

Telehealth Reimbursement Updates for FQHCs and RHCs in 2019

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TRC



House Keeping Items

All participants will be on mute for the duration of the presentation.

Q/A will be at the end of the slide presentation. If you have questions during, please use the chat box or write them down.

This presentation will cover: Medicare Virtual Visits, Medi-Cal fee-for-service updates, FQHC and RHC specific reimbursement scenarios, and Managed Care updates.

This presentation will NOT cover: Commercial Payers, IPAs, or full telehealth reimbursement policies.

For full telehealth polices for the payers discussed in this presentation, please visit our website www.caltrc.org/knowledge-center/reimbursement



MODERN ART GALLERY



I know what you're thinking.....
Just tell me how to get paid already

A doctor wearing blue scrubs and a stethoscope is holding a red-framed sign. The sign has a black background with the word "MEDICARE" written in white, handwritten-style capital letters. The image has a torn paper effect around the edges.

MEDICARE

Traditional Medicare Telehealth Billing Criteria

Recap:

1. The patient must be seen from an “originating site” as defined by CMS.
2. The originating site must be located in an eligible geographic area: <https://data.hrsa.gov/tools/medicare/telehealth>
3. The encounter is performed at the “distant site” by an eligible practitioner.
RHCs and FQHCs cannot provide services as a distant site for Medicare reimbursement. This includes bringing the specialist in to the 4 walls virtually
4. The patient must be present and the encounter must involve interactive audio and video telecommunications
5. Type of Service provided must fall within the Medicare Eligible Services table.

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**.

NOTE: 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**.

NOTE: 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**.



CMS Expansion of Telehealth 2019 Overview

BRIEF COMMUNICATION TECHNOLOGY-BASED SERVICE (AKA Virtual Check-Ins)

- When a physician or other qualified health care professional has a brief, non-face-to face, check-in with a patient via communication technology to assess whether the patient's condition necessitates an office visit
- Not labeled telehealth, therefore not subject to telehealth restrictions
- Code G0071 (FQHC/RHC)

REMOTE EVALUATION OF PRE-RECORDED PATIENT INFORMATION (AKA Store and Forward)

- Remote professional evaluation of patient-transmitted information conducted via pre-recorded "store and forward" video or image technology
- Not labeled telehealth, therefore not subject to telehealth restrictions
- Must be an established patient
- Code G0071 (FQHC/RHC)

CHRONIC CARE MANAGEMENT (CCM)

- FQHC/RHC bill for chronic care management services using G0511 and includes

REMOTE PHYSIOLOGICAL MONITORING (AKA Remote Patient Monitoring)

One of the most frequently asked questions is "What activities count towards the 20 minute requirement for the G0511"? The answer would be:

- Video chat, phone calls, emails, and messaging with the patient and their caregiver and family members
- Lab, report, and image review and processing
- Care plan creation, revision, and review
- Chart documentation
- Medication reconciliation, overseeing patient self-management of medication
- Medication refills
- Referring to and consulting with other providers and time spent closing the referral loop
- Communicating with home and community based providers
- Remote monitoring of physiological data
- Post-discharge follow-up



CMS Expansion of Telehealth 2019 Overview

SUPPORT for Patients and Communities Act

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act requires CMS to remove the originating site geographic requirements for telehealth services on or after **July 1, 2019** for any existing Medicare telehealth originating site (except for a renal dialysis facility) for purposes of treating substance use disorder or co-occurring mental health disorder.

The home was made an eligible originating site for purposes of treating these patients.

***The home does not qualify for the Originating Site fee.**

In the 2020 proposed Physician Fee Schedule, Medicare is proposing to add 3 monthly bundled payments for MAT treatment. The proposed codes are:

- GYYY1: Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.
- GYYY2: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.
- GYYY3: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure).



Virtual Check-Ins



These interactions are patient initiated telephone or live video interactions. They involve a physician or non-physician practitioner having a brief, at least 5 minute, check-in with an established patient to assess whether the patient needs to come in for an office visit. The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

The virtual check-in must be for a condition not related to an E/M service provided within the previous 7 days and does not lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

There are no frequency limitations at this time.

Billable providers are physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers. If the discussion could be conducted by a nurse, health educator, or other clinical personnel, it would not be billable as a virtual communication service.

FQHCs and RHCs are allowed to bill for a Virtual Check-In. Virtual Check-Ins at an FQHC or RHC are billed with **code G0071**. The rate charged will be the physician fee schedule rate, not the all-inclusive rate (AIR) or prospective payment system (PPS).



Remote Evaluation Services – Store & Forward

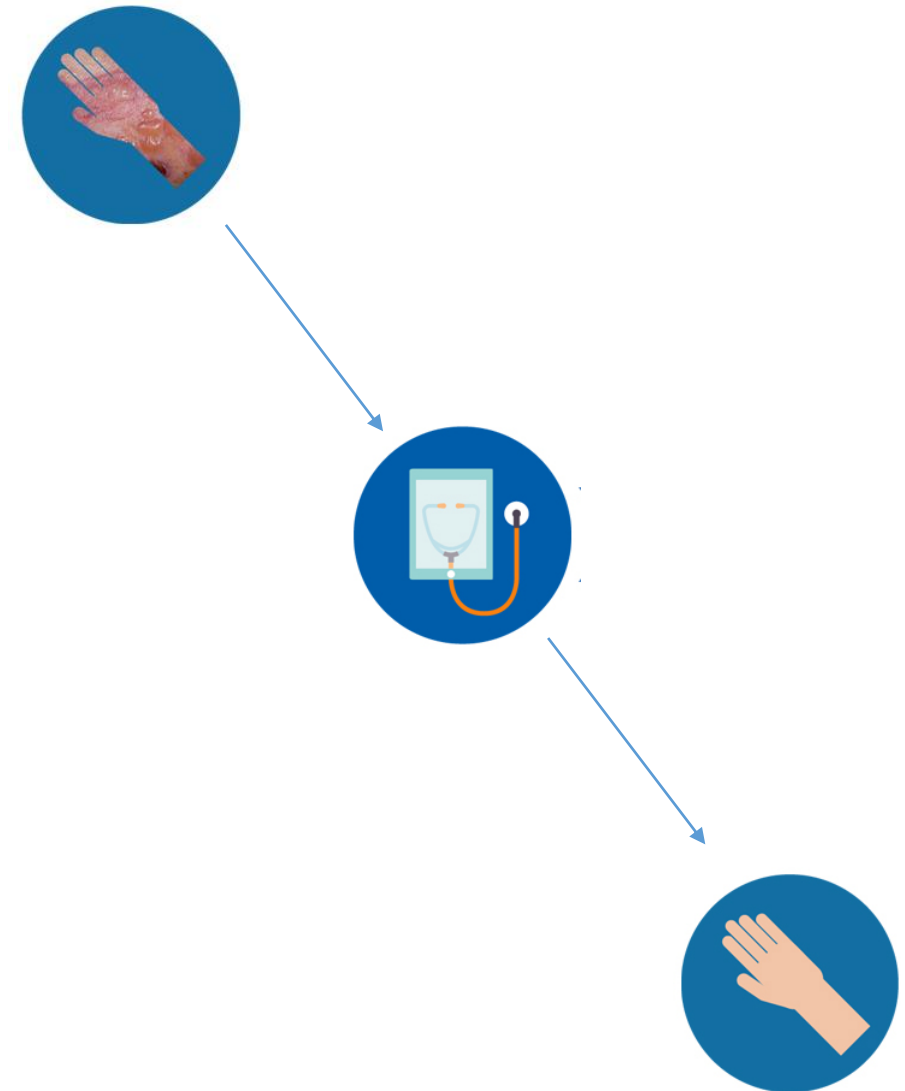
Remote evaluation services are patient initiated and consist of a practitioner evaluating an established patient's transmitted information via pre-recorded video or image. The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

The services can only be billed if the condition is not related to a service provided within the previous 7 days and does not lead to a service provided within the next 24 hours or soonest available appointment.

There are no frequency limitations at this time.

Billable by physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers. If the discussion could be conducted by a nurse, health educator, or other clinical personnel, it would not be billable as a virtual communication service.

FQHCs/RHCs are allowed to bill for Remote Evaluation services when an established patient sends recorded video or images to the FQHC/RHC. Remote Evaluation Services are billed with **code G0071**.



Chronic Care Management - RPM



CCM code 99491 will be included in the rate setting for FQHCs & RHCs. RPM is included under the CCM program.

The new definition for RPM is “the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency.”

Under this definition, RPM will only be reimbursable when reported as a service in the provision of another skilled service.


Home visits for the purpose of supplying or maintaining RPM equipment without the provision of another skilled service will not be separately billable, but will constitute an allowable administrative cost under amendments to 42 CFR 409.46.

For CCM services furnished on or after January 1, 2019, CCM services can be billed by adding G0511 to a FQHC or RHC claim, either alone or with other payable services.

CMS Care Management Services in RHCs and FQHCs - Frequently Asked Questions

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



A doctor wearing blue scrubs and a stethoscope is holding a red-framed sign. The sign has a black background with the word 'MEDI-CAL' written in white, handwritten-style capital letters. The image has a torn paper effect around the edges.

MEDI-CAL

Medi-Cal Fee-For-Service

Originating Site is where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates. For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the patient or by the health care provider is not limited. The type of setting may include, but is not limited to, a hospital, medical office, community clinic or the **patient's home**.

Distant Site is where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.

1. Be licensed in the State of California
2. Enrolled as a Medi-Cal provider
3. Be located in California or reside in a border community *
4. A health care provider who is part of a group, with an office physically located in California, may reside outside California.

* Border communities:

Oregon: Ashland, Brookings, Cave Junction, Grants Pass, Jacksonville, Klamath Falls, Lakeview, Medford, Merrill

Nevada: Carson City, Henderson, Incline Village, Las Vegas, Minden, Reno, Sparks, Zephyr Cove

Arizona: Bullhead City, Kingman, Lake Havasu City, Parker, Yuma



Medi-Cal Fee-For-Service

Modifiers

Only services rendered from the distant site are billed with one of the following modifiers:

95 interactive audio and video telecommunications system (live interactive)
GQ for Store and forward applications.

Place of Service

Health care providers are required to document Place of Service code 02 on the claim, which indicates that services were provided or received through a telecommunications system.

The Place of Service code “02” requirement is not applicable for FQHCs, RHCs or IHS clinics.



Medi-Cal Fee-For-Service

Informed Consent

Health care providers must inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services.

If a health care provider, whether at the originating site or distant site, maintains a general consent agreement that specifically mentions use of telehealth as an acceptable modality for delivery of services, then this is sufficient for documentation of patient consent and should be kept in the patient's medical file.

The consent shall be documented in the patient's medical file DHCS upon request.

Consent shall including the following:

- A description of the risks, benefits and consequences of telemedicine
- The patient retains the right to withdraw at any time
- All existing confidentiality protections apply
- The patient has access to all transmitted medical information
- No dissemination of any patient images or information to other entities without further written consent



Medi-Cal Fee-For-Service

Informed Consent: Asynchronous Store and Forward

A patient receiving teleophthalmology, teledermatology or teledentistry by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician, optometrist, or dentist and shall receive an interactive communication with the distant specialist physician, optometrist or dentist, upon request.

If requested, communication with the distant specialist physician, optometrist or dentist may occur either at the time of the consultation or within 30 days of the patient's notification of the results of the consultation.



Medi-Cal Fee-For-Service

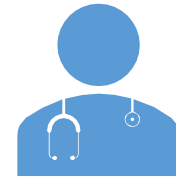
Documentation

All health care practitioners providing covered benefits or services must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT or HCPCS codes.

Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service.

Providers should note the following:

- Health care providers at the distant site must determine that the covered Medi-Cal service or benefit being delivered via telehealth meets the procedural definition and components of the code(s) associated with the Medi-Cal covered service or benefit as well as any other requirements described in this section of the Medi-Cal provider manual.
- Health care providers are not required to document a barrier to an in-person visit for Medi-Cal coverage of services provided via telehealth.
- Health care providers at the distant site are not required to document cost effectiveness of telehealth to be reimbursed for telehealth services or store and forward services.



Medi-Cal Fee-For-Service

Asynchronous Store and Forward

Modifier GQ must be used for all asynchronous benefits or services, including, but not limited to, teleophthalmology, teledermatology, teledentistry, and teleradiology, delivered via asynchronous store and forward telecommunications systems, including through e-consult.

Only the portion(s) rendered from the distant site are billed with modifier GQ.

Health care providers must ensure that the documentation, typically images, sent via store and forward be specific to the patient's condition and adequate for meeting the procedural definition and components of the CPT or HCPCS code that is billed.

The health care provider shall comply with the informed consent provision when a patient receives teleophthalmology and teledermatology by store and forward.

Teleophthalmology and teledermatology does not include single mode consultations by telephone calls, images transmitted via facsimile machines or electronic mail.



Medi-Cal Fee-For-Service

Resources:

Providers may email questions about Medi-Cal telehealth policy to:

Medi-Cal_Telehealth@dhcs.ca.gov



California Department of Health Care Services Medi-Cal Program Telehealth Webpage:

<http://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx>



A healthcare professional, likely a nurse or doctor, is shown from the chest up, wearing blue scrubs and a stethoscope. They are holding a red-framed sign with both hands. The sign has a black background with white text. The image has a torn paper effect around the edges.

FQHC & RHC
BILLING

FQHC and RHC Telehealth Billing

There are a number of factors that determine how to bill for telemedicine services.

Two principles form the foundation:

- The place determined to be the provider site is the billing site **and**
- A provider can, under certain circumstances, enter the four walls virtually using telemedicine

The factors that determine the billing scenario are:

- Where the patient is physically located
- Characteristics of the specialty provider site
- Payment arrangement with the specialty provider
- If there is medical reason for a provider to be present with the patient.



PEOPLE
COMMUNITY



Medicare for FQHCs or RHCs

1. FQHCs or RHC are only allowed to be an originating site for traditional Medicare services, as long as they are in an eligible location.
 - a. If a billable provider has a medical need to be in the room with the patient during the telehealth consult, an FQHC or RHC may bill their PPS rate for an in person visit
 - b. If there was no medical need for a provider to be present during the consult, the FQHC or RHC is eligible to bill a **Q3014** as a part B payment to the MAC
2. FQHCs and RHCs are eligible to utilize some of Medicare's Virtual Care services.
 1. Virtual Check-Ins are billed with **G0071**. The rate charged will be the physician fee schedule rate, not the PPS rate.
 2. Remote Evaluation of Pre-Recorded, Patient Submitted Photos or Recorded Video are also billed with **G0071**.
 3. Chronic Care Management and Remote Physiological Monitoring. If a FQHC or RHC has a CCM program, they are allowed to bill for RPM services. The code billed is **G0511**.

Let's look at the billing models for Virtual Visits and Remote Evaluation for the FQHC or RHC



Scenario 2

Patient (off-site) to an FQHC/RHC

- Provider is physically located at and receives compensation from FQHC/RHC
- Patient is an established patient and initiates a live video or phone call to see if they need to come in to the FQHC/RHC for an in person visit.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.
- Patient has NOT been seen for an E/M code in the previous 7 days, and the appointment does not lead to an in person visit within the next 24 hours or soonest available appointment.

Outcome

- FQHC billable provider spent at least 5 minutes talking to patient.
- Patient has not been seen for this issue in the past 7 days and does not need an in person visit.
- FQHC or RHC can bill for the Virtual Visit Service.

Off-Site Location
(such as the patient's home)



Patient

Patient initiated phone call
or live video call

FQHC or RHC



Provider
(Physician, NP, PA, CNM,
Psychologist, and CSW)



FQHC/RHC bills
G0071 to Medicare

Medicare Remote Evaluation

Scenario 3

Patient (off-site) to an FQHC/RHC

- Provider is physically located at and receives compensation from FQHC/RHC
- Patient is an established patient and initiates an asynchronous transmission of photos or video to the FQHC/RHC.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.
- Patient has NOT been seen for an E/M code in the previous 7 days, and the appointment does not lead to an in person visit within the next 24 hours or soonest available appointment.

Outcome

- FQHC billable provider evaluated the patient transmitted images or video.
- Patient has not been seen for this issue in the past 7 days and does not need an in person visit.
- FQHC or RHC can bill for the Remote Evaluation service.

Off-Site Location
(such as the patient's home)



Patient

Patient initiated phone call
or live video call

FQHC or RHC



Provider
(Physician, NP, PA, CNM,
Psychologist, and CSW)

FQHC/RHC bills
G0071 to Medicare



Medi-Cal Fee-For-Service for FQHCs or RHCs

Things to Consider: FQHC and RHC sites are not eligible to bill an originating site fee or transmission charges for fee-for-service Medi-Cal. The cost of these services should be accounted for in the PPS or AIR calculation. Telehealth services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.



Reimbursement Models: In the following slides we will discuss a few of the popular reimbursement models for Fee-For-Service Medi-Cal and Medi-Cal Managed Care Plans.

First, let's address a few definitions that will help to clarify the policies we will be diving in to in a bit.



Medi-Cal Fee-For-Service for FQHCs or RHCs

Established Patient: is a Medi-Cal eligible recipient who meets one or more of the following conditions:

1. The patient has a health record with the FQHC or RHC that was created, or updated, during a visit that occurred in the clinic within the previous 3 years; or during a synchronous telehealth visit in a patient's home with a clinic provider and a billable provider at the FQHC or RHC. The patient's health record must have been created or updated within the previous three years.
2. The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit, occurring within the last three years, that was provided outside the FQHC or RHC clinic, but within the FQHCs or RHCs service area. All consent for telehealth services for these patients must be documented.
3. The patient is assigned to the FQHC or RHC by their Managed Care Plan (MCP) pursuant to a written agreement between the plan and the FQHC or RHC.
4. When a health record is maintained among multiple FQHCs or RHCs within the same organization, the patient is an established patient of the organization's FQHCs or RHCs.

HHMS: Homeless, Homebound, Seasonal or Migratory Worker.

Homebound: means the patient must have a normal inability to leave home and leaving home must require considerable and taxing effort due to either:

1. An illness or injury where
 - a. There is a need for the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; or
 - b. The use of special transportation; or
 - c. The assistance of another person in order to leave their place of residence.
2. Having a documented condition such that leaving his or her home is medically contraindicated.

Homeless: Shall include all individuals who do not reside in a permanent residence, who do not have a fixed home, or mailing address.

Migratory or seasonal worker: An individual who meets the definition of migratory agricultural worker in Section 330(g)(3)(A) of the Public Health Service Act or seasonal agriculture worker in Section 330(g)(3)(B) of the Public Health Service Act.

Residence or Home: is a fixed or permanent dwelling, such as a house, including a stationary mobile home, an apartment, or a group home, transitional home, skilled nursing facility, intermediate care facility, developmentally disabled home, or other care setting.



Medi-Cal Fee-For-Service for FQHCs or RHCs

Telehealth to the patient's home: FQHCs/RHCs are allowed to provide live video telehealth services to the patient home, however, the following conditions will be in place:

1. The patient must be an established patient and either homeless, homebound, or a migratory or seasonal worker.
2. The FQHC or RHC may bill its PPS rate for services provided outside the Four Walls. The FQHC or RHC must maintain documentation demonstrating that the person is homeless, homebound, or a migratory or seasonal worker. The FQHC or RHC shall meet all of the following requirements:
 - a. The visit must be at the patient's residence.
 - b. The person rendering the service must be employed or under contract with the FQHC or RHC at the time the services are rendered.
 - c. Services must be rendered within the FQHC's Health Resources and Services Administration's (HRSA) approved service area.



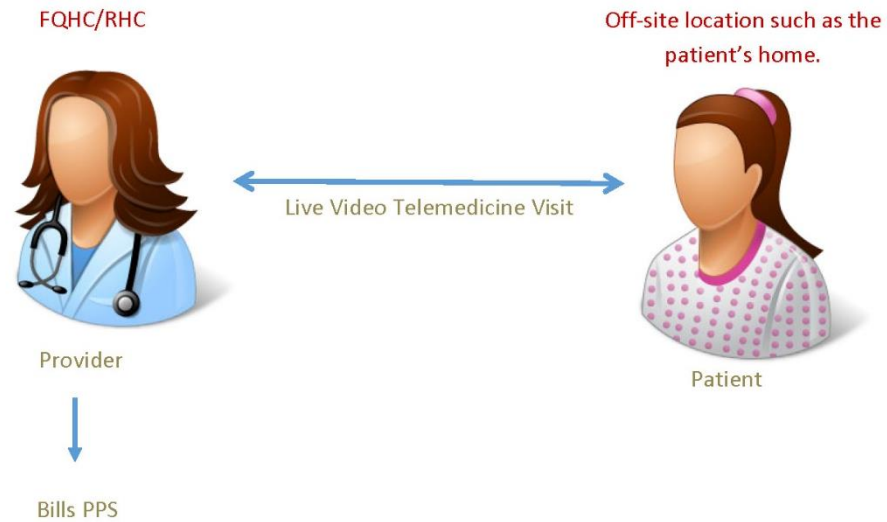
Scenario 9

FQHC/RHC to HHMS Patient Home

- Provider is physically located at and receives compensation from FQHC/RHC
- Patient is an established patient, and either **homebound**, **homeless**, or **a season or migratory worker**.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.

Outcome

- FQHC/RHC is the Distant Site (or Provider Site) and can bill PPS for a face-to-face visit.



Medi-Cal Fee-For-Service for FQHCs or RHCs

Synchronous Live Video Telehealth Services: Services provided through synchronous, live video telehealth for an established patient are subject to the same program restrictions, limitations and coverage that exist when the service is provided in-person.

1. FQHCs and RHCs may bill for a telehealth visit if it is medically necessary for a billable provider to be present with a patient during the telehealth visit.
2. An FQHC or RHC billable provider furnishes services as a distant site.
3. FQHCs and RHCs must submit claims for telehealth services using the appropriate all-inclusive billing code sets and related claims submission requirements.

Originating site and transmission fees: FQHCs and RHCs are not eligible to bill an originating site fee, or transmission charges. The cost of these services should be included in the PPS rate.

Synchronous Live Video Conditions for Payment:

1. If the Originating Site and the Distant Site are FQHCs or RHCs that are part of the same organization, only one site may bill for the visit, even if a billable provider participates at each location.
2. If the Originating Site and the Distant Site are both FQHCs or RHCs but are not part of the same organization, both the Originating Site and Distant Site may each bill for the services at their respective PPS rates if both organizations use medically necessary billable providers. The Originating Site shall not compensate the Distant Site for the Telehealth Services rendered.
3. If the Originating Site is an FQHC or RHC and the Distant Site is not an FQHC or RHC, only the Originating Site can be reimbursed for the Telehealth Service at the PPS rate if a medically necessary billable provider is used. The Originating Site is responsible for reimbursing the Distant Site for the Telehealth Service rendered to its Established patient if a payment arrangement exists.
4. If the Originating Site is not an FQHC or RHC and the Distant Site is a FQHC or RHC, the Distant Site can be reimbursed for the Telehealth Service at the PPS rate. The Originating Site shall not compensate the Distant Site for the Telehealth Services.



Medi-Cal Fee-For-Service for FQHCs or RHCs

Asynchronous Store and Forward Services: Reimbursement is permitted for an established patient for **teleophthalmology, teledermatology and teledentistry**, and furnished by a billable provider at the distant site. An FQHC or RHC may bill at its PPS rate for store and forward ophthalmology, dermatology, and dentistry services provided to its established patient, if it meets all of the following requirements:

1. The Originating Site FQHC or RHC shall comply with the informed consent provision for store and forward prior to its established patient receiving ophthalmology, dermatology and dentistry Store and Forward Services
2. If the Distant Site providing Store and Forward Services is also an FQHC or RHC, the Originating Site may only bill for one visit at its PPS rate, even if the services provided at the Distant Site occurred on a different day. Under no circumstances can two visits be billed for a single Store and Forward Service
3. If the Distant Site is not an FQHC or RHC, the following requirements must be met for the Originating Site FQHC or RHC to be reimbursed at the PPS rate:
 - a. Only one visit can be reimbursed at the PPS rate regardless of the services rendered at the Originating Site
 - b. The Originating Site FQHC or RHC must have an arrangement or current written agreement with the Distant Site to furnish the Store and Forward Services
 - c. The Originating Site FQHC or RHC must compensate the Distant Site for the Store and Forward Services furnished to its patients
 - d. The Distant Site must not directly bill Medi-Cal for the Store and Forward Services.

eConsult: Unfortunately, FQHCs/RHCs are not eligible to bill for eConsult with the new provider manual updates.

Let's look at some of the billing models for Fee-For-Service Medi-Cal for the FQHC or RHC



Medi-Cal Fee-For-Service

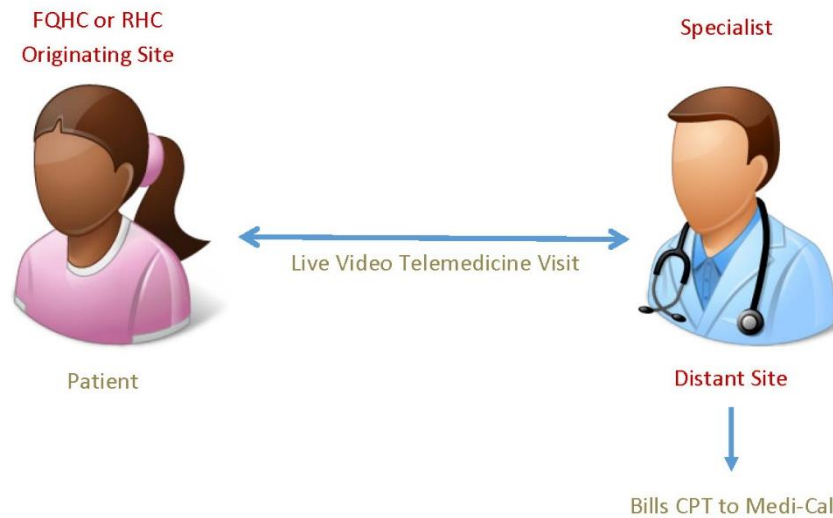
Scenario 4

FQHC/RHC Originating Site to a Fee-For-Service Distant Site

- Patient is physically present at the FQHC or RHC
- Specialist is a Medi-Cal fee-for-service provider not physically present at the FQHC or RHC
- FQHC or RHC and specialist have an agreement to provide services, however the FQHC or RHC does not compensate the specialist
- No medical reason for a provider to be present with the patient at the FQHC or RHC Site

Outcome

- Medi-Cal specialist is the Distant Site and can bill fee-for-service rate
- FQHC or RHC is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face



*Per the Medi-Cal handbook:
FQHCs, RHCs, and IHS clinic PPS
sites may not bill for originating
site or transmission fees.



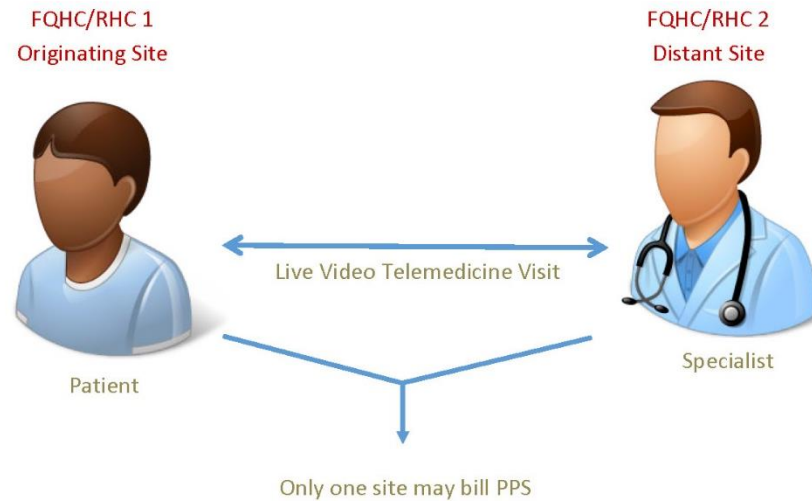
Scenario 7

FQHC/RHC to FQHC/RHC (Within Same Org)

- Patient is physically present at FQHC/RHC 1
- Distant Site Provider is physically at, and receives compensation from, FQHC/RHC 2
- FQHC/RHC 1 and FQHC/RHC 2 have an agreement to provide services and are part of the same organization
- No medical reason for a provider to be present with the patient at the FQHC/RHC 1 Site

Outcome

- FQHC/RHC 2 is the Distant
- FQHC/RHC 1 is the Originating Site
- In this scenario, only 1 FQHC/RHC site may bill since they are part of the same organization.



*Per the Medi-Cal handbook: FQHCs, RHCs, and IHS clinic PPS sites may not bill for originating site or transmission fees.

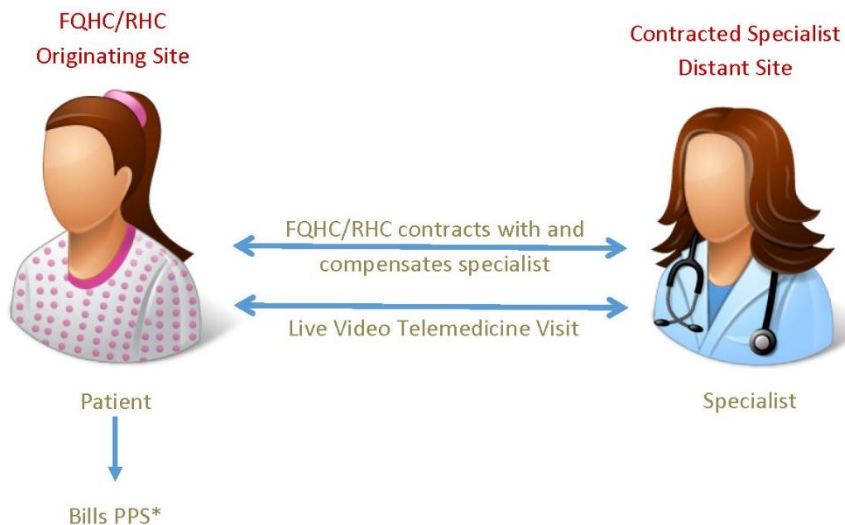
*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.

Scenario 10 FQHC/RHC Originating Site to Contracted Distant Site

- Patient is physically present at FQHC/RHC Site
- Specialist is not physically at the FQHC/RHC
- FQHC/RHC and specialist have a written agreement to provide services. FQHC/RHC compensates specialist outside of an insurance plan.
 - *The agreement should be in writing and clearly state: The time period during which the agreement is in effect; the specific services it covers; any special conditions under which the services are to be provided; and the terms and mechanisms for billing and payment. (See BPHC Policy Information notice 98-23)*
- FQHC or RHC has credentialed the contracted provider in house and with the health plan (if applicable)
- Specialist virtually enters FQHC site via telemedicine

Outcome

- FQHC/RHC becomes the Distant Site and can bill PPS for a face-to-face visit



*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.

Scenario #10 is one of the most popular FQHC/RHC reimbursement scenarios.

1. FQHC/RHC contracts with an outside provider or group to see their patients.
2. FQHC/RHC pays for the specialists time.
3. The specialist does NOT bill payer.
4. FQHC/RHC becomes the distant site and can bill their PPS rate.

Important note: Not all payors will reimburse under this model.



A close-up photograph of a medical professional, likely a doctor, wearing blue scrubs and a stethoscope. The doctor is holding a red-framed sign with both hands. The sign has a black background with the words "MANAGED CARE" written in white, uppercase, sans-serif font. The image has a torn paper effect around the edges.

MANAGED CARE

Payers must have a telehealth policy in place. That policy may be that they do not pay for telemedicine or that they only pay for certain services. Please check with payers to find out their reimbursement policies before providing and billing for telehealth services.

Managed care plans are allowed, and encouraged, to reimburse for services above and beyond what fee-for-service Medi-Cal reimburses for. Most managed care plans in California do not have the restrictions that fee-for-service places on FQHCs.

Most follow Medi-Cal in that they pay for both ends of the consult.

Modifiers may be different (and in some cases, not existent).

Most MCPs allow FQHCs/RHCs to bill both the Q3014 and the T1014.

Most MCPs will allow an FQHC/RHC to be a distant site provider.

Most MCPs allow telehealth to the patient's home, without the HHMS restrictions!



CH&W Holder Slide

CH&W policy slides that were shared during the presentation were for the draft policies. We have removed these slides from the deck.



I. Reimbursement for Traditional Synchronous Telehealth Services

Originating Site

- Patient present
- Provider *optional*

Distant Site

- Provider of service

Partnership HealthPlan of California

K. Reimbursement for Synchronous: Provider to Patient Telehealth Services

Telehealth Advancement Act of 2011 allows for telehealth services to be provided between a qualified provider and patient at a distant location. The location may be a health facility, residential home, patient's home or other location.

Originating Site - Patient Location

- Health facility
- Residential home
- Patient home
- Other location

Provider Site

- Provider Site
- Patient *NOT* present

Covers synchronous live video with modifier 95 and asynchronous store and forward, including eConsult, with modifier GQ.

There are two synchronous models of telehealth services available to plan members.

1. Traditional Live interactive (synchronous) Telehealth Services: connects the patient with a distant provider of health services through audio-video equipment on a real-time basis. This model is commonly used between specialty centers such as UCSF or UCD with outlying physician offices or community health centers.
2. Patient to Provider Telehealth Services: connects a single provider (primary care or specialty provider) to a patient using audio-visual equipment on a real-time basis.

*The patient can be in a health facility, residential group home or **private residence** or other setting, provided the appropriate equipment is used.*

Patient does not need to be HHMS!!

Each telehealth provider must be licensed in the State of California, enrolled as a Medi-Cal provider, and must reside in California (or a border community).

PHC covered services, identified by CPT or HCPC codes, and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

1. The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
2. The services delivered via telehealth meet the procedural definition and components in the CPT-4 or HCPCS code(s) associated with the covered service; and
3. The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Note: A Federally Qualified Health Center (FQHC)/ Rural Health Center (RHC)/Tribal health site may choose to sub-contract with a specialist and pay them directly. Under these circumstances, the FQHC/RHC would bill for the originating site and the specialty service on two separate claims. Designated telehealth specialist providers Referral Authorization Form (RAF) requirements vary, see policy MCUP3124 Referral to Specialists (RAF) Policy. The PHC system would need to be set up for the specific specialty and if not, the Provider Relations Department should be contacted.

Synchronous Live Video Service	CPT Codes
Office or other outpatient visit (new or established patient)	99201-99215
Initial hospital care or subsequent hospital care, critical care (new or established patient)	99221-99233, 99291, 99292, G0508, G0509
Extended Inpatient Care	99356 – 99357
Consultations: Office or other outpatient, initial or follow-up inpatient, Inpatient, and confirmatory	99241-99275
Genetic Counseling	96040, S0265
Nutrition Counseling per PHC Guidelines (See Policy MCUP3052)	97802, 97803, 97804, 99539
Interactive complexity (List separately in addition to the code for primary	90785
Psychiatric diagnostic evaluation	90791
Psychiatric diagnostic evaluation with medical services	90792
Psychotherapy, 30 minutes with patient/or family member	90832
Psychotherapy, 45 minutes with patient/or family member	90834
Psychotherapy, 60 minutes with patient/or family member	90837
Psychotherapy for crisis; first 60 minutes	90839
Additional 30 minutes	90840
Pharmacologic management, including prescription and review of medication, when performed with psychotherapy	90863
Video Visit with provider in office and patient off-site (in lieu of office visit)	G0071 (FQHC/RHC) or G2012 (other providers)
Originating Site Fee	Q3014
Transmission Fee	T1014

Other Covered Procedures that can be provided by Synchronous Live Video: All CPT codes except for these excluded codes:
00100-01999 and 99100-99157; 10021-69990; 96101 to 97546, and 97750 to 97799; 97597 to 97610



There is one asynchronous model of telehealth services available to plan members.

1. Asynchronous telehealth services or store and forward services, connects a member with a distant licensed provider of ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally an image or picture is taken and forwarded to the distant licensed provider to review at a later time.

If a provider uses asynchronous telehealth for diabetic eye exam screenings, through the use of a retinal camera located at the originating site, special billing guidelines apply, when the originating site is paying the specialist directly for reading the results of the retinal photographs. A licensed provider does not need to be present for retinal photography service to be reimbursable. If provider is present during the visit, E&M codes can also be billed as usual.

If no provider is present at visit, bill using one of the following CPT codes:

92250: Retinal photography with interpretation for services provided by optometrists or ophthalmologists

92227: Remote imaging for detection of retinal disease with analysis and report under physician supervision, unilateral or bilateral

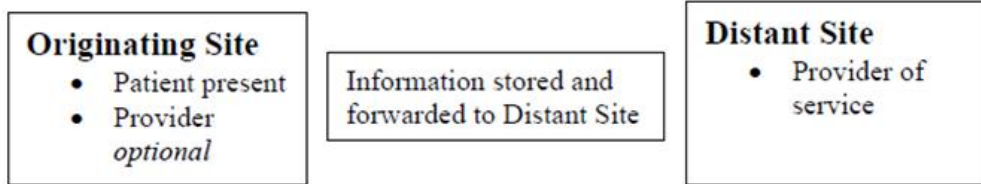
Telephone visits

Any clinician eligible to bill for office visits may conduct a telephone visit with a patient in lieu of an office visit. Such telephone visits must last at least 5 minutes, and be documented in the medical record. Note that these are the same codes used for video visits with the patient at home.

G0071 – FQHCs and RHCs.



J. Reimbursement for Asynchronous Telehealth Services (Store and Forward) for Teleophthamology, Teleoptometry, Teledermatology, Radiology, Electrocardiography and E-Consult Program Services



Special Billing Guidelines for Asynchronous Retinal Photography - Originating Site Providers:
 If a provider uses asynchronous telehealth for diabetic eye exam screenings, through the use of a retinal camera located at the originating site, special billing guidelines apply, when the originating site is paying the specialist directly for reading the results of the retinal photographs. A licensed provider does not need to be present for retinal photography service to be reimbursable. If no provider is present at visit, bill using the following CPT codes:

Asynchronous Store and Forward Service

CPT Codes

Office consultation (new or established patient)	99201-99215
Consultations: Office or other outpatient, initial or follow-up inpatient, Inpatient, and confirmatory	99241-99243, 99231-99233
Remote evaluation of recorded video and/or images submitted by the patient.	G2010
eConsult, electronic consultation	99451
Retinal Photography: with interpretation for services provided by optometrists or ophthalmologists	92250 (no modifier)
Remote imaging for detection of retinal disease with analysis and report under physician supervision, unilateral or bilateral	92227 (no modifier)
Originating Site Fee	Q3014
Transmission Fee	T1014

L. Telephone visits

Any clinician eligible to bill for office visits may conduct a telephone visit with a patient in lieu of an office visit. Such telephone visits must last at least 5 minutes, and be documented in the medical record. Note that these are the same codes used for video visits with the patient at home.

Billing guidelines for Distant Site Providers	
Service	Code
Telephone visit with provider in office and patient remote from office (in lieu of office visit)	G0071 (FQHC and RHC) G2012 (other providers)
Required modifier	GT modifier required for all CPT or HCPCS codes except Transmission Cost codes



IEHP

Unfortunately, there is no telehealth policy available at this time.

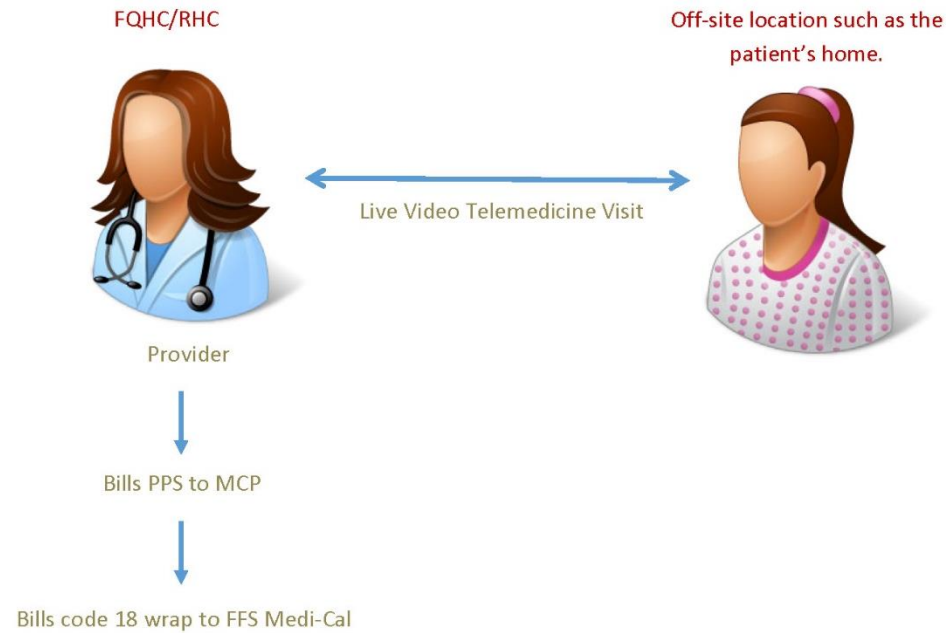


Scenario 12 FQHC/RHC to HHMS Patient Home

- Provider is physically located at and receives compensation from FQHC/RHC
- Patient is an established patient, and either **homebound, homeless, or a season or migratory worker**.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.

Outcome

- FQHC/RHC is the Distant Site (or Provider Site) and can bill MCP.
- Patient is homebound, homeless, or a season or migratory worker, therefore the code 18 wrap CAN be billed to the state.



Scenario 13 FQHC/RHC to Non-HHMS Patient Home

- Provider is physically located at and receives compensation from FQHC/RHC
- Patient is an established patient but is NOT homebound, homeless, or a season or migratory worker.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.

Outcome

- FQHC/RHC is the Distant Site (or Provider Site) and can bill MCP.
- Patient is not homebound, homeless, or a season or migratory worker, therefore the code 18 wrap CANNOT be billed to the state.

