES

An originating site is the location where a Medicare beneficiary gets physician or practitioner medical services through a telecommunications system. The beneficiary must go to the originating site for the services located in either:

- A county outside a Metropolitan Statistical Area (MSA)
- A rural Health Professional Shortage Area (HPSA) in a rural census tract

The Health Resources and Services Administration (HRSA) decides HPSAs, and the Census Bureau decides MSAs. To see a potential Medicare telehealth originating site's payment eligibility, go to HRSA's Medicare Telehealth Payment Eligibility Analyzer.

Providers qualify as originating sites, regardless of location, if they were participating in a Federal telemedicine demonstration project approved by (or getting funding from) the U.S. Department of Health & Human Services as of December 31, 2000.

Beginning July 1, 2019, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act removes the originating site geographic conditions and adds an individual's home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder.

Waived duration of National Emergency

Each December 31 of the prior calendar year (CY), an originating site's geographic eligibility is based on the area's status. This eligibility continues for a full CY. Authorized originating sites include:

- Physician and practitioner offices
- Hospitals
- Critical Access Hospitals (CAHs)
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNFs)
- Community Mental Health Centers (CMHCs)
- Renal Dialysis Facilities
- Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis
- Mobile Stroke Units

Note: Medicare does not apply originating site geographic conditions to hospital-based and CAH-based renal dialysis centers, renal dialysis facilities, and beneficiary homes when practitioners furnish monthly home dialysis ESRD-related medical evaluations. Independent Renal Dialysis Facilities are not eligible originating sites.

Beginning January 1, 2019, the Bipartisan Budget Act of 2018 removed the originating site geographic conditions and added eligible originating sites to diagnose, evaluate, or treat symptoms of an acute stroke. Go to MLN Matters® article, New Modifier for Expanding the Use of Telehealth for Individuals with Stroke to learn how to use the new modifier for billing.

Waived duration of National Emergency

TELEHEALTH ORIGINATING SITES BILLING AND PAYMENT

HCPCS Code Q3014 describes the Medicare telehealth originating sites facility fee. Bill your MAC f
the separately billable Part B originating site facility fee.

Note: The originating site facility fee does not count toward the number of services used to determir
payment for partial hospitalization services when a CMHC serves as an originating site.

This is not helpful during the COVID-19 Pandemic as it has to done in the RHC.
No Originating site fee is paid if the originating site is the home.

HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $26.15. Payment would be $20.92.

Procedure Code	Description	Effective Date	Modifier	
Q3014	Telehealth facility fee	01/01/2019		Display

	01/01/2019	**Locality:**	35
	Tennessee	**Modifier:**	
e	Q3014		

	Non-Facility	Facility	OPPS Cap Non-Facility	OPPS Cap Facility	Reduced Th
mount:	$0.00	$0.00	$0.00	$0.00	
ing Amount:	$0.00	$0.00	$0.00	$0.00	
e Amount:	$0.00	$0.00	$0.00	$0.00	

https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

Medicare Telehealth Frequently Asked Questions (FAQs)
March 17, 2020

1. **Q: How will recently enacted legislation allow CMS to utilize Medicare telehealth to address the declared Coronavirus (COVID-19) public health emergency?**

   A: The Coronavirus Preparedness and Response Supplemental Appropriations Act, as signed into law by the President on March 6, 2020, includes a provision allowing the Secretary of the Department of Health and Human Services to waive certain Medicare telehealth payment requirements during the Public Health Emergency (PHE) declared by the Secretary of Health and Human Services January 31, 2020 to allow beneficiaries in all areas of the country to receive telehealth services, including at their home.

2. **Q: What does this mean? What payment requirements for Medicare telehealth services are affected by the waiver?**

   A: Under the waiver, limitations on where Medicare patients are eligible for telehealth will be removed during the emergency. In particular, patients outside of rural areas, and patients in their homes will be eligible for telehealth services, effective for services starting March 6, 2020.

3. **Q: Why wasn't this done before?**

   A: Current telehealth law only allows Medicare to pay practitioners for services like routine visits furnished through telehealth under certain circumstances. For example, the beneficiary receiving those services must generally be located in a rural area and in a medical facility. Where the beneficiary receives those services is known as the "eligible originating site." The beneficiary's home is generally not an eligible originating site, but under the new 1135 waiver, this will be waived during the emergency. This will now allow telehealth services to be provided in all settings – including at a patient's home.

4. **Q: What services can be provided by telehealth under the new emergency declaration?**

   A: CMS maintains a list of services that are normally furnished in-person that may be furnished via Medicare telehealth. This list is available here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes. These services are described by HCPCS codes and paid under the Physician Fee Schedule. Under the emergency declaration and waivers, these services may be provided to patients by professionals regardless of patient location.

   Medicare pays separately for other professional services that are commonly furnished remotely using telecommunications technology without restrictions that apply to Medicare Telehealth. These services, including physician interpretation of diagnostic tests, care management services and virtual check-ins, are normally furnished through communication technology.

New Patients are allowable during the State of National Emergency

7. Q: Will CMS enforce an established relationship requirement?

A: No. It is imperative during this public health emergency that patients avoid travel, when possible, to physicians' offices, clinics, hospitals, or other health care facilities where they could risk their own or others' exposure to further illness. Accordingly, the Department of Health and Human Services (HHS) is announcing a policy of enforcement discretion for Medicare telehealth services furnished pursuant to the waiver under section 1135(b)(8) of the Act. To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

The Ryan Haight Act normally prohibits this:

https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/ryan-haight-act

13. Q: Can hospitals, nursing homes, home health agencies or other healthcare facilities bill for telehealth services?

A: Billing for Medicare telehealth services is limited to professionals. (Like other professional services, Critical Access Hospitals can report their telehealth services under CAH Method II). If a beneficiary is in a health care facility (even if the facility is not in a rural area or not in a health professional shortage area) and receives a service via telehealth, the health care facility would only be eligible to bill for the originating site facility fee, which is reported under HCPCS code Q3014. But the professional services can be paid for.

This means RHCs can not be a Distant Site as of 3/23/2020

March 15, 2019

Medicare Fee-For-Service

Additional Emergency and Disaster-Related Policies and Procedures That May Be Implemented Only With a § 1135 Waiver

Source Document

https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf

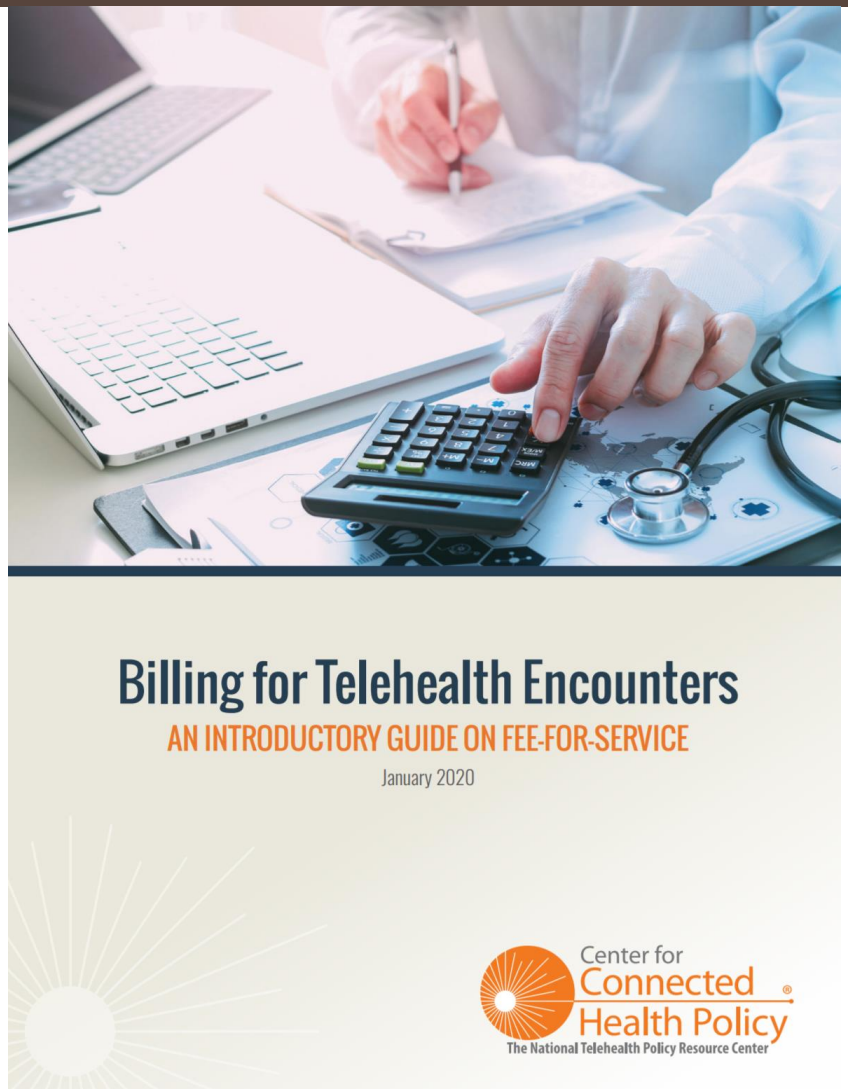
Contents

Question - Can staff provider RHCs services offsite that qualify for the AIR, ie at home virtually?

Answer: No.

V – Rural Health Clinics / Federally Qualified Health Centers

Question Number	Question and Answer
1135V-1	**Question:** If physicians that staff a rural health clinic (RHC) are displaced due to an emergency, may they continue to furnish and bill Medicare for RHC services at a non-RHC location? **Response:** In this circumstance, Medicare coverage or payment rules cannot be waived, even in a disaster or emergency. Only clinics that are certified as RHCs and enrolled in Medicare may bill and be paid for Medicare RHC services. Physicians that are enrolled in Medicare that furnish physicians' services at non-RHC locations may bill Medicare Part B under their own national provider identifiers (NPIs) **Updated:** 12/4/18



https://www.cchpca.org/sites/default/files/2020-01/Billing%20Guide%20for%20Telehealth%20Encounters_FINAL.pdf

Summary of Medicare Telehealth Services

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010 G0071 for RHCs	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

X – Medicare does not pay these codes in RHCs

REMOTE EVALUATION AND VIRTUAL CHECK-IN

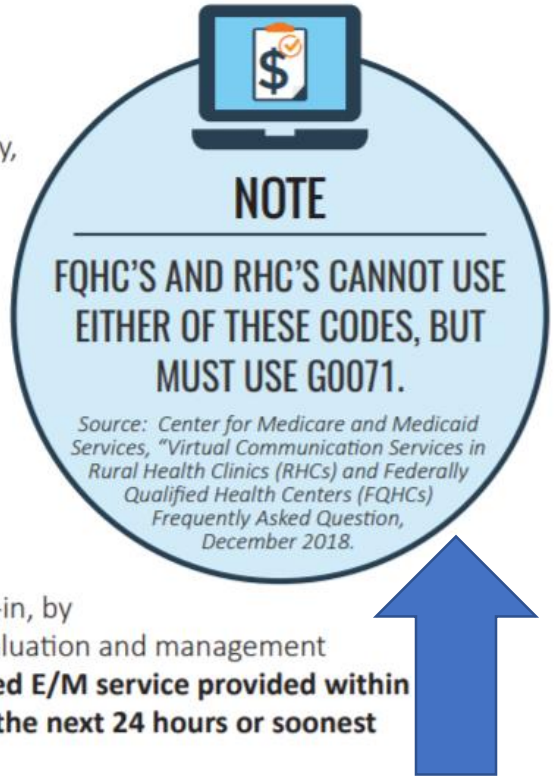
In CY 2019, CMS finalized codes that will benefit from the annual consent policy, as above, and amplified education about cost-sharing. However, there are strict before and after time parameters to consider. These are:

G2010 (Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store-and-forward), including interpretation with follow-up with the patient within 24 business hours, **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)**

And

G2012 (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, **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)

[Emphasis added.]



Last year's Federal Register noted that the G2012 would also be a response to a patient-initiated communication, "[W]e expect that these services would be initiated by the patient, especially since many beneficiaries would be financially liable for sharing in the cost of these services."[10] One could surmise that the annual consent would potentially negate this expectation, since it is basing the expectation on having to inform the patient that this service will result in cost-sharing.

Can we bill for remote patient monitoring CPT codes 99453,99454?

3/20/2020 @ 12:04:00 PM

Contributor: pharper@inquiseek.com

No, RHCs cannot bill for remote patient monitoring.

Patty Harper, RHIA, CHTS-IM, CHTS-PW, CHCR

Healthcare Consultant/Principal

Source:
https://www.web.narhc.org/DiscussionForums/DiscussionDetail.asp?THREADID=15687&ENTRYID=15688&TopicText=NARHC%2DNews&AREA=1

Virtual Visits billable for RHCs pays at $13.69 (2019)

New Virtual Communication Services

Effective January 1, 2019, 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, and both of the following requirements are met:

- 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.

To receive payment for Virtual Communication services, RHCs must submit an RHC claim with HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services. Payment for 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. See Virtual Communication Services Frequently Asked Questions (PDF)

RHC face-to-face requirements are waived when these services are furnished to an RHC patient, and coinsurance and deductibles apply.

Can be a new patient during the National emergency

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

16. Q: How is this different from virtual check-ins and e-visits?

A: A virtual check-in pays professionals for brief (5-10 min) communications that mitigate the need for an in-person visit, whereas a visit furnished via Medicare telehealth is treated the same as an in-person visit, and can be billed using the code for that service, using place of service 02 to indicate the service was performed via telehealth. An e-visit is when a beneficiary communicates with their doctors through online patient portals.

9. **Q: How does a qualified provider bill for telehealth services?**

   A: Medicare telehealth services are generally billed as if the service had been furnished in-person. For Medicare telehealth services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site.

RHCs can not bill this way

10. **Q: How much does Medicare pay for telehealth services?**

    A: Medicare pays the same amount for telehealth services as it would if the service were furnished in person. For services that have different rates in the office versus the facility (the site of service payment differential), Medicare uses the facility payment rate when services are furnished via telehealth.

How long and how much is this going to cost patients?

11. Q: Are there beneficiary out of pocket costs for telehealth services?

A: The use of telehealth does not change the out of pocket costs for beneficiaries with Original Medicare. Beneficiaries are generally liable for their deductible and coinsurance; however, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

12. Q: How long does the telehealth waiver last?

A: The telehealth waiver will be effective until the PHE declared by the Secretary of HHS on January 31, 2020 ends.

Place of Service and Modifiers

Your Telehealth Guide: Billing and CPT Codes

Billing for telehealth can seem complicated and intimidating. That's understandable since there are so many moving parts such as ever-changing legislation and laws related to Medicare and Medicaid. But it may be easier than you think. Here we break down what you need to know about CPT codes.

Understand the CPT codes

CPT Code: Current Procedural Terminology, a medical code set that's used to report medical, surgical and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.

GT: Used for interactive audio and video telecommunications systems. This modifier tells the payer that a provider delivered service via telemedicine.

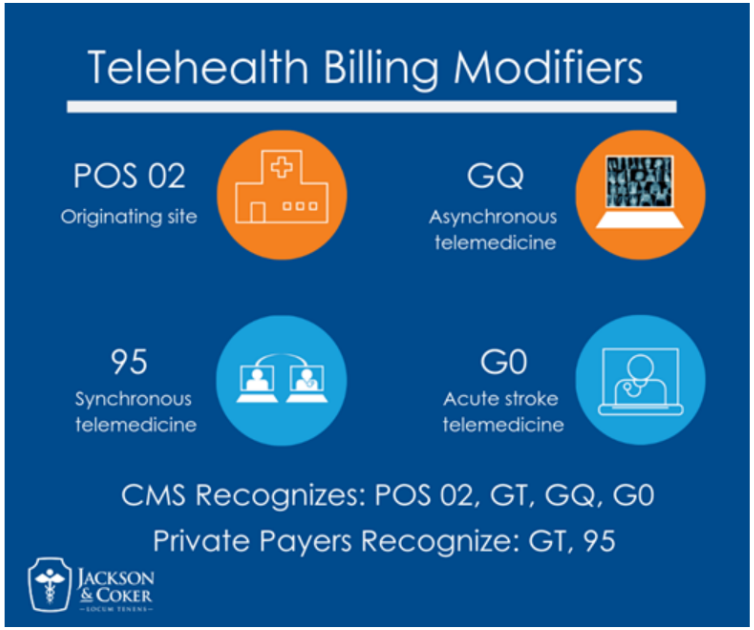
GQ: Used for telehealth service rendered via asynchronous telecommunications system – store-and-forward patient medical data.

95: Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.

G0: Telehealth services for diagnosis, evaluation or treatment of systems of an acute stroke – must be included for Medicare and Medicaid plans.

POS 02: The location where health services and health-related services are provided or received by an eligible Medicare beneficiary, through a telecommunication system. Can be used for synchronous telemedicine visits. Also known as an originating site.

For more information on 2019 CPT codes, visit here.



https://jacksoncoker.com/telehealth/how-it-works/telemedicine-billing-and-cpt-codes/

MODIFIERS AND REVENUE CODE

A modifier[8], according to Noridian, based upon information provided by the AMA is as follows:

- Modifiers can be two digit numbers, two character modifiers, or alpha-numeric indicators. Modifiers provide additional information to payers to make sure your provider gets paid correctly for services rendered.
- If appropriate, more than one modifier may be used with a single procedure code; however, they are not applicable for every category of the CPT codes. Some modifiers can only be used with a particular category and some are not compatible with others.

For Medicare, a modifier is only required for the following:

- **G0** (zero): Used to identify telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.
- **GQ** (not used outside of Alaska or Hawaii): asynchronous telehealth service.
- **GT**: Critical Access Hospital distant site providers billing under CAH Optional Method II. This goes on an instiutional claim and pays 80% of the Professional Fee Service rate.
- **GY**: Notice of Liability Not Issued, Not Required Under Payer Policy. Used to report that an Advanced Beneficiary Notice (ABN) was not issued because item or service is statutorily excluded or does not meet definition of any Medicare benefit.

Managed care and private plan policies on what modifier or POS to use vary. Always check with the plan to see what they require.

Revenue Code 780

Revenue Code 780 is used for telemedicine institutional claims[9]. There is a lot of information concerning the CMS 1500 and professional fee services; however, there is minimal information about submitting institutional billing, except when referencing an FQHC or RHC. Examples will be provided below when this is appropriate to submit on a UB-04.

Question and Answer from CMS on Telehealth Modifiers

18. Q: Will CMS require specific modifiers to be applied to the existing codes?

A: CMS is not requiring additional or different modifiers associated with telehealth services furnished under these waivers. However, consistent with current rules, there are three scenarios where modifiers are required on Medicare telehealth claims. In cases when a telehealth service is furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii, the GQ modifier is required. When a telehealth service is billed under CAH Method II, the GT modifier is required. Finally, when telehealth service is furnished for purposes of diagnosis and treatment of an acute stroke, the G0 modifier is required.

PLACE OF SERVICE

CMS publishes a Place of Service (POS) code list, here[6], so that a practitioner can "tell" the insurer via the billing form where the provider and patient were located during a health encounter. For synchronous telehealth services in Medicare, a POS 02 must go on the bill. The POS used when the services are not synchronous is where the service took place at the time of the encounter.

Medi-Cal's policy

Medi-Cal's policy is: "The distant site for purposes of telehealth can be different from the administrative location." An interpretation of this statement, based on the above discussion, would indicate that the POS 02 address for Box 32 means – the practitioner's "usual" place of business.

This also has implications on what address goes onto the bill. Prior to POS 02, the rule for selecting the POS for telehealth encounter was "where the beneficiary was at the time of the encounter." Thus, the originating site was placed in Box 32. Now, however, based on a a letter exchange between CTeL members and CMS regarding POS 02, CMS indicated that "… practitioners must use the address where they typically practice in Box 32. If they work part of the time out of a clinic and part of the time out of their home, they may use the clinic address. If they work out of their home 100% of the time, as some providers do, they must use their home address." CTeL analysts indicated that "Medicare determines payment amounts based on a number of different factors that make up their Physician Fee Schedule formula. In short, part of the payment formula is based on the locality of the practitioner at the time of service—there are different rates for different localities. This is why Box 32 exists: to let CMS know which payment rate to slot into the formula for accurate reimbursement."

Note that California's Medicare Administrative Contractor (MAC), Noridian, recently held a webinar on Enrollment for Telehealth. According to Noridian, if the provider assigns their enrollment rights to a group or facility, then the group address is what is indicated on the CMS 1500, with the practitioner's address known to CMS, but billed through the group entity.[7]

EXAMPLES

PATIENT 1: The practitioner documented a synchronous telehealth visit, with an established, follow-up patient, aged 65, for a level 3 problem (99213), with a diagnosis XX. *Insurance: Medicare*

CODE IT:[35]

- Check the CMS Telehealth Services List. (CPT codes are listed in the first column, headed "Code.") 99213 is there, so CMS will pay 100% of the PAR fee. No Modifier needed, because POS is 02.

LIST OF MEDICARE TELEHEALTH SERVICES
CY 2019

Code	Short Descriptor
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99211	Office/outpatient visit est
99212	Office/outpatient visit est
99213	Office/outpatient visit est

	QUALIFIER + NDC OR UPN				UNIT QUALIFIER AND QUANTITY	
	DOS FROM	DOS THRU	POS	DELAY EMER	PROC CODE	MODIFIER
2	01 01 19	01 01 19	02		99213	
3						
4						
5						

- Check the patient's originating site clinic address on the HRSA site: Yes! The originating site qualifies for reimbursement.

✔ Yes

Yes, the geocoded address is eligible for Medicare telehealth payment.

Put the address of the distant site provider (your provider) in Box 32:

EDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT?
		PATIENT ACCOUNT NUMBER	YES NO
IGNATURE OF PHYSICIAN OR SUPPLIER ICLUDING DEGREES OR CREDENTIALS certify that the statements on the reverse pply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	
SIGNATURE OF PROVIDER		NAME AND ADDRESS OF SERVICE FACILITY	

2019-Novel Coronavirus (COVID-19) Medicare Provider Enrollment Relief Frequently Asked Questions (FAQs)

1. **How is CMS using its authority under Section 1135 of the Social Security Act to offer flexibilities with Medicare provider enrollment to support the 2019-Novel Coronavirus (COVID-19) national emergency?**

   CMS is exercising its 1135 waiver authority in the following ways:

   Physicians and Non-Physician Practitioners
   - Establish toll-free hotlines to enroll and receive temporary Medicare billing privileges
   - Waive the following screening requirements:
     - Criminal background checks associated with fingerprint-based criminal background checks (FCBC) - 42 C.F.R 424.518 (to the extent applicable)
     - Site visits - 42 C.F.R 424.517
     - Postpone all revalidation actions

   All Other Providers and Suppliers (including DMEPOS)
   - Expedite any pending or new applications
     - All clean web applications will be processed within 7 business days and all clean paper applications in 14 business days
   - Waive the following screening requirements for all enrollment applications received on or after March 1, 2020:
     - Application Fee – 42 C.F.R. 424.514
     - Criminal background checks associated with the FCBC – 42 C.F.R. 424.518 (to the extent applicable)
     - Site-visits – 42 C.F.R. 424.517
     - Postpone all revalidation actions

2. **What are the COVID-19 Medicare Provider Enrollment Hotlines?**

   CMS has established toll-free hotlines at each of the Medicare Administrative Contractors (MACs) to allow physicians and non-physician practitioners to initiate temporary Medicare billing privileges. The hotlines should also be used if providers/suppliers have questions regarding the other provider enrollment flexibilities afforded by the 1135 waiver. The hotlines can also be used for physicians and non-physician practitioners to report a change in practice location.

3. **What are the Medicare Provider Enrollment Hotline numbers and hours of operation?**

   The hotlines are operational Monday – Friday.

https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

11. Can the distant site practitioner furnish Medicare telehealth services from their home? Or do they have to be in a medical facility?

There are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home. The practitioner is required to update their Medicare enrollment with the home location. The practitioner can add their home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline. It would be effective immediately so practitioners could continue providing care without a disruption. More details about this enrollment requirement can be found at 42 CFR 424.516.

If the physician or non-physician practitioner reassigns their benefits to a clinic/group practice, the clinic/group practice is required to update their Medicare enrollment with the individuals' home location. The clinic/group practice can add the individual's home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline.

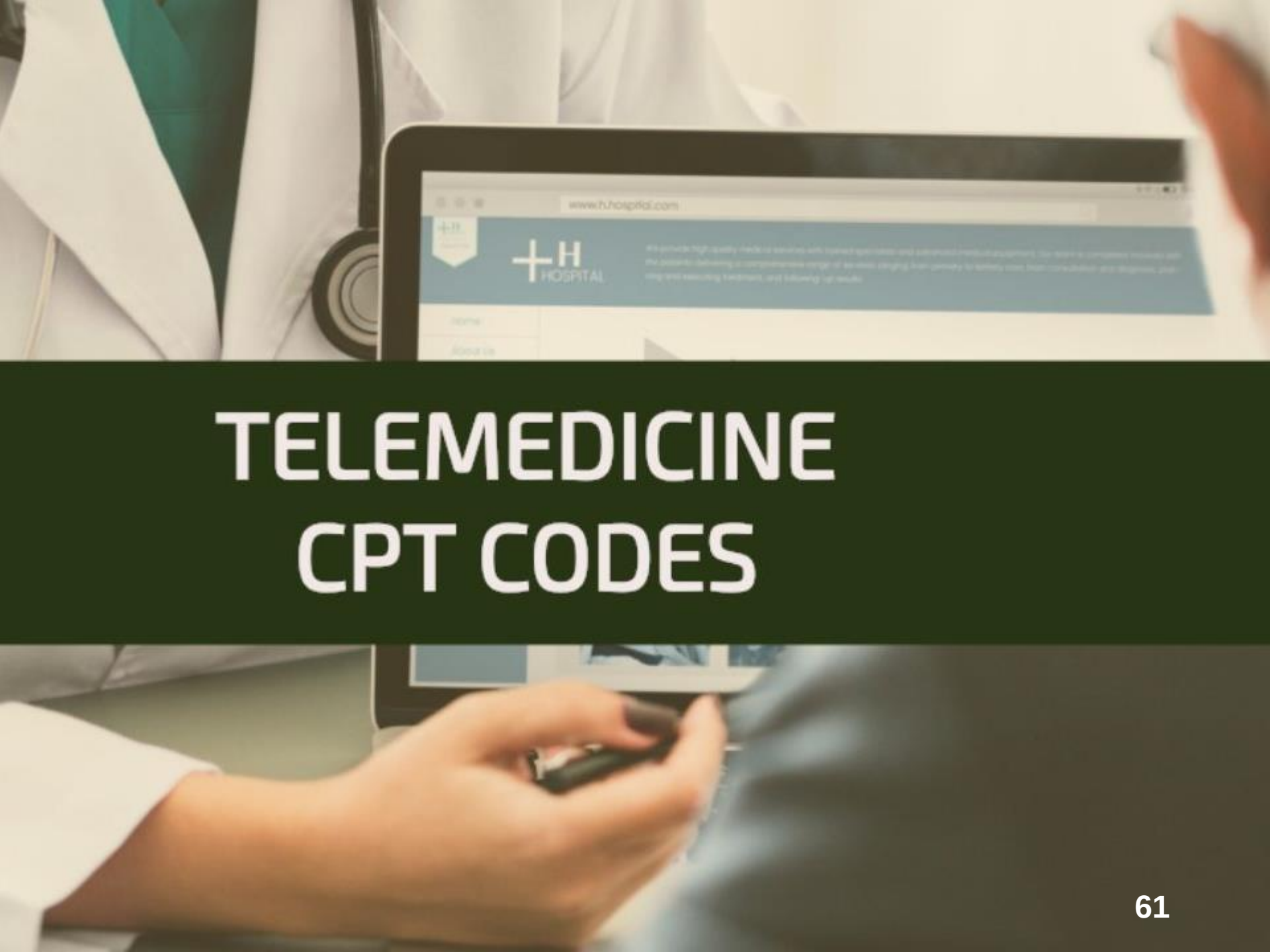
https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

Telehealth in a Rural Health Clinic

- **Case example**
- A Medicare patient presents to a rural health clinic complaining of a headache, nausea and vomiting. A clinical staff employee at the originating site escorts the patient to a room where the patient can interact with the provider using audiovisual equipment. The provider performs the necessary history, and a clinical staff employee obtains the clinical information, such as vital signs, requested by the provider. **How do we get vital signs?**

If the clinic has the appropriate equipment and personnel, diagnostic tests ordered by the provider are performed onsite. The provider renders the patient assessment and plan to be discussed with the patient. During this new patient encounter, the provider performs and documents a detailed history, an expanded problem-focused exam and moderate medical decision-making. Also included in the documentation is information stating that the service was provided through telehealth, the location of the patient and the provider, and the names of any other staff involved in the service.

For the distant site in this example, CPT code 99202 is billed with POS code 02 for the professional provider's service. The originating site should report HCPCS code Q3014 for the services provided.


TELEMEDICINE
CPT CODES

CMS Medicare Excel Listing of all Telehealth Codes

TELEHEALTH SERVICES

You must use an interactive audio and video telecommunications system that permits real-time communication between you at the distant site, and the beneficiary at the originating site.

Transmitting medical information to a physician or practitioner who reviews it later is permitted only in Alaska or Hawaii Federal telemedicine demonstration programs.

CY 2019 Medicare Telehealth Services

Service	HCPCS/CPT Code
Telehealth consultations, emergency department or initial inpatient	G0425–G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	G0406–G0408
Office or other outpatient visits	99201–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	99231–99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	99307–99310
Individual and group kidney disease education services	G0420–G0421
Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction furnished in the initial year training period to ensure effective injection training	G0108–G0109
Individual and group health and behavior assessment and intervention	96150–96154
Individual psychotherapy	90832–90838
Telehealth Pharmacologic Management	G0459
Psychiatric diagnostic interview examination	90791–90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90963

CY 2019 Medicare Telehealth Services (cont.)

Service	HCPCS/CPT Code
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 2–11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90964
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 12–19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90965
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older	90966
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age	90967
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 2–11 years of age	90968
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 12–19 years of age	90969
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	90970
Individual and group medical nutrition therapy	G0270, 97802–97804
Neurobehavioral status examination	96116
Smoking cessation services	G0436, G0437, 99406, 99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	G0396, G0397
Annual alcohol misuse screening, 15 minutes	G0442
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	G0443
Annual depression screening, 15 minutes	G0444

CY 2019 Medicare Telehealth Services (cont.)

Service	HCPCS/CPT Code
High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	G0446
Face-to-face behavioral counseling for obesity, 15 minutes	G0447
Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	99495
Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	99496
Advance Care Planning, 30 minutes	99497
Advance Care Planning, additional 30 minutes	99498
Psychoanalysis	90845
Family psychotherapy (without the patient present)	90846
Family psychotherapy (conjoint psychotherapy) (with patient present)	90847
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	99354
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	99355
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service)	99356
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service)	99357
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit	G0438

CY 2019 Medicare Telehealth Services (cont.)

Service	HCPCS/CPT Code
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit	G0439
Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth	G0508
Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	G0509
Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making	G0296
Interactive Complexity Psychiatry Services and Procedures	90785
Health Risk Assessment	96160, 96161
Comprehensive assessment of and care planning for patients requiring chronic care management	G0506
Psychotherapy for crisis	90839, 90840
Prolonged preventive services	G0513, G0514

A physician, NP, PA, or CNS must furnish at least one ESRD-related "hands on visit" (not telehealth) each month to examine the beneficiary's vascular access site.

Questions

1.Can the telehealth provider be on site at the RHC when doing a Medicare telehealth visit? (Can he do this in his office or does he have to be off site)? Virtual visits in the RHC are good. Other telehealth services would have to be offsite or during non-rhc hours.

2.For Medicare billing, do we just use usual 99211-99215 codes with a modifier? There is a listing of 4 pages of allowable CPT codes in this presentation. Use those codes and Place of service 02 when billing on the 1500 during non-rhc time or a non-rhc location.

3.What documentation specific to telehealth has to be in the documentation? It should be the same, but some of our panelist may be able to give a more detailed answer.

4.What codes do we use for private pay? GT or 95 are common

Senate Bill 4405 Quick Analysis

March 20, 2020: A draft of the Senate Republicans Phase 3 stimulus proposal was released yesterday and in Section 4405 starting at page 176 there is a provision for RHCs to be paid as distant sites for telehealth during the state of National Emergency. The provision would pay RHCs some type of composite rate that would be like the way Chronic Care Management is paid. The rate would most likely be much less than the all-inclusive rate especially for provider based RHCs that are attached to a hospital with less than 50 beds. Here is the document if you would like to read the provisions in the proposed bill. Please note this is just a draft of a proposed bill and does not reflect where the final bill will end up or even if this provision stays in the final bill.

https://www.documentcloud.org/documents/6815336-Senate-Republicans-Phase-3-stimulus-proposal.html

https://static1.squarespace.com/static/53c5f79de4b0f4932a3942a8/t/5e754c6b6e27d0443d24a5c7/1584745580181/2020+Review+of+RHC+Provisions+in+Phase+3+Funding+Bill.pdf

We would love the payment to be as follows

Option 1: RHCs would be paid at the All-Inclusive Rate (AIR) and the cost and visits to be included in the computation of the all-inclusive rate as expenses and visits that are a part of the AIR. This is what RHCs should be asking for when you talk to your Congressman.

As the bill is currently written

Option 2: RHCs would receive a fee for service based up a composite of the current Telehealth payments in Medicare Part B Fee for Service Fee Schedule similar to the chronic care management payment per 20 minutes of time. In this situation the Telehealth costs and visits would be excluded from the all-inclusive rate calculation when the cost report is prepared. The time the physician, NP, or PA worked providing the telehealth visit would also be excluded on Worksheet B, Part 1 of the independent cost report (Form 222-17) and Worksheet M-2 of the Provider-based cost report (Form 2552-10) so as not to adversely affect the productivity screen calculation.

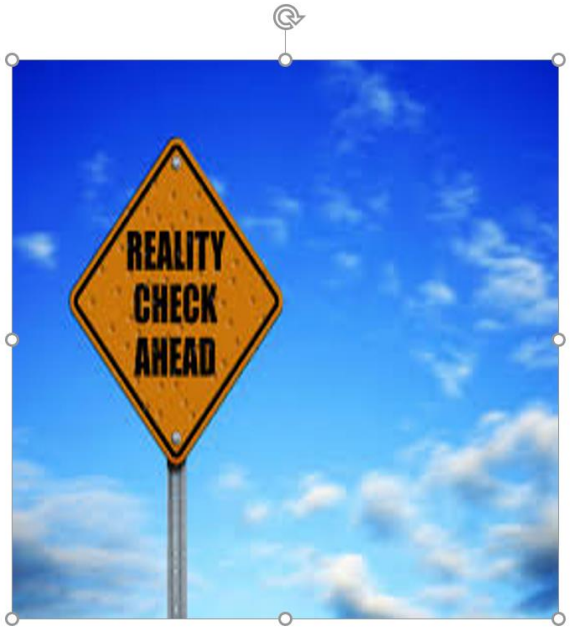
We, of course, want it to be Option 1 as it is easier and, in most cases, will pay the RHC more than the Option 2 methodology as well as support hospitals in rural areas that were already in critical danger of closing before COVID-19.

CMS most likely we push for Option 2 as they are comfortable with that since they already do this for lab, technical components, hospital services, chronic care management. In fact, Telehealth is set up on the cost report in cost center 79 of the RHC cost report (Form 222-17) and treated this way currently. Here is an example from a cost report. This cost is not reimbursable in the calculation of the All-Inclusive rate and it does pull overhead from the allowable expense via a calculation on Worksheet B Part II reducing the AIR.

74.00		TOTAL OVERHEAD (sum of lines 59 and [illegible])	61,059	123,082	184,141	0	184,141	-50	184,091	74.00
		COST OTHER THAN RHC SERVICES								
75.00	7500	PHARMACY	0	0	0	0	0	0	0	75.00
76.00	7600	DENTAL	0	0	0	0	0	0	0	76.00
77.00	7700	OPTOMETRY	0	0	0	0	0	0	0	77.00
78.00	7800	NON-ALLOWABLE GME PASS THROUGH C[illegible]	0	0	0	0	0	0	0	78.00
79.00	7900	TELEHEALTH	0	0	0	0	0	0	0	79.00
80.00	8000	CHRONIC CARE MANAGEMENT	0	0	0	0	0	0	0	80.00
81.00	8100	OTHER THAN RHC SRVCE COSTS (SPECIFY)	0	0	0	0	0	0	0	81.00
81.01	8101	OTHER THAN RHC: HOSPITAL	0	0	0	0	0	0	0	81.01
81.02	8102	OTHER THAN RHC: PRIVATE PRACTICE	0	0	0	0	0	0	0	81.02
81.03	8103	OTHER THAN RHC: LABORATORY	0	100	100	1,922	2,022	0	2,022	81.03
81.04	8104	OTHER THAN RHC: RADIOLOGY	0	0	0	0	0	0	0	81.04
86.00		SUBTOTAL-COST OTHER THAN RHC (sum of lines 75 through 81)	0	100	100	1,922	2,022	0	2,022	86.00
		NON-REIMBURSABLE COSTS								

Non-RHC Hours

Non-RHC Hours - Reality



1. No one is going to jail
2. Not that hard
3. Cost Report is designed for it.
4. AIR will not go down if done correctly

Non-RHC Hours – What you have heard?

1. Your going to jail.
2. Its complicated
3. Cost Report Nightmare
4. AIR will go down.

Keys to making it work

1. Treat everyone the same
2. Keep up with Non-RHC visits
3. Place a sign on the door indicating times
4. Notify your Cost Report Person.
5. Update your RHC Policy and Procedure Manual

Note: When clinics and centers separately bill laboratory services, the cost of the space, equipment, supplies, facility overhead and personnel must be adjusted out of the RHC cost report. This does not include venipuncture, which is included in the all-inclusive rate when furnished in a RHC by a RHC practitioner or furnished incident to a RHC service.

Telehealth Resources

General Provider Telehealth and Telemedicine Tool Kit

Table of Contents

Intent of Toolkit:

Under President Trump's leadership to respond to the need to limit the spread of community COVID-19, the Centers for Medicare & Medicaid Services (CMS) has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility. These policy changes build on the regulatory flexibilities granted under the President's emergency declaration. CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. The benefits are part of the broader effort by CMS and the White House Task Force to ensure that all Americans – particularly those at high-risk of complications from the virus that causes the disease COVID-19, are aware of easy-to-use, accessible benefits that can help keep them healthy while helping to contain the community spread of this virus.

Under this new waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Note, this toolkit is designed to provide information only and not intended to endorse any non-federal entities.

General Provider Telehealth and Telemedicine Tool Kit

Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health. Innovative uses of this kind of technology in the provision of healthcare is increasing. And with the emergence of the virus causing the disease COVID-19, there is an urgency to expand the use of technology to help people who need routine care, and keep vulnerable beneficiaries and beneficiaries with mild symptoms in their homes while maintaining access to the care they need. Limiting community spread of the virus, as well as limiting the exposure to other patients and staff members will slow viral spread.

There are three main types of virtual services physicians and other professionals can provide to Medicare beneficiaries summarized in this fact sheet https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet: Medicare telehealth visits, virtual check-ins and e-visits.

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425-G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

Effective immediately, 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 communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency. For more information: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

CMS encourages all providers to share with patients these new abilities to provide healthcare through telemedicine.

https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf

COVID-19 RESOURCES FOR RHCS

Healthcare Business Specialists is using this COVID-19 website to provide resources for our RHCs. We have provide links to valuable information as you deal with this world-wide pandemic.

March 24, 2020:

- CMS Additional Emergency and Disaster-Related Policies and Procedures That May Be Implemented Only With a § 1135 Waiver
- COVID-19 – Expanded Tele-Health Language for RHCs, FQHCs & Other Safety Net Providers from NOSORH
- Medicare Telemedicine Health Care Provider Fact Sheet dated March 17, 2020
- 2019-Novel Coronavirus (COVID-19) Medicare Provider Enrollment Relief Frequently Asked Questions (FAQs) from March 23, 2020
- CMS COVID-19 Partner Tool Kit

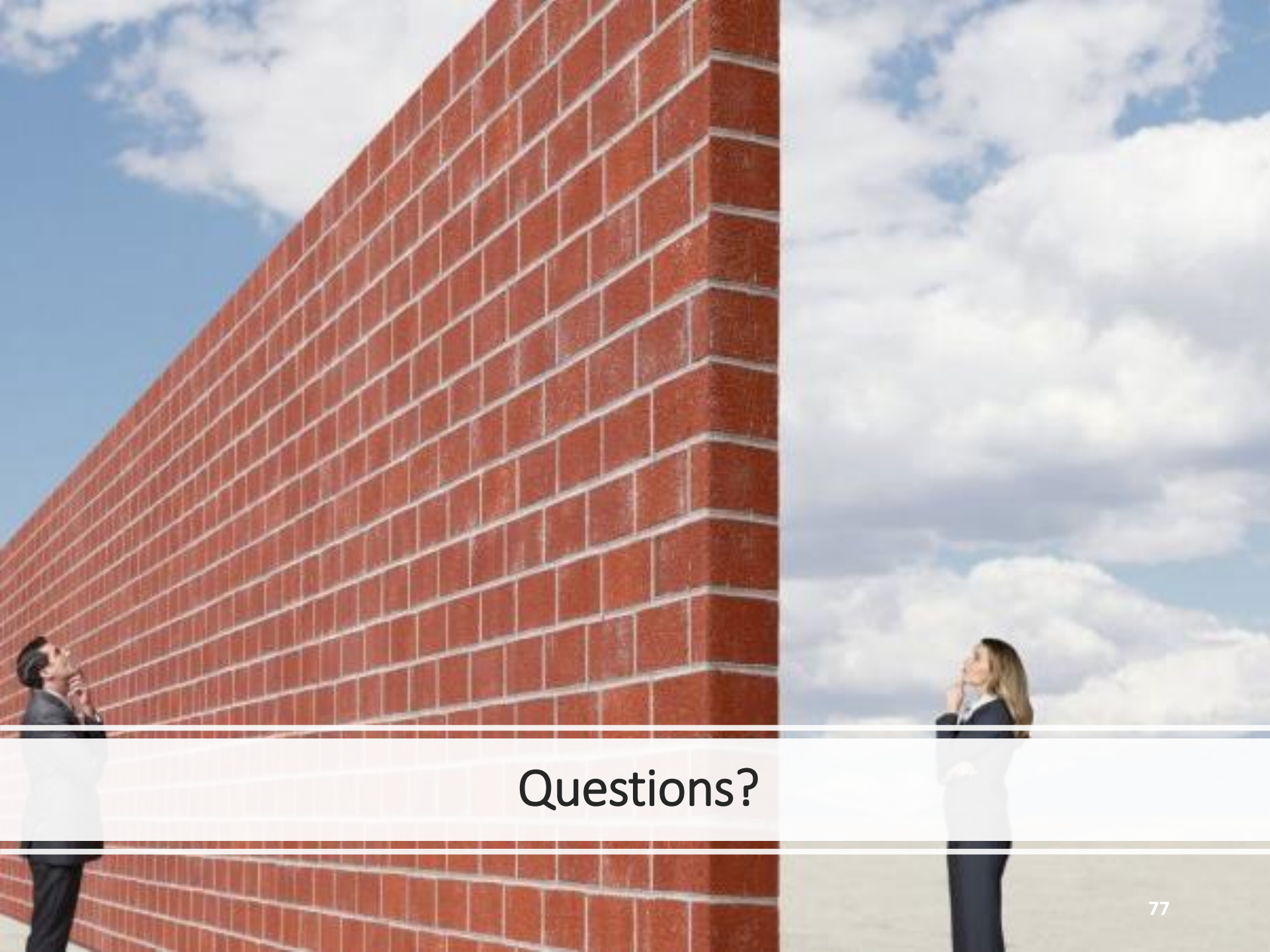
March 23, 2020: CMS released a Telehealth Toolkit for providers on March 20th, 2020 and it is excellent. If you want to start Telehealth services in your clinic, this is a great place to start. One word of caution, it still does not address the distant site issue in RHCs. Additionally, we have added some resources to help you as you implement Telemedicine:

- CMS Telehealth Toolkit released on March 20, 2020
- COVID-19 Telehealth Coding and Billing Practice Management Tips from the American College of Physicians
- CMS announces relief from Quality Reporting requirements for physicians, hospitals, and facilities
- CMS released Frequently Asked Questions on Medicare Provider Enrollment Relief related to COVID
- Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)
- AMA Quick Guide to Telehealth in practice

Many States have relaxed Telehealth regulations as we respond to the COVID-19 Global Pandemic. We have provided a listing of the changed regulations that we are aware of here:

- Center for Connected Health Policy link to State Actions on Telehealth due to COVID-19
- Arizona
- Alabama
- Mississippi
- Tennessee
- Missouri
- Montana
- Kentucky
- Illinois

http://www.ruralhealthclinic.com/covid19



Questions?