



2022



New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE

MTELEHEALTH

MTELEHEALTH, LLC | 255 NE 6th Avenue, Suite A, Delray Beach, FL 33483
ph 561.366.2333 | fx 561-366-2332 | www.mTelehealth.com



New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE

MLN Matters Number: SE20016 **Revised**

Related Change Request (CR) Number: N/A

Article Release Date: **January 13, 2022**

Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: N/A

Note: We revised this article to add the 2022 payment rate for distant site telehealth services and information on RHC payment limits. You'll find substantive content updates in dark red font (see pages 2, 3, 5, 6 and 7). All other information is the same.

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 they provide to Medicare patients.

What You Need To Know

To provide as much support as possible to you and your patients during the COVID-19 PHE, both Congress and we (CMS) have made several changes to RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE, and we'll make other discretionary changes as necessary to make sure that your patients have access to the services they need during the pandemic. For more information, view 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, Congress signed into law the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). [Section 3704 of the CARES Act](#) authorizes RHCs and FQHCs to provide distant site telehealth services to Medicare patients 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 patient. If you have this capability, you can now provide and get paid for telehealth services to Medicare patients for the duration of the COVID-19 PHE.

Any health care practitioner working for you within your scope of practice can provide distant site telehealth services. Practitioners can provide distant site telehealth services (approved by Medicare as a distant site telehealth service under the Physician Fee Schedule (PFS)) from any location, including their home, during the time that they're working for you. A list of these services 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 we develop payment rates similar to the national average payment rates for comparable telehealth services under the PFS. You must use HCPCS code G2025 (the new RHC/FQHC specific G code for distant site telehealth services) to bill services provided via telehealth beginning on January 27, 2020, the date the COVID-19 PHE became effective (see <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>).

Note that the changes in eligible originating site locations, including the patient's home, during the COVID-19 PHE are effective beginning March 6, 2020.

Effective January 1, 2022, the payment rate for distant site telehealth services is \$97.24. From January 1 – December 31, 2021, the payment rate for distant site telehealth services was \$99.45 (see page 3). For services between January 27 – December 31, 2020, your rate was set at \$92.03. These rates are the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS during the given timeframes. Because we made these changes in policy on an emergency basis, we made changes to claims processing systems in several stages.

Claims Requirements for RHCs

For telehealth distant site services provided between January 27 – June 30, 2020, report HCPCS code G2025 on your claims with the CG modifier. You may also append Modifier “95” (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System), but this isn't required. We paid these claims at the RHC's all-inclusive rate (AIR), and the MAC automatically reprocessed these claims beginning on July 1, 2020, at the \$92.03 rate. You don't need to resubmit these claims for the payment adjustment.

Beginning July 1, 2020, you should no longer put the CG modifier on claims with HCPCS code G2025.

Table 1. RHC Claims for Telehealth Services from January 27 – June 30, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CG (required) 95 (optional)

Table 2. RHC Claims for Telehealth Services starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	95 (optional)

Claims Requirements for FQHCs

For telehealth distant site services you provided between January 27 – June 30, 2020, that are also FQHC qualifying visits, report 3 HCPCS/CPT codes:

- The FQHC Prospective Payment System (PPS) specific payment code (G0466, G0467, G0468, G0469, or G0470)
- The HCPCS/CPT code that describes the services provided via telehealth with modifier 95

- G2025 with modifier 95

We paid these claims at the FQHC PPS rate until June 30, 2020, and the MAC automatically reprocessed these claims beginning on July 1, 2020, at the \$92.03 rate. You don't need to resubmit these claims for the payment adjustment.

When providing services via telehealth that aren't FQHC qualifying visits, you should have held these claims until July 1, 2020, and then billed them with HCPCS code G2025. You may append Modifier 95 but it isn't required. (See

<https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf> for a list of FQHC PPS specific payment codes). Beginning July 1, 2020, only submit G2025. You may append Modifier 95 but it isn't required.

Table 3. Example of FQHC Claims for Telehealth Services January 27 – June 30, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G0467 (or other appropriate FQHC Specific Payment Code)	N/A
052X	99214 (or other FQHC PPS Qualifying Payment Code)	95
052X	G2025	95

Table 4. FQHC Claims for Telehealth Services starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	95 (optional)

Payment Rate for 2022

Effective January 1, 2022, the payment rate for distant site telehealth services is set at \$97.24. From January 1 – December 31, 2021, your payment for distant site telehealth services was set at \$99.45. The MAC will automatically reprocess claims with HCPCS code G2025 for dates of service on or after January 1, 2021, that we processed before the rate was updated in the system.

Medicare only authorizes payment for distant site telehealth services to RHCs and FQHCs provided during the COVID-19 PHE. If the COVID-19 PHE is in effect after December 31, 2022, we'll update this rate based on the CY 2023 PFS average payment rate for these services, weighted by volume for those services reported under the PFS.

Cost Reporting

We won't use costs for providing distant site telehealth services to decide the RHC AIR or the FQHC PPS rate, but these costs must be reported on the proper 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.”

Medicare Advantage Wrap-Around

Since telehealth distant site services aren't paid under the RHC AIR or the FQHC PPS, the Medicare Advantage (MA) wrap-around payment doesn't apply to these services. MA plans will adjust wrap-around payment for distant site telehealth services.

Cost-Sharing Related to COVID-19 Testing

For services provided between March 18, 2020 and the duration of the COVID-19 PHE, we'll pay all of the reasonable costs for specified categories of evaluation and management (E/M) services if they result in an order for or administration of a COVID-19 test and relate to the furnishing or administration of such test or to the evaluation of an individual for purposes of deciding the need for such test. This would include applicable telehealth services. (See MLN Matters article [SE20011](#) for more information.) For the specified E/M services related to COVID-19 testing, including when provided via telehealth, you must waive the collection of coinsurance from patients. For services in which Medicare waives the coinsurance, you must put the “CS” modifier on the service line. **We paid your claims with the “CS” modifier with the coinsurance applied, and the MAC automatically reprocessed these claims beginning on July 1, 2020. Don't collect coinsurance from patients if the coinsurance is waived.**

Claims Examples:

Table 5. RHC Claims for Telehealth Services from January 27 – June 30, 2020, when we waive cost sharing:

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CG, CS (required) 95 (optional)

Table 6. RHC Claims for Telehealth Services when we waive cost sharing starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CS (required) 95 (optional)

Table 7. FQHC Claims for Telehealth Services January 27, 2020 – June 30, 2020, when we waive cost sharing

Revenue Code	HCPCS Code	Modifiers
052X	G0467 (or other appropriate FQHC Specific Payment Code)	N/A
052X	G0446 (or other FQHC PPS Qualifying Payment Code)	CS, 95 (required)

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CS, 95 (required)

Table 8. FQHC Claims for Telehealth Services starting July 1, 2020, when we waive cost sharing

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CS (required) 95 (optional)

Other Telehealth Flexibilities

During the COVID-19 PHE, you can provide any Medicare-approved telehealth service under the PFS. (See <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>.) Also, effective March 1, 2020, these services include CPT codes 99441, 99442, and 99443, which are audio-only telephone Evaluation and Management (E/M) services. You can provide and bill for these services using HCPCS code G2025. To bill for these services, a physician or Medicare provider who may report E/M services must provide at least 5 minutes of telephone E/M service to an established patient, parent, or guardian. You can't bill for these services if they start 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.

Telehealth Services with Cost Sharing

For the CPT and HCPCS codes included in the list of telehealth codes at the link above, we'll adjust the coinsurance and payment calculation for distant site telehealth services you provided to reflect the method used to calculate coinsurance and payment under the PFS. The coinsurance for these services will be 20% of the lesser of the allowed amount (\$92.03 for 2020 claims, \$99.45 for 2021, or \$97.24 for 2022 claims based on date of service) or actual charges. The payment will be 80% of the lesser of the allowed amount (\$92.03 for 2020 claims, \$99.45 for 2021 claims, or \$97.24 for 2022 claims based on date of service) or the actual charges.

Before the adjustment, the coinsurance for distant site services you provided was 20% of the actual charges and the payment was the allowed amount (\$92.03 for 2020 claims, \$99.45 for 2021 claims, or \$97.24 for 2022 claims based on date of service) minus the coinsurance.

MACs will automatically reprocess any claims with HCPCS code G2025 for services you provided on or after January 27 – November 16, 2020, that we paid before we updated the claims processing system to pay HCPCS code G2025 based on the “lesser of” methodology, as described above.

Telehealth Services with Cost Sharing Waived

The list of telehealth codes at the link above includes several CPT and HCPCS codes that describe preventive services that have waived cost sharing. As stated earlier in this article, bill telehealth services on this list using HCPCS code G2025. To distinguish those telehealth services that don't have cost sharing waived from those that do, like some preventive services,

also report modifier CS. We've modified the descriptor of the CS modifier to account for this additional use as follows:

CS – Cost sharing waived 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.

For preventive services provided via telehealth that have cost sharing waived, RHCs must report G2025 on claims with the CG and CS modifier and FQHCs must report G2025 with the CS modifier on or after July 1, 2020.

See the above-referenced claim examples for Cost-Sharing Related to COVID-19 Testing. These examples will also apply to preventive services that have cost sharing waived.

Expansion of Virtual Communication Services

Payment for virtual communication services now includes 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 get payment for the new online digital evaluation and management (CPT codes 99421, 99422, and 99423) or virtual communication services (HCPCS codes G2012 and G2010), you 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. We'll pay \$24.76 for claims submitted with G0071 on or after March 1, 2020 – December 31, 2020.

From January 1 – December 31, 2021, we'll pay \$23.73 for claims submitted with G0071.

Effective January 1 – December 31, 2022, we'll pay the new rate of \$23.88 for claims submitted with G0071.

Revision of Home Health Agency Shortage Requirement for Visiting Nursing Services

You can bill for visiting nursing services provided by an Registered Nurse (RN) or Licensed Practical Nurse (LPN) to homebound individuals under a written treatment plan in areas with a shortage of home health agencies (HHAs). Effective March 1, 2020, and for the duration of the COVID-19 PHE, we have found that the area typically served by the RHC, and the area included in the FQHC service area plan, have a shortage of HHAs, and this finding doesn't require a request. Check the HIPAA Eligibility Transaction System (HETS) before providing

visiting nurse services to make sure that the patient isn't already under a home health plan of care.

Consent for Care Management and Virtual Communication Services

Medicare requires patient consent for all services, including non-face-to-face services. During the COVID-19 PHE, you may get patient consent at the same time you initially provide the services. This means that someone working under your general supervision can get patient consent. Direct supervision isn't required to get consent. In general, auxiliary personnel under general supervision of the billing practitioner can get patient consent for these services. The person getting consent can be an employee, independent contractor, or leased employee of the billing practitioner. (See <https://www.cms.gov/files/document/covid-final-ifc.pdf>).

Revision of Bed Count Methodology for Determining Provider-Based RHCs Exemption to the RHC Payment Limit

Note: [Section 132 of the Consolidated Appropriations Act, 2021](#), restructures the payment limits for all independent and provider-based RHCs beginning April 1, 2021. See [CR12185](#) and [CR12489](#) for more information on establishing certain provider-based RHC payment limits.

Prior to April 1, 2021, if you're an RHC provider based to a hospital with fewer than 50 beds, you're exempt from the national per-visit payment limit for RHCs. Due to the COVID-19 PHE, some hospitals have been or are planning to increase inpatient bed capacity to address the increased need for inpatient care. If you're currently exempt from the national per-visit payment, we're working to prevent you from losing your exemption due to the COVID-19 PHE and to encourage hospitals to increase bed capacity if needed. We'll use the number of beds from the cost reporting period prior to the start of the COVID-19 PHE as the official hospital bed count for deciding exemption to the payment limit.

Exception to the Productivity Standards for RHCs

We use productivity standards to help decide the average cost per patient for your Medicare reimbursement. Physicians, nurse practitioners, physician assistants, and certified nurse midwives are held to a minimum number of visits per Full-Time Employee (FTE) that they're expected to provide in the RHC. Failure to meet this minimum may show that they're operating at an excessive staffing level, thus, generating excessive cost.

Many RHCs have had to change the way they staff their clinics and bill for RHC services during the COVID-19 PHE. As a result, these RHCs may have difficulty in meeting the productivity standards. To minimize the burden on RHCs, your MAC may grant exceptions to the productivity standard during the COVID-19 PHE. Your MAC will provide further direction.

More Information

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

Review information on the [current emergencies](#) webpage.

For more information, [find your MAC's website](#).

DOCUMENT HISTORY

Date of Change	Description
January 13, 2022	We revised this article to add the 2022 payment rate for distant site telehealth services and information on RHC payment limits. You'll find substantive content updates in dark red font (see pages 2, 3, 5, 6, and 7). All other information is the same.
February 23, 2021	We revised this article to provide the updated rate effective January 1, 2021, for G2025. You'll find substantive content updates in dark red font (see pages 2, 3, and 5). We also updated the rate for G0071 on page 6.
December 3, 2020	We revised this article to provide additional guidance on telehealth services that have cost-sharing and cost-sharing waived. You'll find substantive content updates (see pages 5-6). We also made other language changes for clarity, but these changes didn't change the substance of the article.
July 6, 2020	We revised this article to provide: <ul style="list-style-type: none"> - Additional guidance on telehealth services that have cost sharing waived and additional claim examples - An additional section on the RHC Productivity Standards All other information remains the same.
April 30, 2020	We revised this article to provide: <ul style="list-style-type: none"> - Additional claims submission and processing instructions - Information on cost-sharing related to COVID-19 testing - Additional information on telehealth flexibilities - Information on provider-based RHCs exemption to the RHC payment limit All other information remains the same.
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 2021 American Medical Association. All rights reserved.

Copyright © 2013-2022, 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.