ADVANCED RHC BILLING 2021
OREGON RURAL HEALTH ASSOCIATION

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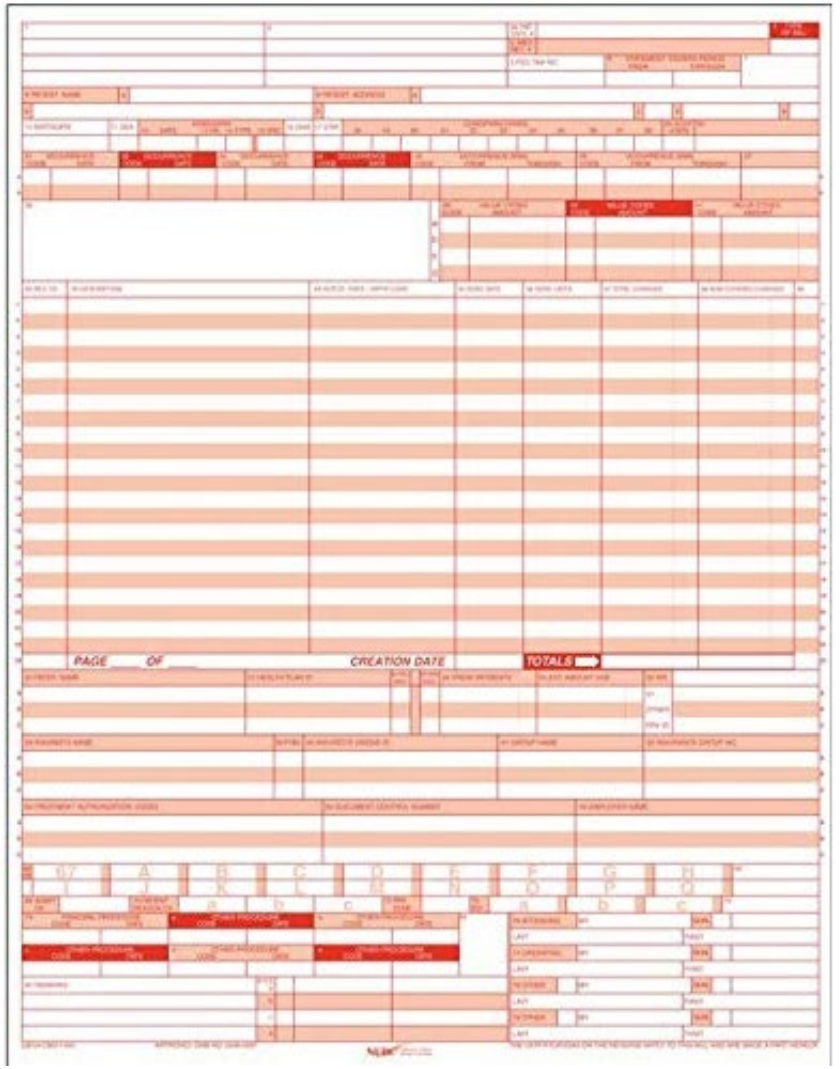
NORTH AMERICAN HEALTHCARE MANAGEMENT SERVICES

CLAIM SCENARIOS

- Welcome to Medicare vs Annual Wellness Visits
- Behavioral Health and Clinic Visits on the Same Day
- Immunizations, Procedures and other Clinical Visits
- Nursing Home
- CCM and TCM
- Nurse-only visits, SBIRT visits and Tdap
- Telehealth for Medicare



WHAT WE ALREADY KNOW: QUALIFYING VISITS

Medical Services RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the RHC Qualifying Visit List. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line.

RHC Qualifying Visit List

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf

MEDICARE QUALIFIED RHC PROVIDERS

Medicare Qualified RHC Providers	
Physicians (MD, or DO)	Clinical Psychologist (PhD)
Nurse Practitioners	Clinical Social Worker
Physician Assistants	
Certified Nurse Midwives	
Chiropractor, Dentist, Optometrist, Podiatrist	

RHC SERVICES

50.1 - RHC Services

(Rev. 252, Issued: 12- 07-18, Effective: 01-01-19, Implementation: 01- 02-19)

RHC services include:

- ✓ Physicians' services, as described in section 110;
- ✓ Services and supplies incident to a physician’s services, as described in section 120;
- ✓ Services of NPs, PAs, and CNMs, as described in section 130;
- ✓ Services and supplies incident to the services of NPs, PAs, and CNMs, as described in section 140;
- ✓ CP and CSW services, as described in section 150;
- ✓ Services and supplies incident to the services of CPs, as described in section 160; and
- ✓ Visiting nurse services to patients confined to the home, as described in section 190.
- ✓ Certain care management services, as described in section 230.
- ✓ Certain virtual communication services, as described in section 240.

RHC SERVICES

50.1 - RHC Services

(Rev. 252, Issued: 12- 07-18, Effective: 01-01-19, Implementation: 01- 02-19)

RHC services also include certain preventive services (see section 220 – Preventive Health Services). These services include:

- Influenza, Pneumococcal, Hepatitis B vaccinations;
- IPPE;
- Annual Wellness Visit (AWV); and
- Medicare-covered preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) with a grade of A or B, as appropriate for the individual.

MEDICARE RHC LOCATIONS

RHC visits may take place in:

- ✓ the RHC or FQHC,
- ✓ the patient's residence (including an assisted living facility),
- ✓ a Medicare-covered Part A SNF (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 20.1.1), or
- ✓ the scene of an accident.

(Medicare Benefit Policy Manual. Chapter 13. Section 40.1)

REVENUE CODES

0521	All Clinic Visits and Professional Services by qualified RHC provider;
0522	Home visit by RHC provider;
0524	Visit by RHC provider to a Part A SNF bed;
0525	Visit by RHC provider to a non-SNF bed, NF or other residential facility (non-Part A);
0527	Visiting Nurse service in home health shortage area
0528	Visit by RHC provider to other non-RHC site (scene of an accident)
0250	Pharmacy (Does not need the HCPCS)
0300	Venipuncture
0636	Injection/Immunization
0780	Telehealth
0900	Behavioral Health

ONE QUALIFYING VISIT – MAJORITY OF THE CARE

Medical Services RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the RHC Qualifying Visit List. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line.

QUALIFYING VISIT LINE CHARGE (052X) VS TOTAL CHARGE (0001)

- ✓ Medicare does not adjudicate RHC claims based on the 0001 Total Charge amount.
- ✓ Medicare adjudicates RHC claims using the Qualifying Visit Line.
- ✓ The qualifying visit line should be the sum of all RHC charges minus any preventive services.
- ✓ Total Charges WILL be reported as allowed charges on remits, BUT:
- ✓ Patient Co-Insurance/Deductible amounts are based on the Qualifying Visit Line.

BILLING EXAMPLE: CG MODIFIER

An established patient is seen and a qualifying visit of 99213 for $100 is generated. The applicable coinsurance and/or deductible is calculated using $100.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99213CG	04/02/2020	1	$ 100.00
0001	Total Charge				$ 100.00

BILLING EXAMPLE: INCIDENT-TO SERVICES

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2019	1	$ 150.00
0636	Injection Admin	96372	4/2/2019	1	$ 20.00
0636	Toradol	J1885	4/2/2019	1	$ 30.00
0001	Total Charge				$ 200.00

- ✓ J1885 and 96372 are bundled with 99213 on the qualifying visit line.
- ✓ The total QVL Charge is $150.00; the sum of all services reported on the claim.
- ✓ The total charge line (0001) is artificially inflated.
- ✓ Total Charges WILL show on the remittance advice.
- ✓ Patient Co-Insurance will be based on the QVL.

“ALTERNATE METHOD” SERVICE DETAIL REPORTING

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	4/2/2019	1	$ 150.02
0636	Injection Admin	96372	4/2/2019	1	$ 0.01
0636	Toradol	J1885	4/2/2019	1	$ 0.01
0001	Total Charge				$ 150.04

- ✓ The Injection and Medication Charges ($20.00/$30.00) are added to the 99213 qualifying visit line.
- ✓ The detail lines are reported as $.01.
- ✓ The total charges are no longer falsely inflated.

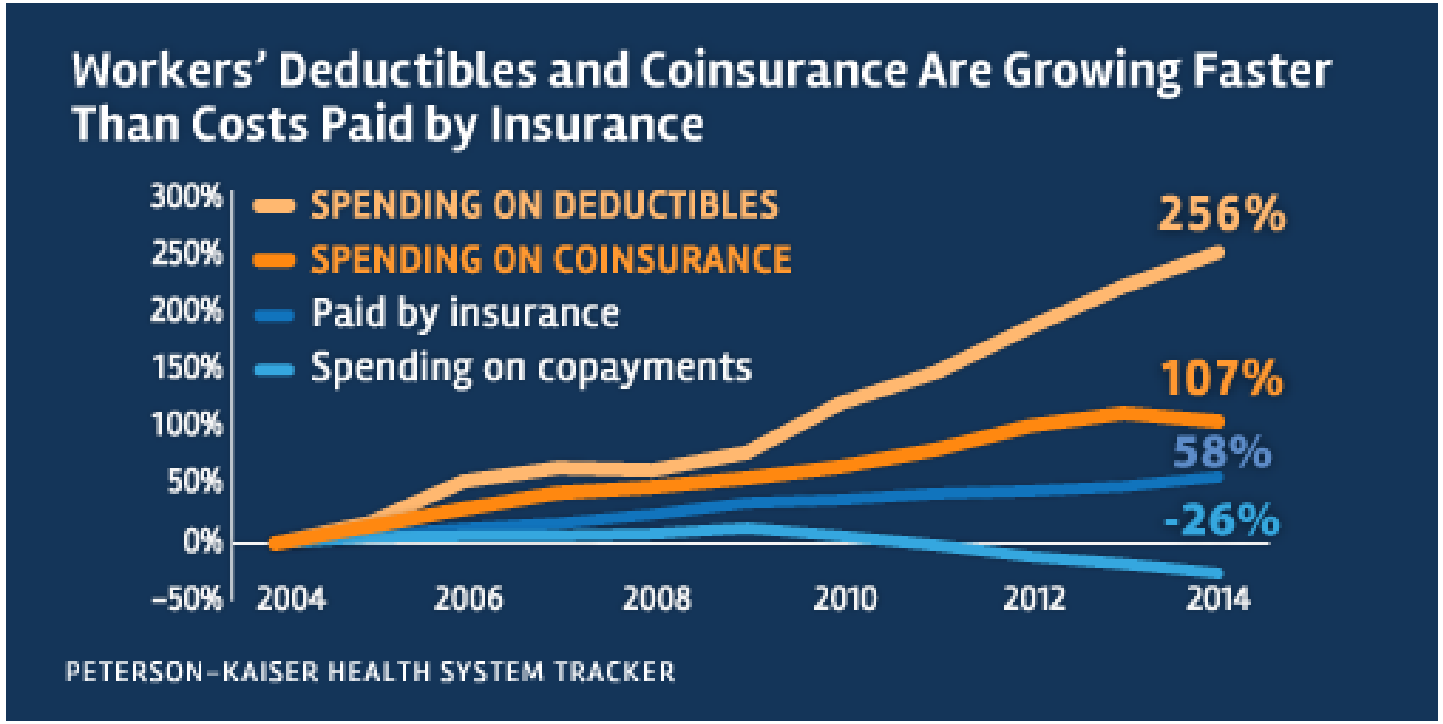
NURSING HOME VISIT REPORTING

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0525	NH Visit - Established	99308CG	04/21/2021	1	$ 150.00
0001	Total Charge				$ 150.00

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0522	Home Visit – Moderate Est	99349CG	04/21/2021	1	$ 150.00
0001	Total Charge				$ 150.00

INCIDENT-TO SERVICES EFFECT

The *effect on payment is an increase in the charge*, and therefore in the co-insurance.



NURSE-ONLY VISITS

“Services that are covered by Medicare but do not meet the requirements for a medically necessary or qualified preventive health visit with an RHC or FQHC practitioner (e.g., blood pressure checks, allergy injections, prescriptions, nursing services, etc.) are considered incident to services.”

“The cost of providing these services may be included on the cost report, but the provision of these services does not generate a billable visit.

Incident to services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe.”

DIRECT SUPERVISION FOR INCIDENT-TO SERVICES

Services and supplies furnished incident to physician's services *are limited to situations in which there is direct physician supervision* of the person performing the service, except for authorized care management services (as described in section 230) which may be furnished under general supervision.

(MBPM Chapter 13; 120.1)

MULTIPLE ENCOUNTERS ARE ALLOWED WHEN:

- ✓ The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (2 visits), or
- ✓ The patient has a medical visit and a Behavioral health visit on the same day (2 visits), or
- ✓ The patient has his/her IPPE and a separate medical and/or Behavioral health visit on the same day (2 or 3 visits).

✓ (Medicare Benefit Policy Manual. Chapter 13. Section 40.3)

RHC USE OF MODIFIERS -59 AND -25

Modifier-59 indicates that separate conditions on the same treated are unrelated. This is used only a subsequent illness or injury on the same day as another visit. Modifier-25 in an RHC in interchangeable with -59!

- ✓ Modifier-59 and -25 indicate two encounters. -25 is different in an RHC. Modifier 25 or 59 is only on the SECOND line item UB-04 on a claim form.
- ✓ **RHC Pro Tip:** Modifier-25 is NOT used to distinguish an Evaluation and Management Service from a procedure.

CG MODIFIER FAQ: SUBSEQUENT ILLNESS OR INJURY

Is modifier CG reported on a ***subsequent*** visit which occurs on the same day as an earlier visit?

✓ A13. No.

Q14. Should modifier CG and modifier 25 or modifier 59 be reported on the same service line together to indicate a ***subsequent*** medically necessary visit?

✓ A14. No.

From A15: *Modifier 25 or 59 is reported only on the line that represents the primary reason for the subsequent visit.*

MODIFIER-59 EXAMPLE: SUBSEQUENT INJURY

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	04/02/2020	1	$ 350.00
521	Laceration Repair	12002 59	04/02/2020	1	$ 0.01
0001	Total Charge				$ 350.01

Modifier CG and modifiers 25/59 are NOT reported on the same service line together to indicate a subsequent medically necessary visit.

MEDICARE BEHAVIORAL HEALTH QUALIFIED VISITS

HCPCS	Description
90791	Psych Diagnostic Evaluation
90792	Psych Diag Eval w/Med Services
90832	Psytx Pt/Family 30 minutes
90834	Psytx Pt/Family 45 minutes
90837	Psytx Pt/Family 60 minutes
90839	Psytx Crisis Initial 60 minutes
90845	Psychoanalysis

BEHAVIORAL HEALTH CLAIM

Behavioral Health Services performed by a qualified provider are billed using Revenue Code 0900.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0900	Psytx Pt Family 30 Min	90836 CG	10/04/2021	1	$ 120.00
0001	Total Charge				$ 120.00

CLINICAL VISIT AND BEHAVIORAL HEALTH

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Office Visit Est III	99213CG	10/04/2021	1	$ 220.00
0900	Rx Management	90832CG	10/04/2021	1	$ 120.00
0001	Total Charge				$ 340.00

NOTE: Unique scenario that requires TWO CG Modifiers!

Modifier CG should be reported once per day for a qualified medical visit (revenue code 052x) and/or once per day for a qualified Behavioral health visit (revenue code 0900).

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT)

SBIRT is an approach to the delivery of early intervention and treatment to people with substance use disorders and those at risk of developing these disorders. (https://www.samhsa.gov/sbirt)

PREVENTIVE RHC SERVICES

RHC services also include certain preventive services. These include:

- ✓ Welcome To Medicare Visit (G0402)
- ✓ Annual Wellness Visit/Subsequent Annual Wellness (G0438/G0439)
- ✓ Medicare-covered Preventive Services (DMST is NOT eligible as an RHC Visit!)
- ✓ Influenza, Pneumococcal (Medicare Cost Report – Medicare Flu/Pneumo Only)
- ✓ Immunizations
- ✓ Chronic Care Management (G0511/G0512)
- ✓ Virtual Communication Services (G0071)

(Medicare Benefit Policy Manual Chapter 13)

PREVENTIVE SERVICES AND SAME DAY BILLING

"RHC/FQHC can receive a separate payment for an encounter in addition to the payment for the [Certain Preventive Services] when they are performed on the same day."

MLN SE1039

The IPPE (G0402) is the only Medicare Preventive Service eligible for same-day billing.

INITIAL PREVENTIVE PHYSICAL EXAM (G0402)

- ✓ The IPPE is a one-time exam that must occur within the first 12 months following the beneficiary's enrollment.
- ✓ If an IPPE visit is furnished on the same day as another billable visit, two visits may be billed. It is a "stand-alone" visit.
- ✓ No other Medicare Preventive Screenings are eligible as "stand-alone."
- ✓ The IPPE (G0402) is the only Medicare Preventive Service eligible for same-day billing.
- ✓ The beneficiary coinsurance and deductible are waived.

BILLING EXAMPLE: IPPE PLUS OFFICE VISIT

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient III	99213CG	04/02/2020	1	$ 100.00
0521	IPPE	G0402	04/02/2020	1	$ 200.00
0001	Total Charge				$ 300.00

"Modifier CG does not need to be reported with the IPPE HCPCS code whether it is billed alone or with other payable services on a claim. When IPPE is furnished with another medically necessary face-to-face service, modifier CG is reported with the HCPCS code for the other billable service." RHC Reporting FAQ

STAND-ALONE ENCOUNTERS

If a “Stand Alone” encounter is the only service rendered on a particular date of service, then it will be paid at the AIR. If it is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible may be waived, depending on the service rendered.

- ✓ Annual Wellness Visit (AWV) and Personalized Prevention Plan Services (PPPS)
- ✓ Subsequent Annual Wellness Visit
- ✓ Advanced Care Planning
- ✓ Medicare Preventive Screenings

ANNUAL WELLNESS VISIT (G0438 AND G0439)

The AWV is a personalized prevention plan for beneficiaries who are not within the first 12 months of their first Part B coverage period and have not received an IPPE or AWV within the past 12 months.

- ✓ The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC practitioner.
- ✓ If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit.
- ✓ The beneficiary coinsurance and deductible are waived.

OFFICE VISIT AND PREVENTIVE W. ANCILLARY

An established patient is seen and a qualifying visit of 99213 for $100 is generated. An Annual Wellness Visit was also performed for $100.00. A venipuncture was performed for $20.00.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213 CG	04/02/2021	1	$ 120.01
0521	AWV	G0438	04/02/2021	1	$ 100.00
0300	Venipuncture	36415	04/02/2021	1	$ 0.01
0001	Total Charge				$ 220.02

- ✓ The charge for the AWV should NOT be bundled in the 99213 line.
- ✓ The $20.00 venipuncture charge will be bundled with the 99213 charge for $100.00.
- ✓ The AWV does not result in direct reimbursement.

BILLING EXAMPLE: WELL-WOMAN EXAM

Medicare does not pay a well-woman exams (99381-99387). An annual or subsequent wellness visit (G0438/G0439) is reported for the examination, plus the breast/pelvic exam (G0101), and the pap smear (Q0091).

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Subsq AWV	G0439 CG	04/02/2021	1	$ 175.00
0521	Breast/Pelvic	G0101	04/02/2021	1	$ 75.00
0521	Pap Smear	Q0091	04/02/2021	1	$ 50.00
0001	Total Charge				$ 300.00

All Preventive Services are listed to capture quality measure and to report utilization to Medicare for COB. The patient is not responsible for any co-insurance or deductible for these Medicare Preventive Services.

STAND ALONE ENCOUNTERS
PREVENTIVE SERVICE CODES

Code	Description
G0101	CA Screen/Pelvic
G0102*	Prostate screening
G0117*	Glaucoma Screen
G0118*	Glaucoma Screen - Supervised
G0296	Visit to determine LDCT Eligibility (Lung Cancer)
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel >10
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel

* Co-Insurance and Deductible apply

STAND ALONE VISIT CODES

Qualifying Visit	
G0444	Depression screen annual
G0445	High intensity behavioral counseling, 30 min
G0446	Intensive behavioral therapy - Cardio diagnostic
G0447	Behavioral counseling obesity, 15 min
Q0091	Obtaining screening pap smear

DIABETES COUNSELING AND MEDICAL NUTRITION SERVICES

Diabetes counseling or medical nutrition services provided by a registered dietician or nutritional professional at a RHC may be considered incident to a visit with a RHC practitioner provided all applicable conditions are met.

- ✓ RHCs are permitted to become certified providers of DSMT services and report the cost of such services on their cost report for inclusion in the computation of their AIR.

CMS QUICK REFERENCE GUIDE

- ✓ See the following chart for a quick reference on RHC billing.
- ✓ This is also posted on www.northamericanhms.com.

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

INFLUENZA (G0008) AND PNEUMOCOCCAL VACCINES (G0009)

Influenza and pneumococcal vaccines and their administration are paid at 100 percent of reasonable cost through the cost report. No visit is billed, and these costs should not be included on the claim. The beneficiary coinsurance and deductible are waived.

HEPATITIS B VACCINE (G0010)

Hepatitis B vaccine and its administration is included in the RHC visit and is not separately billable. The cost of the vaccine and its administration can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if vaccine administration is the only service the RHC provides. The beneficiary coinsurance and deductible are waived.

TDAP SHOTS

“Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) don’t cover the Tdap shot.

Generally, Medicare prescription drug coverage (Part D) covers all commercially available shots needed to prevent illness. Contact [patient] Medicare drug plan for more information about coverage.”

www.medicare.gov/coverage/tdap-shots

G0511: GENERAL CARE MANAGEMENT SERVICES

Payment for G0511 is set at the average of the 3 national non-facility PFS payment rates for the CCM (CPT code 99490 and CPT code 99487) and general BHI (CPT code 99484).

- ✓ The *current* 2021 *payment rate is* $66.77.
- ✓ The rate is updated annually based on the PFS amounts and coinsurance applies.

G0511 PATIENT ELIGIBILITY

Option A: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, OR

Option B: Any behavioral health or psychiatric condition being treated by the RHC or FQHC practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services.

G0512: PSYCHIATRIC COORDINATION OF CARE MANAGEMENT

G0512: Psychiatric Coordination of Care Management

- ✓ billed alone or with other payable services on a RHC or FQHC claim.
- ✓ This code could only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period.
- ✓ Payment for G0512 is set at the average of the 2 national non-facility PFS payment rates for CoCM (CPT code 99492 and CPT code 99493).

The Psychiatric CoCM payment for 2020 is $141.83. Coinsurance applies.

CCM CLAIM EXAMPLE

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	CCM	G0511	04/02/2020	1	$ 75.00
0001	Total Charge				$ 75.00

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient III	99213CG	04/02/2020	1	$ 100.00
0521	CCM	G0511	04/02/2020	1	$ 75.00
0001	Total Charge				$ 175.00

TCM CLAIM EXAMPLE

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Tx Care Management	99495CG	4/2/2021	1	$ 150.00
0001	Total Charge				$ 150.00

- ✓ TCM cannot be billed with Care Management Services.
- ✓ TCM are billed and paid at the All-Inclusive Rate (AIR).
- ✓ Stand-alone billable visit: If it is furnished on the same day as another visit, only one visit is paid.

RHC TELEHEALTH BILLING

TELEHEALTH VS TELEMEDICINE SERVICES

- ✓ Telehealth is the broad range of services rendered via audio visual technology.
- ✓ Telemedicine refers to the professional services…rendered via Telehealth.

MEDICARE TELEHEALTH: EFFECTIVE MARCH 27, 2020

On March 27, 2020, the (CARES Act) was signed into law. Section 3704 authorizes RHCs and FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE.

- ✓ Medicare telehealth services require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient.
- ✓ *RHCs and FQHCs with this capability can immediately provide and be paid for telehealth services to patients covered by Medicare for the duration of the COVID-19 PHE.*

G2025 ONLY

RHCs and FQHCs must use HCPCS code G2025, the new RHC/FQHC specific G-code for distant site telehealth services, to identify services that were furnished via telehealth beginning on January 27, 2020, the date the COVID-19 PHE became effective.

https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx).

DISTANT SITE PROVIDERS

Distant site telehealth services can be furnished by *any health care practitioner* working for the RHC or the FQHC within their scope of practice. (This includes 99201 and 99211.)

Practitioners can furnish distant site telehealth services from any location, including their home, during the time that they are working for the RHC or FQHC, and can furnish any telehealth service that is approved as a distant site telehealth service under the Physician Fee Schedule (PFS)!!

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

MEDICARE TELEPHONE ONLY VISITS = G2025

During the COVID-19 PHE, RHCs and FQHCs can furnish any telehealth service that is approved as a Medicare Telehealth Service under the PFS. (See Medicare Approved Telehealth Services)

Effective March 1, 2020, these services include CPT codes ***99441, 99442, and 99443***, which are audio-only telephone evaluation and management (E/M) services. RHCs and FQHCs can furnish and bill for these services using HCPCS code G2025.

*Prior guidance CMS had indicated that telephone only visits could only be billed as G0071 – Virtual Check-In. The **CURRENT guidance:** We can adjust telephone only claims that were billed G0071 to G2025 to be paid the higher rate – back to March 1, 2020.*

See MLN SE20016. Revised July 6, 2020 https://www.cms.gov/files/document/se20016.pdf

MEDICARE *TELEPHONE ONLY VISITS*

RHCs and FQHCs ***can*** furnish and bill for these services using HCPCS code G2025. To bill for these services:

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

ANNUAL WELLNESS VISITS AND TELEHEALTH

"Currently, Medicare policy allows for the billing of the AWV (G0438-G0439) when delivered via telehealth provided that all elements of the AWV are provided (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf).

For the duration of the public health emergency, the AWV may be administered using audio-only technology, if a video connection with the patient is not possible. If the patient can self-report elements of the AWV (i.e., height. weight, blood pressure, other measurements deemed appropriate based on medical and family history), those measurements may be included and recorded in the medical record as reported by the patient. Guidance for when the patient cannot self-report is currently under review, and CMS plans to issue guidance soon."

COVID-19 Help Desk Team

CS MODIFIER FOR COVID-RELATED SERVICES: CO-INSURANCE MUST BE WAIVED

For services related to COVID-19 testing, including telehealth, RHCs and FQHCs must waive the collection of co-insurance from beneficiaries.

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

TELEHEALTH CO-INSURANCE AND DEDUCTIBLE

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

TELEHEALTH SERVICES COST SHARING WAIVED

Per SE20016 revised: “There are several CPT and HCPCS codes included in the list of telehealth codes at the link above that describe preventive services that have waived cost-sharing.

As stated earlier in this article, telehealth services on this list are billed using HCPCS code G2025. *In order to distinguish those telehealth services that do not have cost sharing waived from those that do, such as certain preventive services, RHCs and FQHCs must also report modifier CS.*

SE20016 REVISED: CS – MODIFIER

CS - Cost-sharing waived:

for specified COVID-19 testing-related services that result in and order for or administration of a COVID-19 test, **and/or**

for **cost-sharing waived preventive services furnished via telehealth in Rural Health Clinics** and Federally Qualified Health Centers during the COVID-19 public health emergency.

RHC TELEHEALTH DISTANT SITE SERVICES:

Rev CD	Desc	HCPCS/CPT	DOS	Units	Total Charge
0521	RHC Distant Site	G2025	08/21/2021	1	$ 99.45
0001	Total Charge				$ 99.45

Beginning July 1, 2020, RHCs should no longer put the CG modifier on claims with HCPCS code G2025. **These claims will be paid at $99.45.***

TELEHEALTH ORIGINATING SITE CLAIM EXAMPLE

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0780	Telehealth	Q3014	4/2/2020	1	$ 23.17
0001	Total Charge				$ 23.17

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

“RHCs and FQHCs may serve as an originating site for telehealth services, which is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. RHCs and FQHCs that serve as an originating site for telehealth services are paid an originating site facility fee.”

RHC - CMS RESOURCES

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

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

Medicare Benefit Policy Manual – Chapter 13 RHC/FQHC

www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

Medicare Claims Processing Manual UB04 Completion

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

Medicare Benefit Policy Manual- Chapter 15 Other Services

www.cms.gov/Regulations-and_Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

RHC - CMS RESOURCES

State Operations Manual Appendix G (Updated 2.10.20)

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

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

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

REFERENCE

Centers for Medicare and Medicaid Services. MLN 20016 Revised. "New and Expanded Flexibilities for Rural Health Clinics (FQHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)". February 23, 2021.

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