



New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)

MLN Matters Number: SE20016

Related Change Request (CR) Number: N/A

Article Release Date: April 17, 2020

Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: N/A

PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) during the COVID-19 Public Health Emergency (PHE) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

To provide as much support as possible to RHCs and FQHCs and their patients during the COVID-19 PHE, both Congress and the Centers for Medicare & Medicaid Services (CMS) have made several changes to the RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE, and we will make additional discretionary changes as necessary to assure that RHC and FQHC patients have access to the services they need during the pandemic. For additional information, please see the RHC/FQHC COVID-19 FAQs at <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>.

BACKGROUND

New Payment for Telehealth Services

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

Distant site telehealth services can be furnished by any health care practitioner working for the RHC or the FQHC within their scope of practice. Practitioners can furnish distant site telehealth services from any location, including their home, during the time that they are working for the RHC or FQHC, and can furnish any telehealth service that is approved as a distant site telehealth service under the Physician Fee Schedule (PFS). A list of these is available at

<https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip>.

The statutory language authorizing RHCs and FQHCs as distant site telehealth providers requires that CMS develop payment rates for these services that are similar to the national average payment rates for comparable telehealth services under the PFS. Payment to RHCs and FQHCs for distant site telehealth services is set at \$92, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS.

For telehealth distant site services furnished between January 27, 2020, and June 30, 2020, RHCs and FQHCs must put Modifier “95” (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) on the claim. RHCs will be paid at their all-inclusive rate (AIR), and FQHCs will be paid based on the FQHC Prospective Payment System (PPS) rate. **These claims will be automatically reprocessed in July when the Medicare claims processing system is updated with the new payment rate. RHCs and FQHCs do not need to resubmit these claims for the payment adjustment.**

For telehealth distant site services furnished between July 1, 2020, and the end of the COVID-19 PHE, RHCs and FQHCs will use an RHC/FQHC specific G code, G2025, to identify services that were furnished via telehealth. RHC and FQHC claims with the new G code will be paid at the \$92 rate. Only distant site telehealth services furnished during the COVID-19 PHE are authorized for payment to RHCs and FQHCs. If the COVID-PHE is in effect after December 31, 2020, this rate will be updated based on the 2021 PFS average payment rate for these services, weighted by volume for those services reported under the PFS.

Costs for furnishing distant site telehealth services will not be used to determine the RHC AIR or the FQHC PPS rates but must be reported on the appropriate cost report form. RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled “Cost Other Than RHC Services.” FQHCs must report both originating and distant site telehealth costs on Form CMS-224-14, the Federally Qualified Health Center Cost Report, on line 66 of the Worksheet A, in the section titled “Other FQHC Services”.

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

During the COVID-19 PHE, CMS will pay all of the reasonable costs for any service related to COVID-19 testing, including applicable telehealth services, for services furnished beginning on March 1, 2020. For services related to COVID-19 testing, including telehealth, RHCs and FQHCs must waive the collection of co-insurance from beneficiaries. For services in which the coinsurance is waived, RHCs and FQHCs must put the “CS” modifier on the service line. **RHC and FQHC claims with the “CS” modifier will be paid with the coinsurance applied, and the Medicare Administrative Contractor (MAC) will automatically reprocess these claims beginning on July 1. Coinsurance should not be collected from beneficiaries if the coinsurance is waived.**

Expansion of Virtual Communication Services

Payment for virtual communication services now include online digital evaluation and management services. Online digital evaluation and management services are non-face-to-face,

patient-initiated, digital communications using a secure patient portal. The online digital evaluation and management codes that are billable during the COVID-19 PHE are:

- CPT code 99421 (5-10 minutes over a 7-day period)
- CPT code 99422 (11-20 minutes over a 7-day period)
- CPT code 99423 (21 minutes or more over a 7-day period)

To receive payment for the new online digital evaluation and management (CPT codes 99421, 99433, and 99423) or virtual communication services (HCPCS codes G2012 and G2010), RHCs and FQHCs must submit an RHC or FQHC claim with HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services. For claims submitted with HCPCS code G0071 on or after March 1, 2020, and for the duration of the COVID-19 PHE, payment for HCPCS code G0071 is set at the average of the national non-facility PFS payment rates for these 5 codes. Claims submitted with G0071 on or after March 1 and for the duration of the PHE will be paid at the new rate of \$24.76, instead of the CY 2020 rate of \$13.53. **MACs will automatically reprocess any claims with G0071 for services furnished on or after March 1 that were paid before the claims processing system was updated.**

Revision of Home Health Agency Shortage Requirement for Visiting Nursing Services

RHCs and FQHCs can bill for visiting nursing services furnished by an RN or LPN to homebound individuals under a written plan of treatment in areas with a shortage of home health agencies (HHAs). Effective March 1, 2020, and for the duration of the COVID-19 PHE, the area typically served by the RHC, and the area included in the FQHC service area plan, is determined to have a shortage of HHAs, and no request for this determination is required. RHCs and FQHCs must check the HIPAA Eligibility Transaction System (HETS) before providing visiting nurse services to ensure that the patient is not already under a home health plan of care.

Consent for Care Management and Virtual Communication Services

Beneficiary consent is required for all services, including non-face-to-face services. During the PHE, beneficiary consent may be obtained at the same time the services are initially furnished. For RHCs and FQHCs, this means that beneficiary consent can be obtained by someone working under general supervision of the RHC or FQHC practitioner, and direct supervision is not required to obtain consent. In general, beneficiary consent to receive these services may be obtained by auxiliary personnel under general supervision of the billing practitioner; and the person obtaining consent can be an employee, independent contractor, or leased employee of the billing practitioner. For RHCs and FQHCs, beneficiary consent to receive these services may be obtained by auxiliary personnel under general supervision of the RHC or FQHC practitioner; and the person obtaining consent can be an employee, independent contractor, or leased employee of the RHC or FQHC practitioner (see: <https://www.cms.gov/files/document/covid-final-ifc.pdf>).

Accelerated/Advance Payments

In order to increase cash flow to providers and suppliers impacted by COVID-19, CMS has expanded our current Accelerated and Advance Payment Program. An accelerated/advance payment is a payment intended to provide necessary funds when there is a disruption in claims

submission and/or claims processing. CMS is authorized to provide accelerated or advance payments during the period of the PHE to any RHC or FQHC who submits a request to their MAC and meets the required qualifications. Each MAC will work to review requests and issue payments within seven calendar days of receiving the request. Traditionally repayment of these advance/accelerated payments begins at 90 days; however, for the purposes of the COVID-19 pandemic, CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment. Providers can get more information on this process at <https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf>.

ADDITIONAL INFORMATION

View the [complete list](#) of coronavirus waivers.

Review information on the current emergencies webpage at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

DOCUMENT HISTORY

Date of Change	Description
April 17, 2020	Initial article released.

Disclaimer: Paid for by the Department of Health & Human Services. This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2019 American Medical Association. All rights reserved.

Copyright © 2013-2020, the American Hospital Association, Chicago, Illinois. Reproduced by CMS with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816. You may also contact us at ub04@healthforum.com

The American Hospital Association (the "AHA") has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.