Getting Telehealth and Virtual Communicating Services (VCS) in Rural/Community Health

A Focus on Documentation, Coding, and Billing

Association for Rural & Community Health Professional Coding
Metro-Atlanta, GA

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  - Therefore, you need a printed version of the CPT EVERY YEAR unless the AMA releases such documentation guidance in new format(s) and/or makes updates throughout the year.

- CEUs are available upon successful completion of the course requirements, including watching the full video and passing the post-class quiz.

ArchProCoding's
TARGET AUDIENCE

Clinical Providers

Document 100% of what is done (CPT/HCPCS-II) and why (ICD-10-CM) per the official guidelines?

Facility Leadership

Coordinate your staff to code 100% of your services by facilitating effective communications with clinical and business staff via the "encounter form."

Billing & Quality

Get paid 100% of what you should (*and no more than allowed*) by understanding differing payer rules and using different claim forms?

MORE INTERNAL CONTROL :::::::::: **LESS INTERNAL CONTROL**

Telehealth vs Virtual Communication Services (VCS) High-Level Items for Discussion

- Key resources to study and follow
- Comparing coding options for Telehealth, Virtual Communication Services (VCS), and Online/Digital Visits
- Identifying billing options for distant site telehealth services for RHC/FQHC
- Recent 2022 updates on CMS-approved Mental Health Telehealth Visits
- Details on the 2 main types of Virtual Communication Services
- Course wrap-up, after the PHE, and CEU instructions

Key resources to stay updated

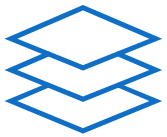
Does each office/nurse's station have each of the current federally-mandated HIPAA Code manuals used by RHCs and FQHCs or are you too dependent on software?

Do you have access to and understand the contents of key CMS updates as well as their Policy and/or Benefits Manuals such as chapters 9, 13?

Insurance participation contracts should outline how to report quality, bill for services, charge patients, and outline coverage. Can you locate these in your current/future contracts?

CMS VALID ENCOUNTERS for RHC/FQHC :: An Overview

01



Face-to-Face Visit?

Exceptions?

02

Authorized Core Provider?

Slight differences for RHC vs. FQHC

03

"Medically Necessary"?

Familiar with NCDs vs. LCDs and where to get them?

LINK

Try this link!

04

Authorized location?

Office, Part A SNF, patient's residence, where else?

"An RHC or FQHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one of more RHC or FQHC services are rendered." – CMS Benefits Manual, Chapter 13, Section 40

Key CMS Resources to Download and Study!

HYPERLINKS

Ch. 9 – CMS Claims Processing Manual
Updated 1-12-22

Ch. 13 – CMS Benefit Policy Manual
Updated 4-26-21

Virtual Communications Services in RHC/FQHC FAQs - December 2018

2021/2022 CMS Evaluation & Management Updates

New and Expanded Flexibility for RHC/FQHC during the COVID-19 PHE – MLM #SE20016 (last updated 1-13-22)

Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

70.7 - Virtual Communication Services
(Rev. 10357, Issued: 09-18-2020, Effective: 10-19-2020, Implementation: 10-19-2020)

+

Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

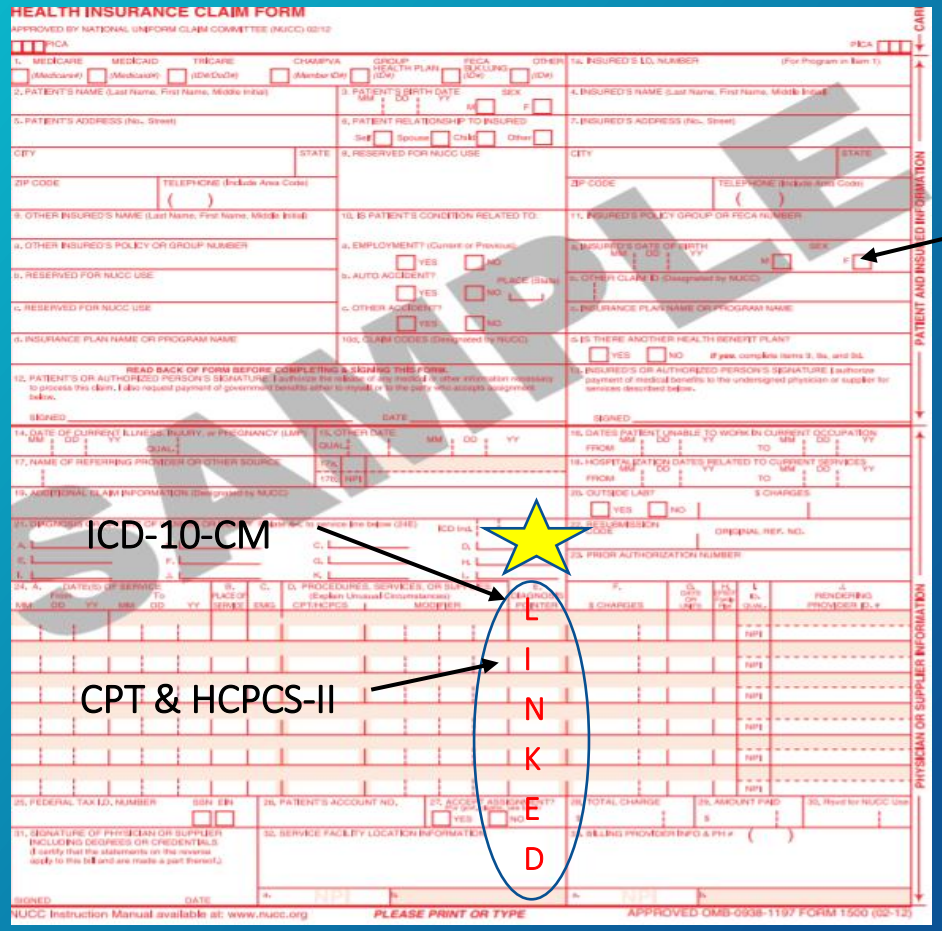
200 - Telehealth Services
(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

240 – Virtual Communication Services
(Rev. 252, Issued: 12-07-18, Effective: 01-01-19, Implementation: 01- 02-19)

CMS Guidance on Virtual Communication Services and Telehealth (Ch. 9 and 13)

COMPARE :: CMS 1500 form
(aka the "HCFA" or 837p)

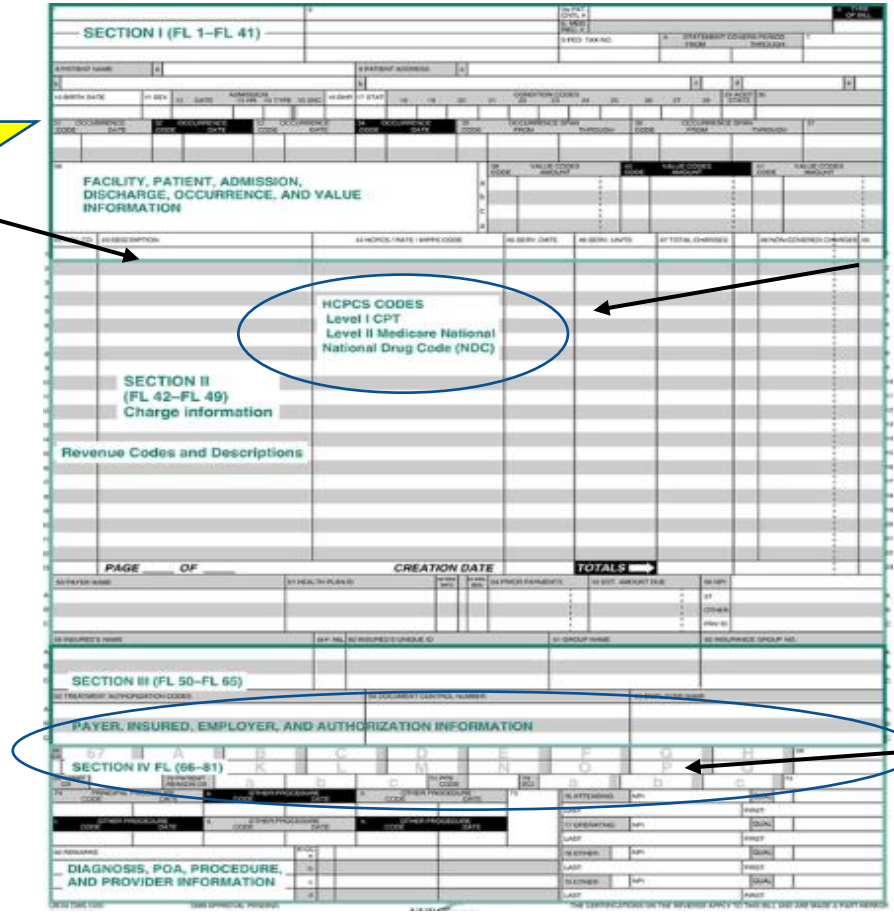
Used by RHC/FQHC reporting non-RHC/FQHC services such as the technical component of diagnostic tests on Medicare claims + to commercial and non-Medicare carriers expecting to receive Fee-for-Service (FFS) payments.



HYPERLINKS to sample instructions

CONTRAST :: CMS 1450 form
(aka the "UB" or 837i)

Used by RHC/FQHC submitting claims to Medicare (*and some Medicaid carriers*) for "valid encounters" when expecting the AIR/PPS rate whose claim form also requires Type of Bill and Revenue Codes.



CPT & HCPCS-II

CPT & HCPCS-II and ICD-10-CM are NOT LINKED !

ICD-10-CM

Coding Options for Telehealth and Virtual Communications Services

Telemedicine CPT Code Issues

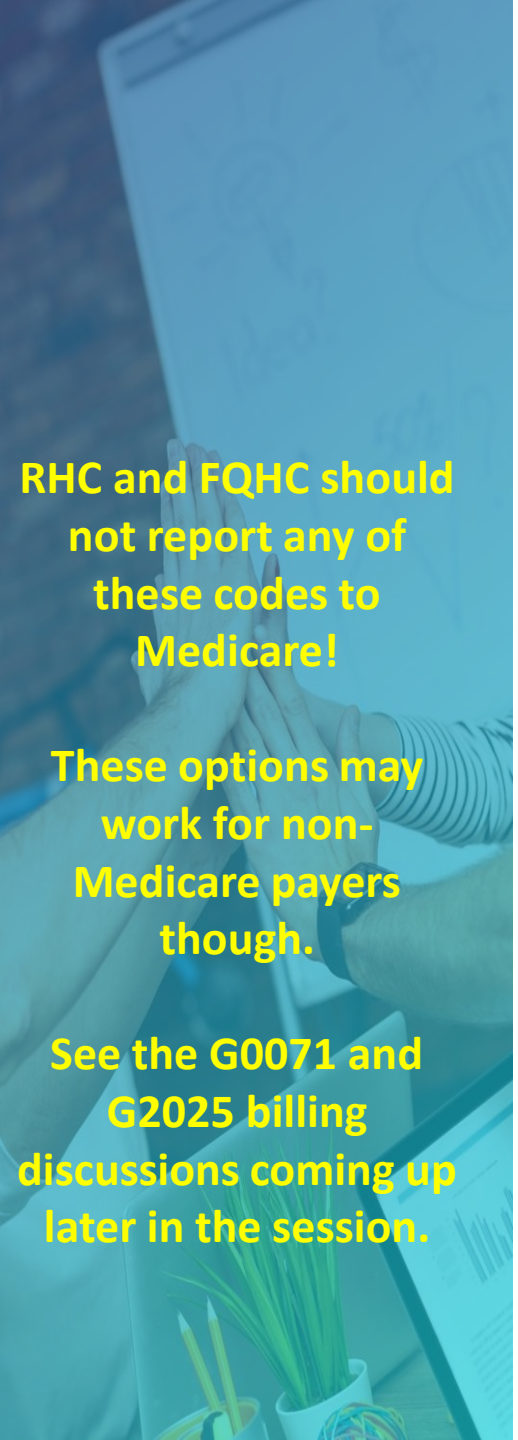
2022 Place of Service (POS) codes

- **POS Code 02** = currently defined as telehealth via telecommunication service but will "soon" be updated to report telehealth when the patient is somewhere other than their home.
- **"New" POS 10** = Effective mid-2022 and beyond, newly created POS code 10 was created after the 2022 CPT manual was printed and will be required by some non-Medicare carriers to report telehealth services when the patient is in their home.
- See slide 27 for hyperlinks for more details on POS updates

Telehealth CPT modifier -95

- **Modifier -95 in Appendix A** = "Synchronous telemedicine service rendered via real-time interactive Audio and Video Telecommunications System"

CPT codes for digital and telephone visits



RHC and FQHC should not report any of these codes to Medicare!

These options may work for non-Medicare payers though.

See the G0071 and G2025 billing discussions coming up later in the session.

- **98970-98972** = Qualified nonphysician healthcare professional online digital E/M service for an established patient, for up to 7 days, cumulative time during the 7 days; **5-10 minutes** + others.

- **Digital assessments** which are non-face-to-face, patient-initiated, digital communications using a secure online patient portal:
  - **99421** = Online digital E/M service for an established patient, for up to 7 days, cumulative time during the 7 days; **5-10 minutes**.
  - **99422** = Online digital E/M service …. ; **11-20 minutes**
  - **99423** = Online digital E/M service …. ; **21 minutes or more**

- **Traditional telehealth services:**
  - **99441** = Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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**
  - **99422** = Telephone evaluation and management service…;**11-20 minutes of medical discussion**
  - **99423** = Telephone evaluation and management service…;**21-30 minutes of medical discussion**

Available Telemedicine HCPCS-II Codes for consideration depending on payer policy

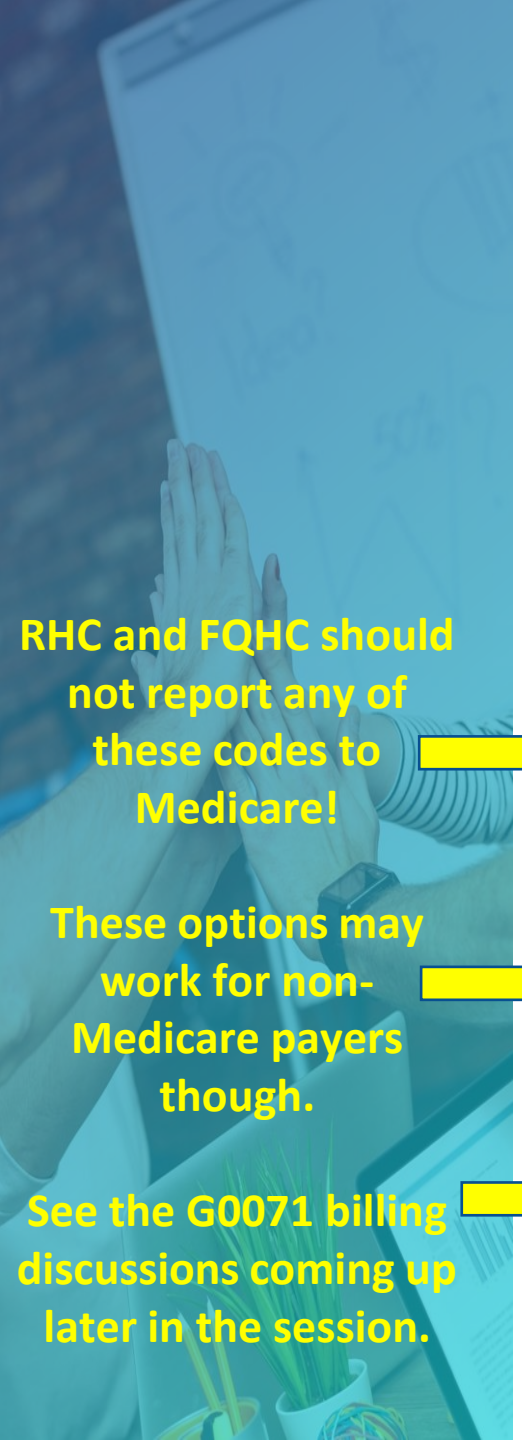
- Medicare identified modifier –CS to be used "*for specified COVID-19 testing related services that result in an order for or administration of a COVID-19 test and/or used for cost sharing waived preventive services provided via telehealth in RHCs and FQHCs during the COVID-19 PHE.*"

- **Originating Site Code Options:**
  - **Q3014** = Telehealth originating site facility fee)
  - **T1014** = Telehealth transmission, per minute, professional services bill separately) – use with Medicaid only if it is on their fee schedule and is performed by an authorized provider.

- **Alternate distant site telehealth service provided by RHC/FQHC to Medicare:**
  - **G2025** = Payment for a telehealth distant site service furnished by a rural health clinic (RHC) or federally qualified health center (FQHC) only.
  - RHC performing preventive services via telehealth will need modifiers –CG and –CS

- Options that some carriers may want include telehealth services **provided by non-physicians** such as G2061-G2063 and/or 98966-98972.

Virtual Communications Services (VCS) HCPCS-II Coding/Billing Options



RHC and FQHC should not report any of these codes to Medicare!

These options may work for non-Medicare payers though.

See the G0071 billing discussions coming up later in the session.

- **G0071** = Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a Rural Health Clinic (RHC) or Federally Qualified Health Center (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.
- **G2250** = Remote assessment 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 service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.
- **G2251** = Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; **5-10 minutes of clinical discussion.**
- **G2252** = Brief communication technology-based service, e.g. virtual check-in……..**;11-20 minutes of clinical discussion.**

Billing Options for Telehealth for RHC/FQHC

RHC/FQHC reporting distant site telehealth options for non-Medicare payers

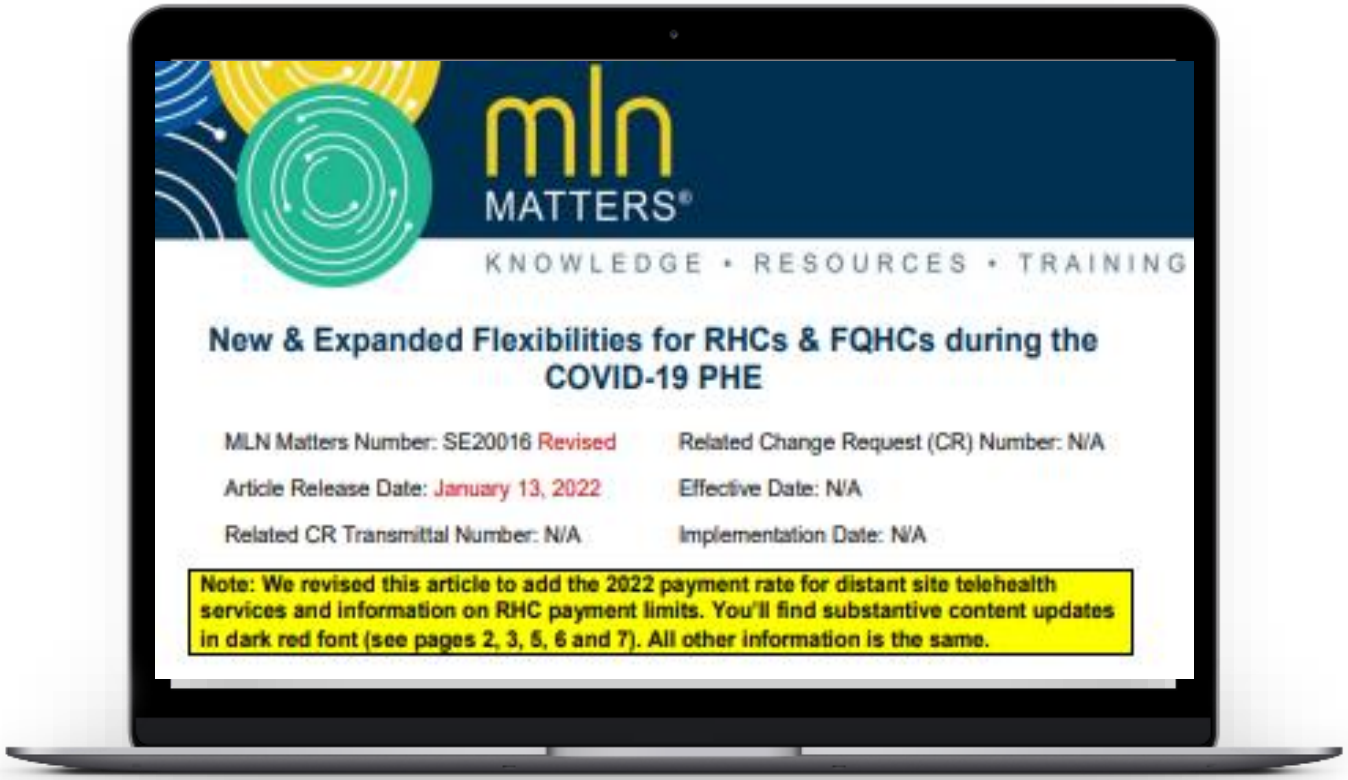
- Most commercial fee-for-service payers want RHC/FQHC clinics to report approved **distant site** telehealth services by billing the appropriate CPT/HCPCS-II code documented and performed **PLUS the billing staff will likely need to add at least one** of the following:
  - Modifier -95 added to a CPT/HCPCS-II code to indicate the service was done via telehealth.
  - Place of Service (POS) code 02 (*or newly created POS 10*) to identify that the service was performed via telehealth.

- New for 2022 modifier -FQ identifying that a telehealth service was furnished using real-time audio-only communication technology OR new for 2022 modifier -FR – indicating that a supervising practitioner was present through a real-time two-way, audio/visual communication technology

RHC/FQHC reporting approved distant site telehealth visits to Medicare

- **Approved Telehealth Visits in RHC/FQHC**
- For Medicare medical visits, RHCs/FQHCs must refer to G2025 and expect $97.24 in reimbursement from your MAC and patients with an 80%/20% patient split. Most other carriers prefer the CPT/HCPCS-II code + modifier -95 and maybe POS 02.
  - Check for periodic updates to CMS' List of Telehealth Services for 2022 last updated 1/5/22
  - Get the CMS Med Learn Matters #SE20016 (*last release 1-13-22*) for updates, revenue code info, modifiers, and other great billing info – https://www.cms.gov/files/document/se20016.pdf
  - FQHCs were given recent April 2022 guidance to report their G0469/G0470 code along with revenue code 0900 and the code from their Qualifying Visit List – heads-up!

Please review MLM #SE20016 and be prepared for updates – this version is correct as of June 14, 2022



New and Expanded Flexibility for RHC/FQHC during the COVID-19 PHE – MLM #SE20016 (last updated 1-13-22)

Excerpt From CMS Approved Telehealth List

A	B	C	D	E
		SERVICES effective January 1, 2022 - updated January 5, 2022		
Code	**Short Descriptor**	**Status**	**Can Audio-only Interaction Meet the Requirements**	**Medicare Payment Limitations**
97802	Medical nutrition indiv in		Yes	
97803	Med nutrition indiv subseq		Yes	
97804	Medical nutrition group		Yes	
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			
99214	Office/outpatient visit est			
99215	Office/outpatient visit est			
99217	Observation care discharge	Available up Through December 31, 2023		
99218	Initial observation care	Temporary Addition for the PHE for the		

There are many codes on this list that we are NOT used to getting paid for. Also – what about audio-only visits?

Comagine Health

SOUTHWEST TELEHEALTH RESOURCE CENTER TRC

Telehealth and Virtual Services:
A Guide for FQHCs and RHCs

HYPERLINK

Additional info and links on RHC/FQHC telehealth service options

Description	Code
Advance care planning (ACP). Now more than ever, advance care planning is a critical component of health care service delivery. FQHCs should offer ACP to all patients; completing advance directives is not a required component, and this is a great opportunity to apply team-based care. 1. Advance Care Planning Fact Sheet. CMS. Updated October 2020. 2. Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services. CMS. Updated July 2016 (but still relevant). Check question No. 4 "Who can perform ACP services?"	
ACP, including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate	99497
Each additional 30 min of ACP. List separately in addition to code for primary procedure.	99498
Transitional Care Management (TCM). CMS has responded to findings on the benefits and low usage of transitional care management services by increasing reimbursement (not applicable for FQHCs/RHCs that are paid by PPS/AIR) and removing several co-billing restrictions, including allowing TCM services to be billed concurrently with chronic care management codes. TCM is a critical tool for ensuring that patients are supported during the transition to home after a hospital or skilled nursing facility stay. Note that face-to-face does not mean in person; a telehealth visit is face-to-face when using audio and video. 1. Transitional Care Management Services (updated July 2021 and the accompanying FAQ sheet (updated March 2016 and does not reflect that TCM and chronic and principal care management can now be billed during the same calendar month). *CMS.* 2. Transitional Care Management. *American Academy of Family Physicians.*	
Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; **medical decision-making of at least moderate complexity** during the service period; face-to-face visit **within 14 calendar days of discharge**	99495
Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; **medical decision-making of at least high complexity** during the service period; face-to-face visit **within 7 calendar days of discharge**	99496
Initial and subsequent annual wellness visits (AWV): Many primary care practices already provide in-person initial preventive physical examinations (IPPE) and AWVs for their Medicare patients, but these can also be conducted through telehealth. 1. Medicare Wellness Visits. CMS. Updated October 2020.	
Annual wellness visit, includes a personalized prevention plan of service, initial visit	G0438
Annual wellness visit, includes a personalized prevention plan of service, subsequent visit	G0439
Additional telehealth opportunities. While this guide includes several common primary care services, there are many more that may be relevant to your practice. Additional options are in the truncated table below, but check the Medicare List of Telehealth Services to ensure you are using all of the telehealth options available to clinicians and care teams in a primary care practice.	
Medical nutrition therapy (MNT) – individual and group	97802-97804
Diabetes self-management training (DSMT) – individual and group	G0108,G0109
Chronic kidney disease patient education – individual and group	G0420,G0421
Counseling visit to discuss need for lung cancer screening using low-dose CT scan (CMS' Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography) – see also CMS' Patient Page on Lung Cancer Screening	G0296
Treatment for opioid use disorder – several codes and services – a few are listed here. Barriers & Challenges to FQHC use of Telehealth for Substance Use Disorder	G2086-G2088

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CMS Preventive Service Chart for RHC

Service	HCPCS Code	Short Descriptor	Paid at the AIR	Eligible for Same Day Billing	Coinsurance /Deductible	CMS Pub 100-04
AWV	G0438	Ppps, initial visit	Yes	No	Waived	Ch. 18 §140
	G0439	Ppps, subseq visit	Yes	No	Waived	
Screening Pelvic Exam	G0101	Ca screen; pelvic/breast exam	Yes	No	Waived	Ch. 18 §40
Prostate Cancer Screening	G0102	Prostate ca screening; dre	Yes	No	Not Waived	Ch. 18 §50
Glaucoma Screening	G0117	Glaucoma scrn hgh risk direc	Yes	No	Not Waived	Ch. 18 §70
	G0118	Glaucoma scrn hgh risk direc	Yes	No	Not Waived	
Screening Pap Test	Q0091	Obtaining screen pap smear	Yes	No	Waived	Ch. 18 §30
Alcohol Screening and Behavioral Counseling	G0442	Annual alcohol screen 15 min	Yes	No	Waived	Ch. 18 §180
	G0443	Brief alcohol misuse counsel	Yes	No	Waived	
Screening for Depression	G0444	Depression screen annual	Yes	No	Waived	Ch. 18 §190

2 HYPERLINKS

CMS Preventive Service Chart for FQHC

Service	HCPCS Code	Short Descriptor	Paid under the PPS methodology	Increase in the PPS rate by 34%[1]	Coinsurance	CMS Pub 100-04
Diabetes Self-Management Training (DSMT)	G0108	Diab manage trn per indiv	Yes	No	Not Waived	Ch. 9 §181 Ch. 18 §120
Medical Nutrition Therapy (MNT)	97802	Medical nutrition indiv in	Yes	No	Waived	Ch. 9 §182
	97803	Med nutrition indiv subseq	Yes	No	Waived	
	G0270	Mnt subs tx for change dx	Yes	No	Waived	
AWV	G0438	Ppps, initial visit	Yes	Yes	Waived	Ch. 18 §140
	G0439	Ppps, subseq visit	Yes	Yes	Waived	
Screening Pelvic Exam	G0101	Ca screen; pelvic/breast exam	Yes	No	Waived	Ch. 18 §40
Prostate Cancer Screening	G0102	Prostate ca screening; dre	Yes	No	Not Waived	Ch. 18 §50
Glaucoma Screening	G0117	Glaucoma scrn hgh risk direc	Yes	No	Not Waived	Ch. 18 §70
	G0118	Glaucoma scrn hgh risk direc	Yes	No	Not Waived	

Recent 2022 Updates on CMS-approved Mental Health Telehealth Visits

2022 CMS Updates on Mental Health Telehealth During/After the PHE

- For 2022 – CMS now pays RHC and FQHC their traditional AIR/PPS encounter-based payments for approved mental health telehealth visits instead of the ~$97 flat payment as before. See https://www.cms.gov/sites/default/files/2021-12/CY_2022_PFS_Final_Rule_FQHC_FAQs_v2_12212021.pdf for FAQs from CMS.

- For FQHCs in 2022 Medicare mental health telehealth visits should be reported with the FQHC-only G0469-G0470 codes followed by the FQHC qualifying visit code plus add a modifier -95 that may now be required as of 2022 if done via audio and video **or** the newly created HCPCS-II modifier –FQ if done audio-only.

2022 CMS Updates on Mental Health Telehealth During/After the PHE

- RHCs/FQHCs are now formally allowed to report mental health visits done via *"real-time telecommunication technology in the same way they currently do when visits take place in-person, including audio-only visits when the beneficiary is not capable of, or does not consent to, the use of video technology."*

- AFTER the Public Health Emergency there must be an in-person mental health service (*using revenue code 0900*) furnished "within 6 months prior to the furnishing of the telecommunications service…" and an in-person mental health visit every 12 months while they are receiving telehealth visits by the original telehealth practitioner or a colleague in the same subspecialty and in the same group practice, though there are limited exceptions.

2022 CMS Updates on Mental Health Telehealth During/After the PHE

- Track potential continuing updates to CMS' and MLN Matters #MM12427 "New/Modifications to the Place of Service (POS) codes for Telehealth" affecting POS 02 (*patient in other than in their home*) and the newly created POS 10 (*patient is in their home*), though as of this class "Medicare hasn't identified a need for new POS 10."

- Note the effective date of April 4, 2022.

- *"During the PHE, Medicare does not require use of telehealth POS codes" as per CMS' Guidance to MACs.*

Virtual Communication Services Details

Virtual Communications Services (VCS)

Purpose: The purpose of VCS is to aid community/rural health providers who engage in "virtual check-ins" via phone and or the "store and forward" technique via a patient portal interpret images/audio submitted by patients for over 5 minutes for condition(s) unrelated to recent visits and that do not result in an immediate visit.

Research: For Medicare's guidelines for RHC/FQHC reporting Virtual Communication Services in the CMS Benefits Policy Manual Chapter 13 – section 240

FAQs: CMS prepared an 8-page set of frequently asked questions (FAQ) that is specific for RHC/FQHC providers in December 2018. Get it at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf

Contrast: Virtual Communication Services (VCS) with contact initiated by the patient

- **Virtual Check-in** - Via telephone or other electronic means
  - HCPCS II code G2251-G2252
  - RHC/FQHC should use G0071 to Medicare (~$24)

- **"Store and Forward" Audio/Video -** Via video/images uploaded by a patient via a patient EHR portal and reviewed by a provider.
  - HCPCS II code G2250
  - RHC/FQHC should use G0071 to Medicare (~$24)

- **Online Digital E/M Services -** Online digital E/M visits reported once per 7 days.
  - CPT codes 99421-99423 to non-Medicare FFS payers for RHC/FQHC
  - RHC/FQHC should use G0071 to Medicare (~$24)

Documentation & Coding for VCS "Virtual Check-in"

- The contact must be initiated by the patient if using the "virtual check-in" element.

- VCS refers to providers who receive contact via non-face-to-face "communication technology-based" (*i.e. a virtual check-in via phone*) from an established patient lasting more than 5 minutes or more regarding a condition(s) NOT related to a visit in the past 7 days and that does not result in an appointment in the next 24 hours or next available appointment slot.

- For RHCs/FQHCs billing commercial carriers refer to codes **G2051-G2052** whereas a RHC/FQHC should use code **G0071** to Medicare.

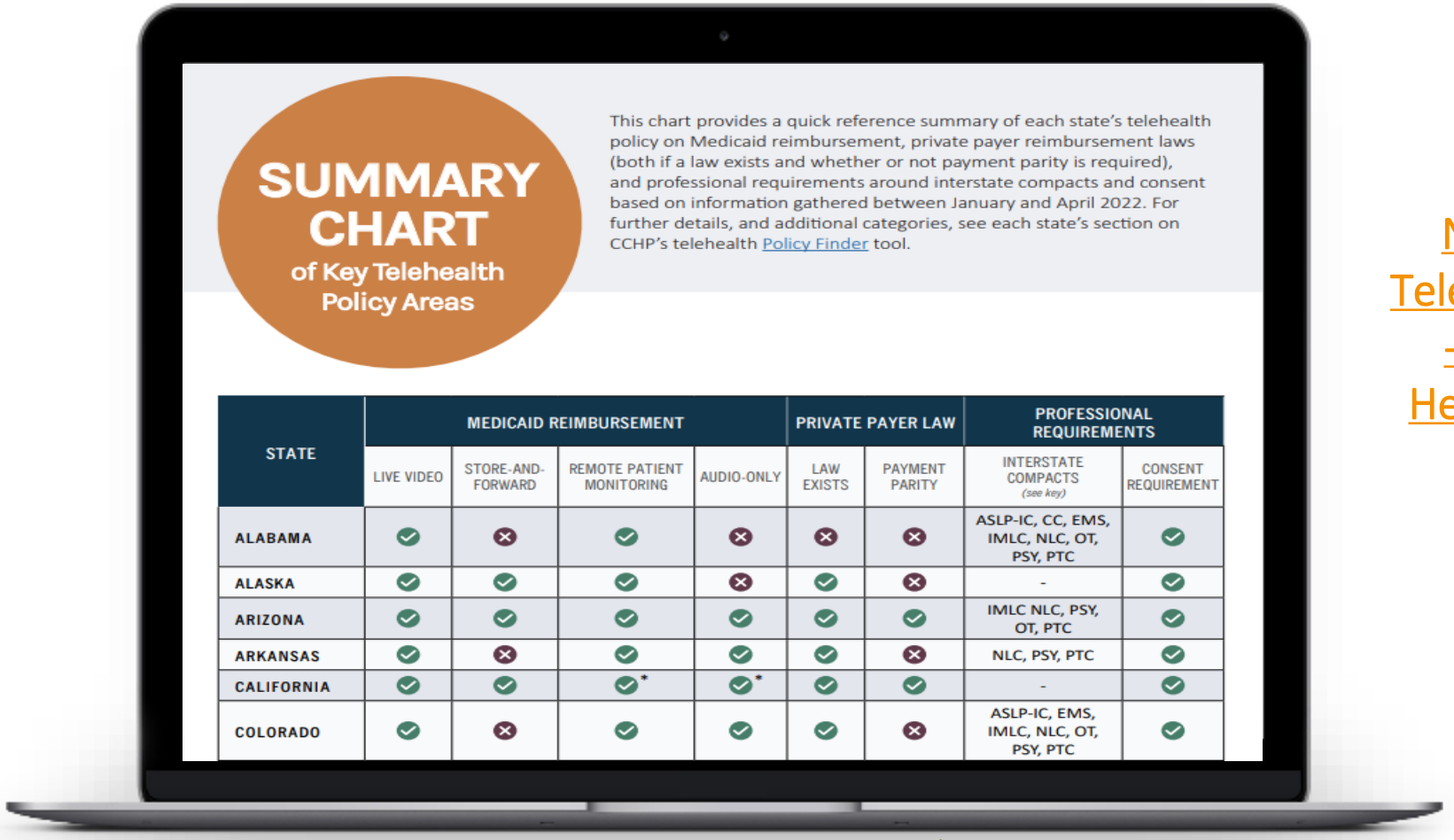
Documentation & Coding for VCS "Store and Forward" of audio/video

- Another type of VCS refers to providers who interpret and follow-up with patients within 24 hours of when patients send them pictures/video for conditions NOT originating from a related E/M service within the previous 7 days and does not lead to an E/M service or procedure within the next 24 hours or soonest appointment slot.

- ACOs often utilize a patient portal where they can send information/pictures/videos to their provider – if you are using this "store-and-forward" technique to report VCS the information must be reviewed within 24 hours of its submission by the patient.

- For RHCs/FQHCs billing commercial carriers refer to code **G2250** whereas a RHC/FQHC should use code **G0071** to Medicare.

For info on state telehealth laws and reimbursement policies check out this resource



SUMMARY CHART
of Key Telehealth Policy Areas

This chart provides a quick reference summary of each state's telehealth policy on Medicaid reimbursement, private payer reimbursement laws (both if a law exists and whether or not payment parity is required), and professional requirements around interstate compacts and consent based on information gathered between January and April 2022. For further details, and additional categories, see each state's section on CCHP's telehealth Policy Finder tool.

STATE	MEDICAID REIMBURSEMENT				PRIVATE PAYER LAW		PROFESSIONAL REQUIREMENTS	
	LIVE VIDEO	STORE-AND-FORWARD	REMOTE PATIENT MONITORING	AUDIO-ONLY	LAW EXISTS	PAYMENT PARITY	INTERSTATE COMPACTS (see key)	CONSENT REQUIREMENT
ALABAMA	✓	✗	✓	✗	✗	✗	ASLP-IC, CC, EMS, IMLC, NLC, OT, PSY, PTC	✓
ALASKA	✓	✓	✓	✗	✓	✗	-	✓
ARIZONA	✓	✓	✓	✓	✓	✓	IMLC NLC, PSY, OT, PTC	✓
ARKANSAS	✓	✗	✓	✓	✓	✗	NLC, PSY, PTC	✓
CALIFORNIA	✓	✓	✓*	✓*	✓	✓	-	✓
COLORADO	✓	✗	✓	✓	✓	✗	ASLP-IC, EMS, IMLC, NLC, OT, PSY, PTC	✓

National Consortium of Telehealth Resource Centers - Center for Connected Health Policy - Spring 2022

Considerations for beyond the Public Health Emergency related to Telehealth

- Expanded federal telehealth coverage is due to go away 151 days after the end of the PHE. All signs point to additional guidance being delivered 60 before the end of the PHE giving approximately 6 months of a heads-up on new guidelines.
- Likelihood of need to obtain a HIPAA-secure platform for telehealth which was probably waived during the PHE. Start analyzing vendors now.
- Face-to-face visit needed for all new patients and for periodic mental health services? What about non-physician practitioners for Medicaid?
- Possible prescriptions limitations on which drugs can be authorized via telehealth.
- Audio-only visits may remain eligible and approved patient locations could differ by payer.

What to do after class to get Continuing Education Units

How do you determine training success?

Do you now have access to key references and resources related to clinical documentation, coding, and billing in order to keep track of the inevitable changes that are bound to occur?

Are you aware of possible areas where your different payers may interpret rules differently and still be legally binding?

Can you think of anyone else at your facility that would benefit from this kind of training?

Thanks for your attention!
Now is our time to shine!

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