Simplifying Care Management Services and Telemedicine for RHCs

Oregon Office of Rural Health

41st Annual Conference

Bend, Oregon

October 3, 2024

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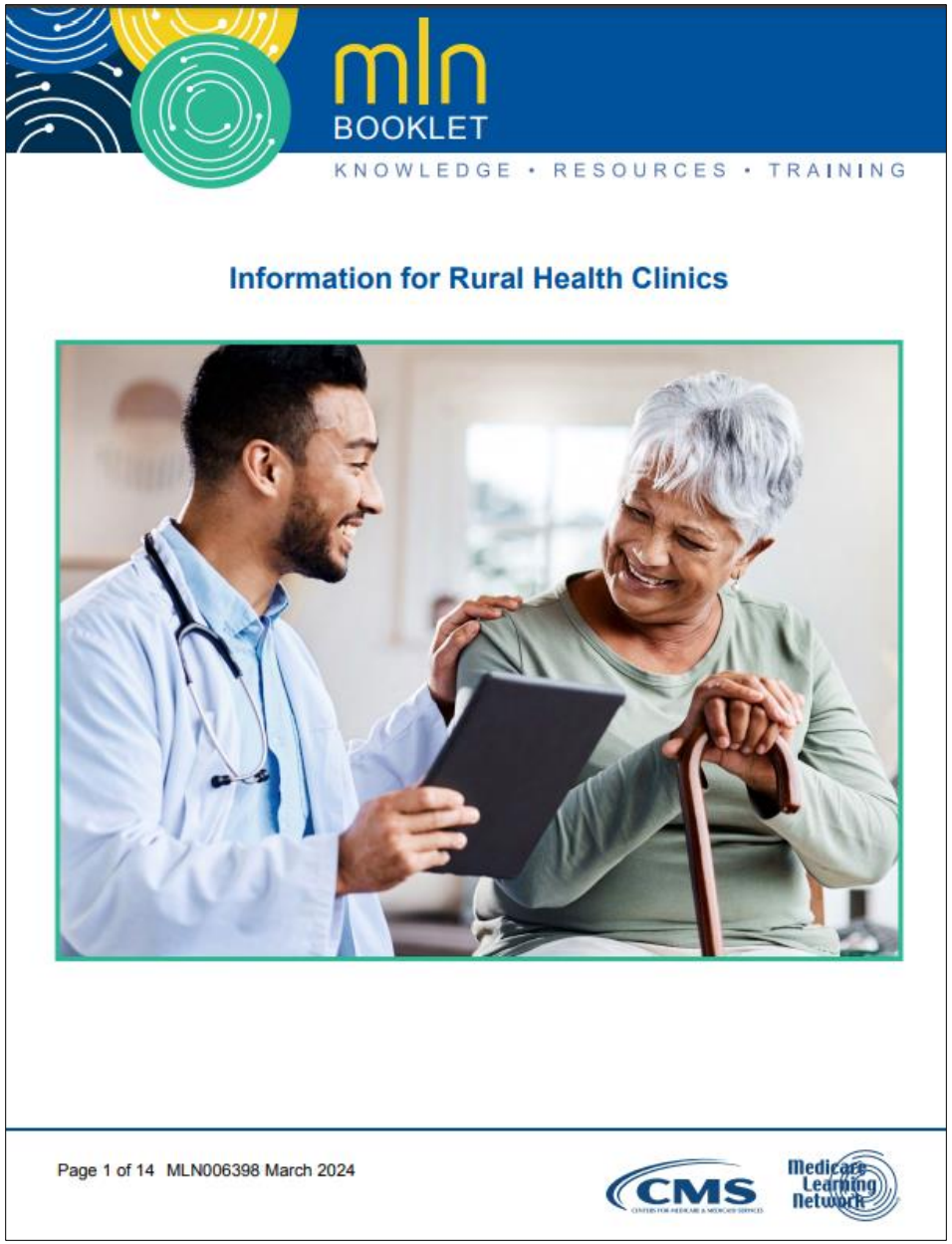
Implementing Care Management Services



https://www.cms.gov/files/document/mln006398-information-rural-health-clinics.pdf

Care Management Services

- Transitional Care Management
- Chronic Care Management
- Principal Care Management
- General Behavioral Integrations
- Other services reported under G0511: Remote Patient Monitoring, Remote Therapeutic Monitoring, Community Health Integration, Principal Illness Navigation, Principal Illness Navigation-Peer Supported

Transitional Care Management

A Transitional Care Management (TCM) service can also be an RHC or FQHC visit. Services furnished must be within the practitioner's state scope of practice, and only services that require the skill level of the RHC or FQHC practitioner are considered RHC or FQHC visits. (Policy Benefit Manual, Section 40)

Effective January 1, 2013, RHCs and FQHCs are paid for TCM services furnished by an RHC or FQHC practitioner when all TCM requirements are met. TCM services must be furnished within 30 days of the date of the patient's discharge from a hospital (including outpatient observation or partial hospitalization), SNF, or community mental health center. Communication (direct contact, telephone, or electronic) with the patient or caregiver must commence within 2 business days of discharge, and a face-to-face visit must occur within 14 days of discharge for moderate complexity decision making (CPT code 99495),or within 7 days of discharge for high complexity decision making (CPT code 99496).

The TCM visit is billed on the day that the TCM visit takes place, and only one TCM visit may be paid per beneficiary for services furnished during that 30 day post-discharge period. TCM services are billed by adding CPT code 99495 or CPT code 99496 to an RHC or FQHC claim, either alone or with other payable services. If it is the only medical service provided on that day with an RHC or FQHC practitioner it is paid as a standalone billable visit. If it is furnished on the same day as another visit, only one visit is paid. (Policy Benefit Manual, Section 230)

Transitional Care Management (TCM)

- Face-to-face visit within 14 days of discharge
  - 99495 – moderate medical decision complexity
  - 99496 – high medical decision complexity
- Only 1 health care professional may report TCM
- Report once per beneficiary during TCM
- **For RHC, Date of service used is the Face-to-Face visit day**
- **Reimburses the AIR rate. Is considered an RHC Encounter**
- TCM cannot be billed during a global period
- Documentation required:
  - Date of discharge
  - Date of interactive contact with patient and/or caregiver (within 2 business days)
  - Date of face-to-face visit
  - Complexity of Medical Decision making

Other Care Management Services

- RHCs may bill HCPCS code G0511 multiple times in a calendar month for the codes listed in the table below as long as they've met all requirements and there isn't double counting. For example, RHCs can bill HCPCS code G0511 twice for 20 minutes of qualifying CCM services and 30 minutes of qualifying PCM services, as long as the clinical staff minutes don't overlap.

General Care Management Services	HCPCS/CPT Codes	Per Month
CCM Chronic Care Management	99487, 99490, 99491	20 minutes
PCM Principal Care Management	99424, 99426	30 minutes
CPM Chronic Pain Care Management	G3002	30 minutes
General BHI Behavioral Health Integration	99484	20 minutes
		20 minutes

General Care Management Services	HCPCS/CPT Codes	Per Month
RPM Remote Patient Monitoring	99453, 99454, 99457, 99091	30 Days
RTM Remote Therapeutic Monitoring	98975, 98976, 98977, 98980	30 Days
CHI Community Health Integration	G0019	60 minutes
PIN Principle Illness Navigation	G0023	60 minutes
PIN-PS Principle Illness Navigation- Peer	G0140	60 minutes

Although G0511 is used as an umbrella code, the specific service requirements must be met for each respective code billed under G0511.

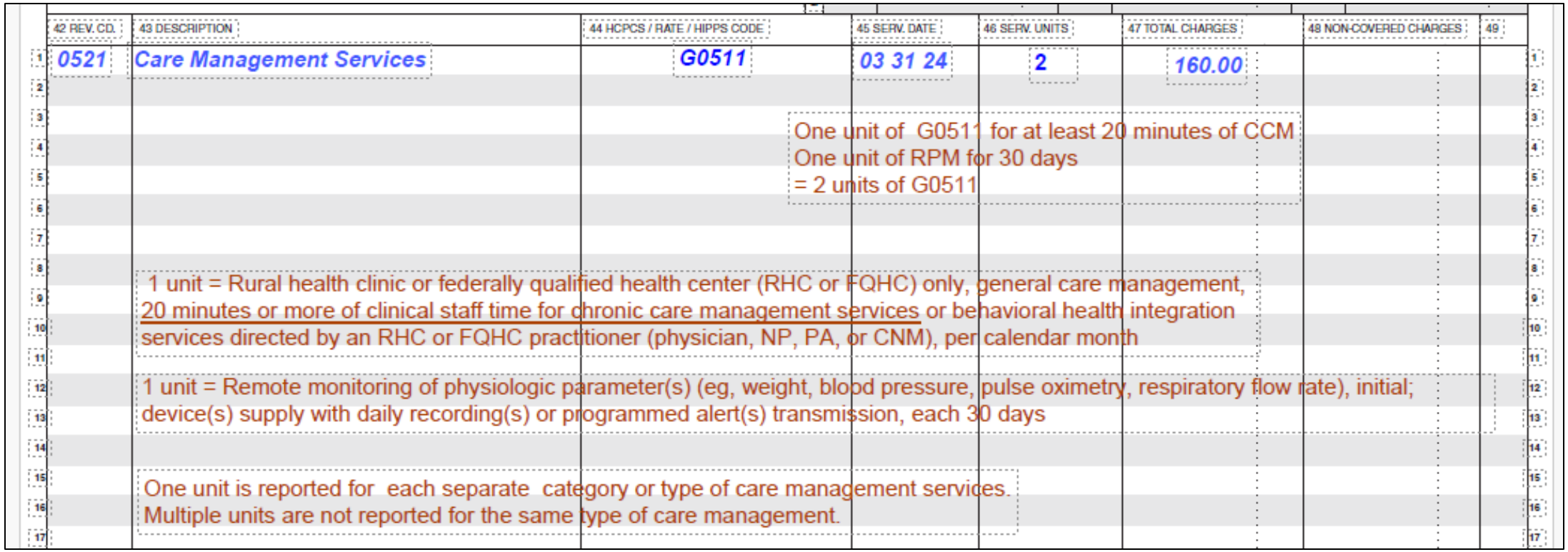
- **Use the time of time or service descriptions for the individual CPT codes to determine if the minimum number of minutes per month has been met for each type of care management.**

- **You cannot overlap minutes between two different types of care management when billing multiple units of G0511.**

- **You cannot bill multiple units of care management for exceeding the minimum units. For example: General care management is at least 20 minutes per month. If there are 40 minutes of general care management, there is sill only one billable unit.**

- **If you have 20 minutes of general care management and you also have met the requirements for RPT per the description without overlapping minutes, then two units of G0511 are billable.**

Billing Multiple Units of G0511



42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0521	Care Management Services	G0511	03 31 24	2	160.00		

One unit of G0511 for at least 20 minutes of CCM
One unit of RPM for 30 days
= 2 units of G0511

1 unit = Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month

1 unit = Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

One unit is reported for each separate category or type of care management services.
Multiple units are not reported for the same type of care management.

All units must be reported for same date. RHC claims cannot have different date spans. If dates are different, then separate claims.

Example of CCM Billing

CCM Reported Alone

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	CCM	G0511	02/01/2024	1	75.00
0001	Total Charge				75.00

The –CG Modifier is NOT appended to G0511 because the service is paid under fee-for-service reimbursement. Deductibles and co-insurance apply. **The 2024 rate for G0511 is $72.90 The patient's coinsurance will be 20% of the allowable.**

Example of CCM Billed with an Encounter

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	OV Est 3	99213-CG	02/28/2024	1	100.00
0521	CCM	G0511	02/28/2024	1	75.00
0001	Total Charge				175.00

If CCM is billed with another RHC service, the charge for CCM is NOT added to the first line. The –CG modifier is only added on the first line. The clinic will receive the RHC all-inclusive rate for the office visit/encounter and the allowable fee schedule amount for G0511. The coinsurance will be $20.00 for the office visit and another $14.58 for the CCM (Total $33.35). It is important to explain to the patient the value of the CCM when enrolling them.

Implementing Chronic Care Management In-house

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

Frequently Asked Questions

December 2019

Topics:

I. Care Management Services – General

II. Care Management Services – Billing, Claims Processing, and Payment

III. Care Management Services – Program Requirements

- a. Initiating Visit
- b. Consent and Opting Out
- c. Care Plan

IV. Care Management Service - Care Team

- a. Behavioral Health Care Manager
- b. Psychiatric Consultant
- c. Auxiliary Staff

I. Care Management Services – General

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

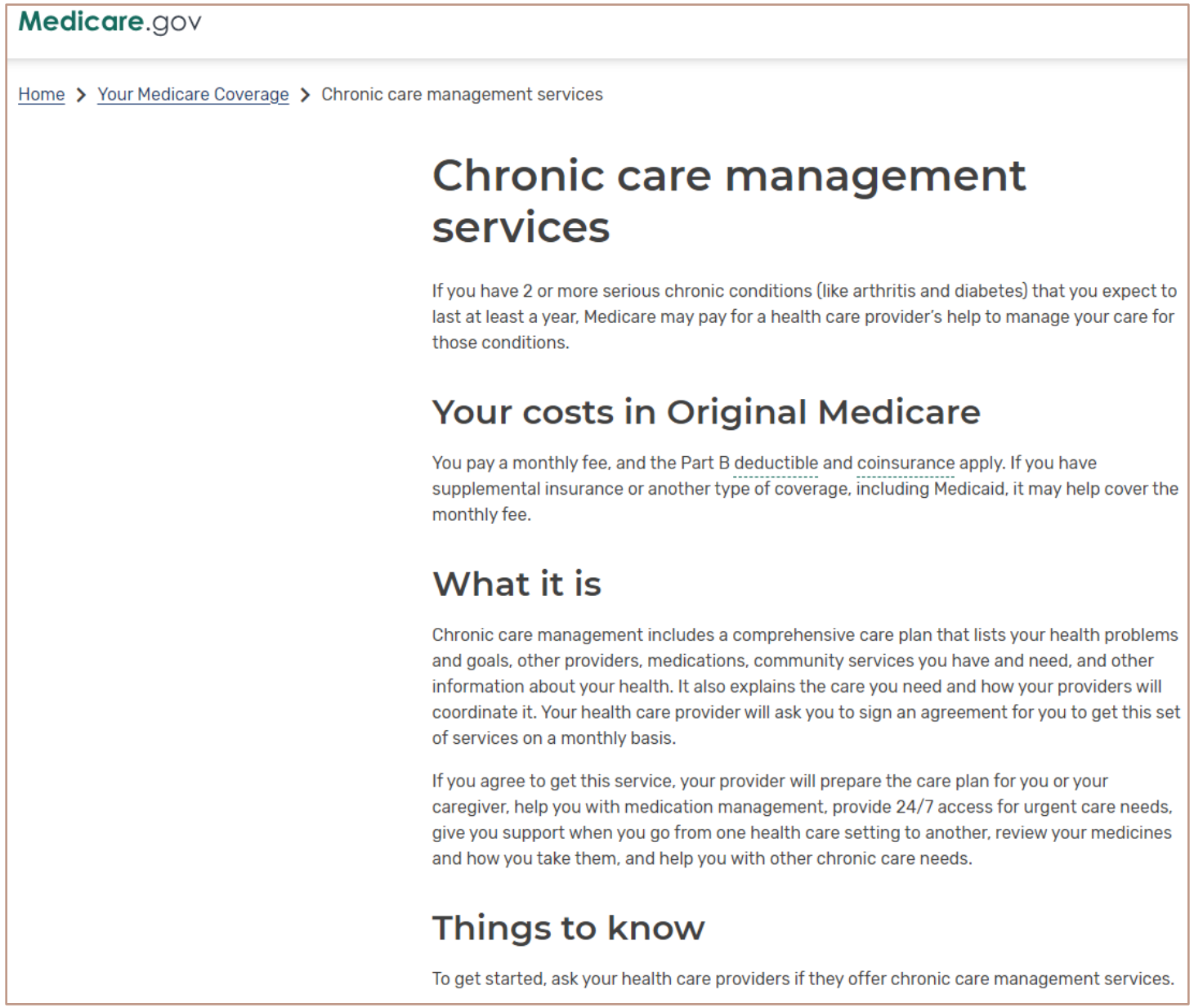
Addendum I
CCM, General BHI, and Psychiatric CoCM Requirements and Payment For RHCs and FQHCs

Requirements	CCM	General BHI	Psychiatric CoCM
Initiating Visit	An E/M, AWV, or IPPE visit occurring no more than one-year prior to commencing care coordination services.	Same	Same
	Furnished by a primary care physician, NP, PA, or CNM.	Same	Same
	Separately billable RHC/FQHC visit.	Same	Same
Beneficiary Consent	Obtained during or after initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff.	Same	Same
	Written or verbal, documented in the medical record.	Same	Same
	Includes information: • On the availability of care coordination services and applicable cost-sharing; • That only one practitioner can furnish and be paid for care coordination services during a calendar month; • That the patient has right to stop care coordination services at any time (effective at the end of the calendar month); and • That the patient has given permission to consult with relevant specialists.	Same	Same
Billing Requirements	At least 20 minutes of care coordination services per calendar month that is: • Furnished under the direction of the RHC or FQHC primary care	Same	At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric

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

Requirements before Initiating Care Management Services

- **Initiating Visit**: E & M, AWV or IPPE visits no more than 12-months prior to starting care coordination services. An RHC provider must perform the initiating visit.
- **Beneficiary Consent**: Written or verbal; documented in medical record; patient educated on care coordination services; must give patient information about the cost-sharing for care management; that only one provider can furnish CCM; that the patient has the right to stop care; that the patient is giving permission for the RHC to consult and refer other providers.



Medicare.gov

Home > Your Medicare Coverage > Chronic care management services

Chronic care management services

If you have 2 or more serious chronic conditions (like arthritis and diabetes) that you expect to last at least a year, Medicare may pay for a health care provider's help to manage your care for those conditions.

Your costs in Original Medicare

You pay a monthly fee, and the Part B deductible and coinsurance apply. If you have supplemental insurance or another type of coverage, including Medicaid, it may help cover the monthly fee.

What it is

Chronic care management includes a comprehensive care plan that lists your health problems and goals, other providers, medications, community services you have and need, and other information about your health. It also explains the care you need and how your providers will coordinate it. Your health care provider will ask you to sign an agreement for you to get this set of services on a monthly basis.

If you agree to get this service, your provider will prepare the care plan for you or your caregiver, help you with medication management, provide 24/7 access for urgent care needs, give you support when you go from one health care setting to another, review your medicines and how you take them, and help you with other chronic care needs.

Things to know

To get started, ask your health care providers if they offer chronic care management services.

CMS even gives you the language you need when educating the patient.

https://www.medicare.gov/coverage/chronic-care-management-services

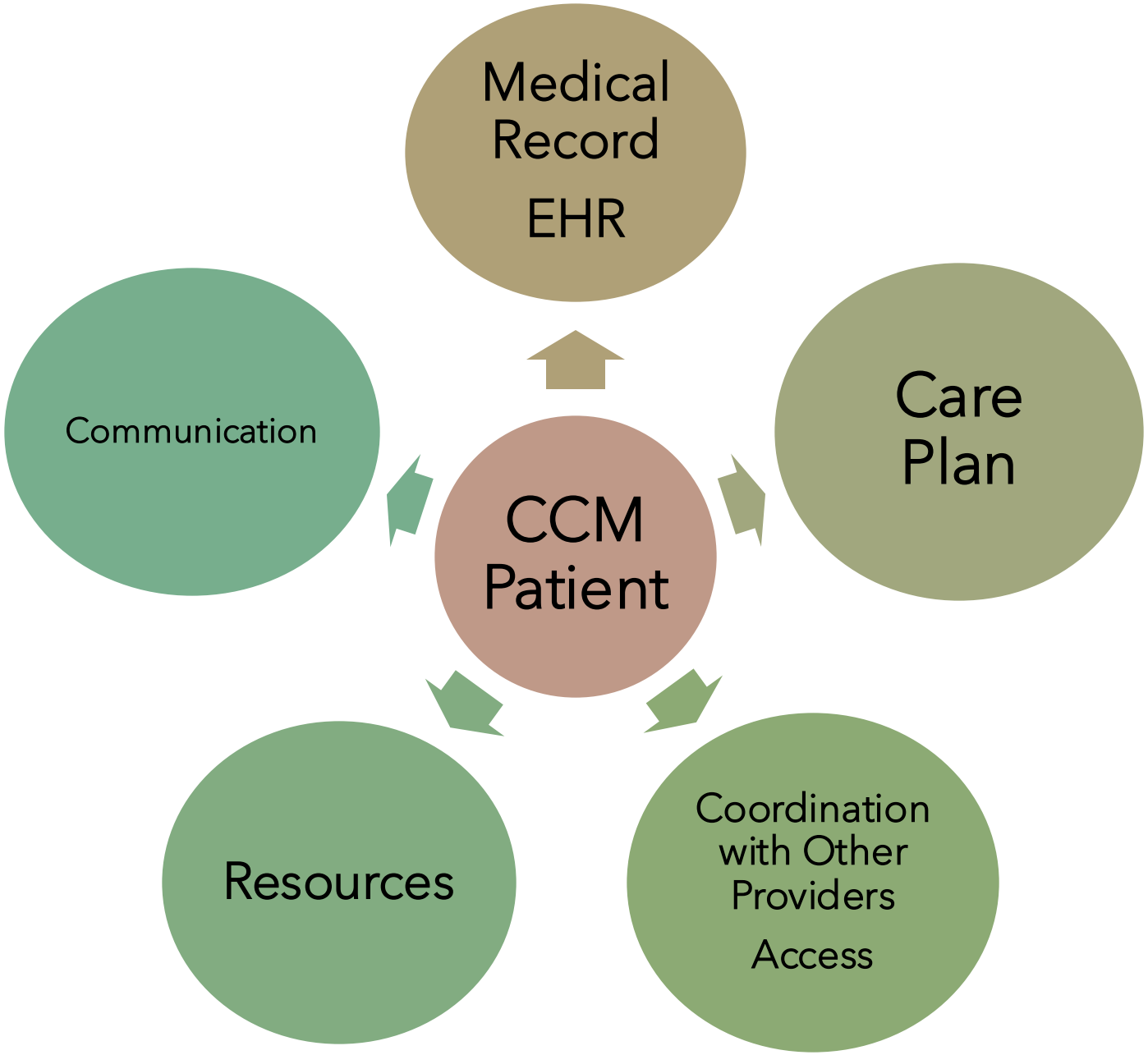
Patient Eligibility

- Multiple (2 or more) chronic conditions expected to last more than 12 months or until the patient's demise.
- The conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Examples: Congestive Heart Failure, Diabetes, Heart Disease, Kidney Disease, Arthritis

Requirements	CCM	General BHI	Psychiatric CoCM
		practitioner, warrants BHI services	
Requirement Service Elements	Includes: • Structured recording of patient health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care; • 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; • Comprehensive care management including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications; • Comprehensive care plan including the creation, revision,	Includes: • Initial assessment or follow-up monitoring, including the use of applicable validated rating scales; • Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; • Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation); and • Continuity of care with a designated member of the care team.	Includes: <u>RHC or FQHC primary care practitioner:</u> • Direct the behavioral health care manager or clinical staff; • Oversee the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed; and • Remain involved through ongoing oversight, management, collaboration and reassessment <u>Behavioral Health Care Manager:</u> • Provide assessment and care management services, including the administration of validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; provision of brief psychosocial interventions; ongoing

Chronic Care Management Service Requirements

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



- Identification
- Assessment
- Care Plan
- Documentation
- Management
- Coordination of Care
- Care Transitions
- Communication
- Patient-Centered

Prior to On-boarding Patients

Create your infrastructure

Have a dedicated care management coordinator/manager; don't add something on to an already overloaded nurse.

Design Your Program

How is it going to work?
Who will do what?
What is the workflow?
How to document?

Build external connections & communications

Emergency dept
Case Management
Other Providers
Pharmacy
Social Services

In-house Organic Patient Onboarding

Start with your schedule

Identify patients who are already receiving care as the starting point; Who is coming in this week? Next week? Who has an AWV scheduled?

In-Person Consent & Enrollment

Not required but more effective and personable; can begin personalizing care plan

Care Management Begins

This facilitates more controlled growth of the program although growth may be slower at first.

Provide Care Management

Engage the Patient

Don't just call and question the patient. Bring them into their own care plan so that the goals and outcomes can be obtained.

Feedback Loop with Provider and other caregivers

Don't run the program in a vacuum. Communication is key to success.

Update Care Plan as Needed

Provide Care Management

Engage the Patient

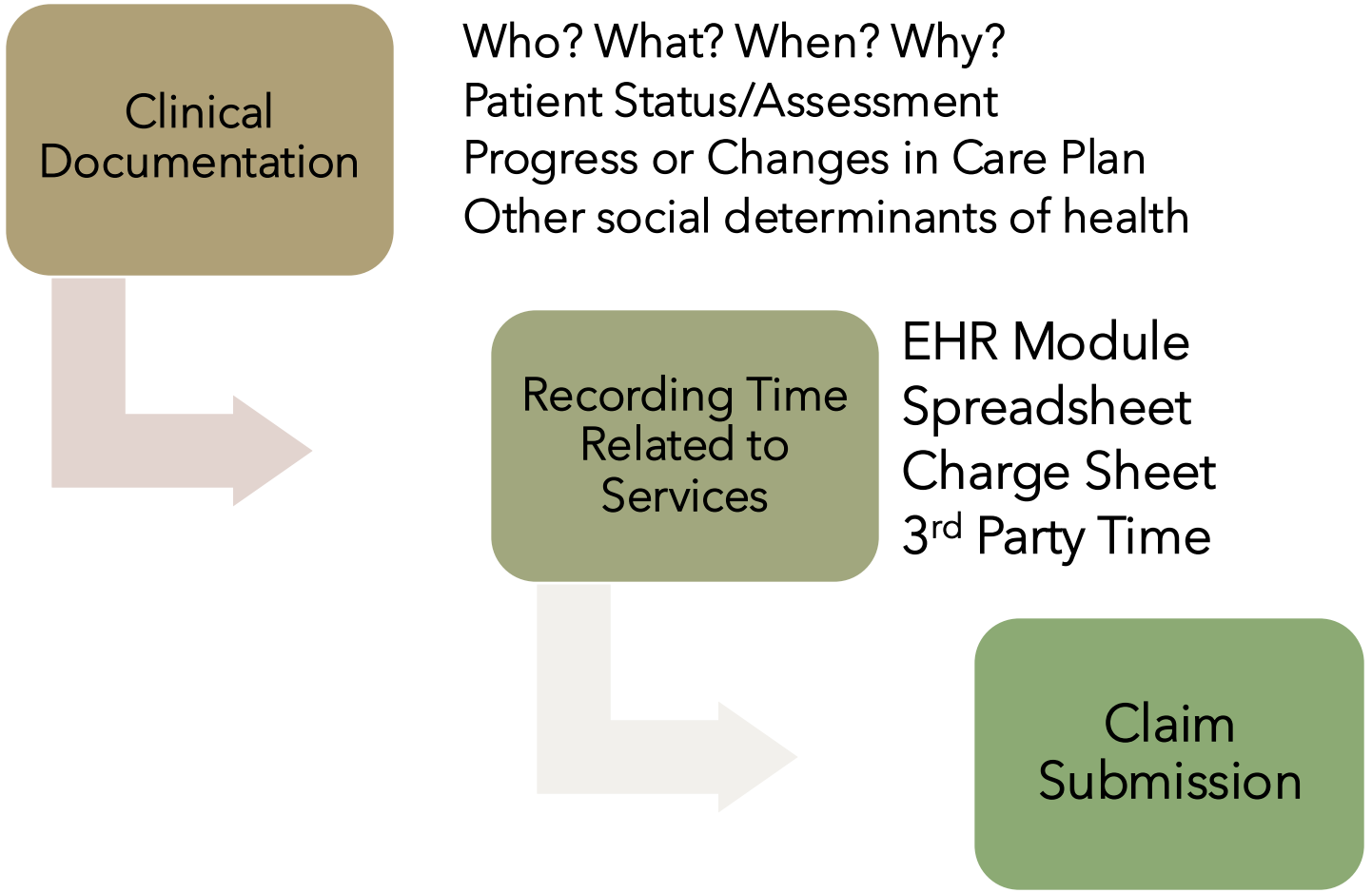
Don’t just call and question the patient. Bring them into their own care plan so that the goals and outcomes can be obtained.

Feedback Loop with Providers and other caregivers

Don’t run the program in a vacuum. Communication is key to success.

Update Care Plan as Needed

Documentation and Recordkeeping



Discussion on Care Management Questions/Comments?

Special thanks to Kristen Ogden (The Compliance Team); Aubrey Haynes (Pillow Clinic/NARHC) and Lesa Schlatman (Hometown Health) who assisted me in compiling some of this content.

Medicare Telehealth Update

Prior to 2025 Final Rule

Telehealth Definitions

Distant Site versus Originating Site

Audio/Video/Two-Way Synchronous

The provider is usually at their practice location or another appropriate location.

Patient is usually at home or another appropriate location. When a hospital or clinic hosts a patient for a telehealth service with a distant site provider, **the hosting facility is the originating site.**

Originating site is defined by CMS as where the patient is located during the telehealth encounter or consult.

Provider is at the distant site away from the patient usually their practice location

Patient is at home or another facility

Distant site is defined by CMS as the telehealth site ***where the provider or specialist is "seeing" the patient at a distance.***

Originating Site Requirements

CAHs and RHCs

Social Security Act, Section 1834, Payment for Telehealth

C) Originating site.—
(i)[173] In general.—Except as provided in paragraph (5), (6), and (7), the term "originating site" means only those sites described in clause (ii) at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system and only if such site is located—
(I) in an area that is designated as a rural health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A));
(II) in a county that is not included in a Metropolitan Statistical Area; or
(III) from an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.
(ii) Sites described.—The sites referred to in clause (i) are the following sites:

(I) The office of a physician or practitioner.
(II) A critical access hospital (as defined in section 1861(mm)(1)).
(III) A rural health clinic (as defined in section 1861(aa)(2)).
(IV) A Federally qualified health center (as defined in section 1861(aa)(4)).
(V) A hospital (as defined in section 1861(e)).
(VI) A hospital-based or critical access hospital- based renal dialysis center (including satellites).
(VII) A skilled nursing facility (as defined in section 1819(a)).
(VIII) A community mental health center (as defined in section 1861(ff)(3)(B))
(IX)[174] A renal dialysis facility, but only for purposes of section 1881(b)(3)(B).
(X)[175] The home of an individual, but only for purposes of section 1881(b)(3)(B) or telehealth services described in paragraph (7).

Distant Site Requirements

Patient is **at home** or another originating site

Provider is in **their practice location** or their home (12/31/2024)

Before and After the PHE

- CAHs and RHCs are statutorily excluded from being distance site providers though the Social Security Act.
- During the PHE, temporary emergency orders allowed these provider types to perform telehealth/telemedicine services.
- These flexibilities and waivers have been extended to RHCs through 12/31/2024.
- The 2025 MPFS proposed rule would extend some of these flexibilities into 2025 if finalized.

What is the billing location for the provider when the provider is at home?

Through 12/31/2024:

In response, CMS finalized, through CY 2024, that we would continue to permit a distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home.

"We are therefore proposing that through CY 2025 ***we will continue to permit the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home."***

--2025 Physician Fee Schedule Proposed Rule, page 61,633.

Situation	Originating Site	Distance Site	What is billed?
Patient is at home and the provider is at their own clinic	Patient's Home	Provider's Clinic	The provider or their clinic bills a distance site telehealth service
Patient is at the CAH or RHC but the provider is at an outside office	CAH or RHC	Outside provider's location	The facility where the patient is being hosted bills an originating site telehealth service
Provider is at home and the patient is at home	Patient's Home	Provider's normal practice location	The provider or their clinic bills a distance site telehealth service unless the rule changes.
Patient is in a nursing home and the provider is at their normal practice location.	Skilled Nursing Facility	Provider's normal practice location	The provider or their clinic bills a distance site telehealth service.

Audio-Visual Telehealth

Two-Way Synchronization/Definition

When is Audio-Only Allowed?

§ 410.78Telehealth services

2025 MPFS Proposed Rule

a) * * *

- (3) Interactive telecommunications system means, except as otherwise provided in this paragraph (a)(3), multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. Interactive telecommunications system may also include two-way, real-time audio-only communication technology for any telehealth service furnished to a patient in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system as defined in the previous sentence, but the patient is not capable of, or does not consent to, the use of video technology. The following modifiers must be appended to a claim for telehealth services furnished using two-way, real-time audio-only communication technology to verify that the conditions set forth in the prior sentence have been met:
  - Current Procedural Terminology (CPT) modifier “93”; and
  - (ii) For rural health clinics (RHCs) and federally qualified health centers (FQHCs), Medicare modifier “FQ”.

https://www.federalregister.gov/d/2024-14828/p-5298

Audio-Only Modifiers

- Audio-Only services are only appropriate when the provider has capabilities for two-way synchronous telecommunications BUT the patient does not.
- The reason for the patient not being able to participate in audio-visual communications should be documented in the visit note.
- These modifier as used to indicate audio-only.

Type of Claim	Modifier
Fee for Service	93
Rural Health Clinic/FQHC	FQ

- Claim Examples are included in additional slides.

Which services are approved by CMS for telemedicine?

CMS Telehealth List

Determination of whether a service qualifies for telehealth

CMS Telehealth List

https://www.cms.gov/medicare/coverage/telehealth/list-services

List of Telehealth Services

List of services payable under the Medicare Physician Fee Schedule when furnished via telehealth.

List of Telehealth Services for Calendar Year 2024 (ZIP) - Updated 11/13/2023

Annual Updates to the CMS Telemedicine List

- CMS has a very specific criterion that is used to determine if a service can qualify as a telehealth service. This is explained in the 2025 MPFS Proposed Rule.
- Other factors determine if the service can be audio-only. Not all codes on the list can be audio-only.
- Codes are determined to be either provisional or permanent in status.
- Providers and the Public can submit HCPCS/CPT® codes to CMS for consideration.
- Upon finalization of the MPFS rule, the list of approved codes will be updated for 2025.
- The list of codes is not all-inclusive to all facility or provider types.
- Medicaid or Commercial telehealth rules may be different.

	LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2024 - updated November 13, 2023			
	HCPCS	Short Descriptor	Can Audio-Only Interaction Meet the Requirements?	Category
1	0362T	Bhv id suprt assmt ea 15 min	No	provisional
2	0373T	Adapt bhv tx ea 15 min	No	provisional
3	0591T	Hlth&wb coaching indiv 1st	Yes	provisional
4	0592T	Hlth&wb coaching indiv f-up	Yes	provisional
5	0593T	Hlth&wb coaching indiv group	Yes	provisional
6	77427	Radiation tx management x5	No	provisional
7	90785	Psytx complex interactive	Yes	permanent
8	90791	Psych diagnostic evaluation	Yes	permanent
9	90792	Psych diag eval w/med srvcs	Yes	permanent
10	90832	Psytx w pt 30 minutes	Yes	permanent
11	90833	Psytx w pt w e/m 30 min	Yes	permanent
12	90834	Psytx w pt 45 minutes	Yes	permanent
13	90836	Psytx w pt w e/m 45 min	Yes	permanent
14	90837	Psytx w pt 60 minutes	Yes	permanent
15	90838	Psytx w pt w e/m 60 min	Yes	permanent
16	90839	Psytx crisis initial 60 min	Yes	permanent
17	90840	Psytx crisis ea addl 30 min	Yes	permanent
18	90845	Psychoanalysis	Yes	permanent

Telehealth Reimbursement for CAHs and RHCs

It’s not apples to apples

CAHs and RHCs

- Cost-based Reimbursement for Medicare.
- Not necessarily reimbursed off the fee schedule.
- Even when paid from the fee schedule, the reimbursement may differ from fee-for-service providers and groups.
- May be a % of the fee schedule (+/-) or may pay using a specific facility-specific code.
- Different reimbursement amounts depending on originating or distance site service.

Originating Site Reimbursement

- Both CAHs and RHCs are reimbursed an originating facility fee when hosting the patient for a distance site service performed by a remote provider.
- Q3014 is the code used to report this originating facility fee.

Year	Reimbursement for Q3014
2023	$26.64
2024	$29.96
2025 (proposed	$30.14

- The amount is updated each year based on an MEI.

https://www.federalregister.gov/d/2024-14828/page-61637

RHCs: Distant Site Reimbursement

- RHCs are reimbursed by reporting G2025 on the UB-04/837I claim for the rural health clinic.
- The amount is a consolidated fee schedule amount that is determined by averaging all the applicable codes on the CMS Telehealth List.
- G2025 is approved for use through 12/31/2024.
- The current reimbursement for G2025 is $95.27 for claims submitted between January 1, 2024- December 31, 2024.
- The 2025 proposed MPFS rule would extend the distant site services through 12/31/2025. A new consolidated fee schedule amount will be determined when the rule is finalized.
- Since G2025 does not pay the AIR, visits and costs for G2025 are excluded from allowable costs on the RHC cost report.

RHCs: Distant Site Reimbursement in Proposed Rule

"We are also proposing, on a temporary basis, to allow payment for non-behavioral health visits furnished via telecommunication technology in a manner that would closely align with the payment mechanisms mandated by statute through December 31, 2024, that is, RHCs and FQHCs would continue to bill for RHC and FQHC services furnished using telecommunication technology services by reporting HCPCS code G2025 on the claim through December 31, 2025.

In addition, we are proposing to continue to delay the in-person visit requirement for mental health services furnished via communication technology by RHCs and FQHCs to beneficiaries in their homes until January 1, 2026."

https://www.federalregister.gov/d/2024-14828/p-4878

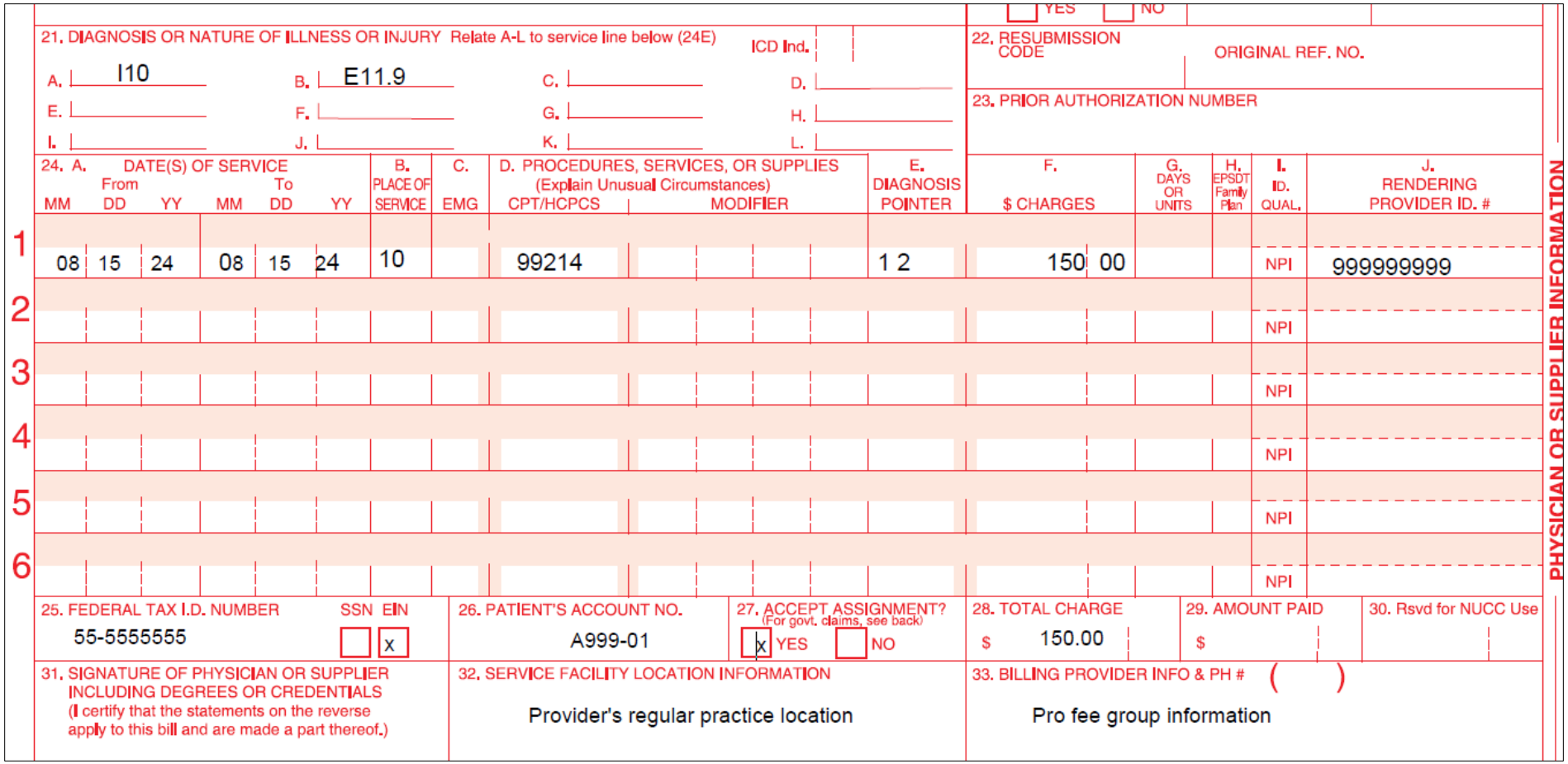
2024 Reimbursement Comparison

Type of Claim	Originating Fee*	Distant Site Pro Fee	Modifiers
Critical Access Hospital	Q3014/ $29.96	80% of MPFS	GT for Method II on Distant Site; 95 for telehealth on other institutional claim/POS types.
Rural Health Clinic	Q3014/ $29.96	G2025 for approved services $95.27 (2024)	FQ for Audio Only on approved services; No CG modifier onG2025.
Fee for Service (Pro Fee, Part B)	Not applicable	MPFS for approved services	93 for Audio Only on approved services; POS 10 for pt at home; POS 02 for other pt location,

- For traditional Medicare, CAHs and RHCs should not report both the originating service and the distant site service for the same encounter. There is no facility fee when a distant site pro fee service is performed. Some other payers will reimburse both under some situations.

Claims Scenarios for Medical Telehealth

Example 1: A patient is at home and receives a telemedicine service from a non-RHC provider who is in their normal practice location delivering the service via a two-way synchronous, HIPAA compliant platform. The provider documents verbal consent for the visit. **The claim is Medicare fee-for-service billed under a Part B pro fee group to which the provider has reassigned benefits.**



YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. I10 B. E11.9 C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	08	15	24	08	15	24	10		99214		1 2	150 00			NPI	999999999
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 55-5555555 [ ] [X]

26. PATIENT'S ACCOUNT NO.: A999-01

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE: $ 150.00

29. AMOUNT PAID: $

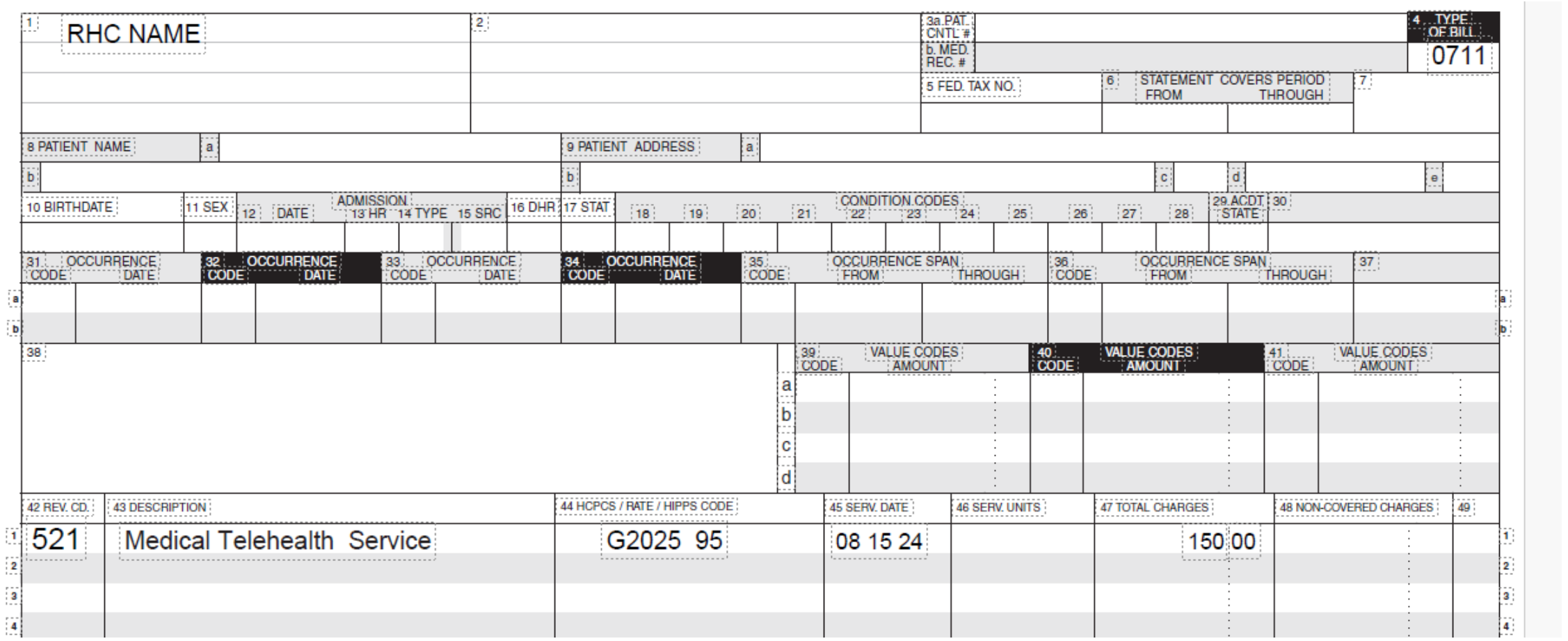
30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

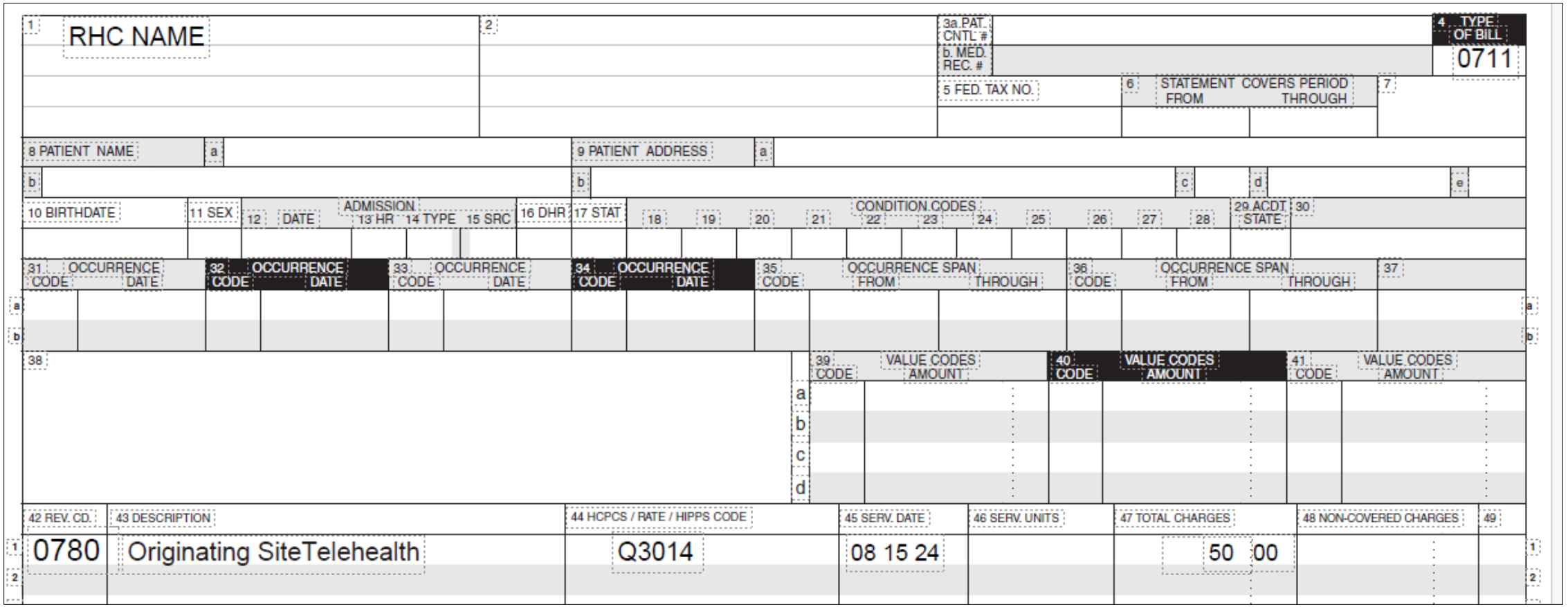
32. SERVICE FACILITY LOCATION INFORMATION: Provider's regular practice location

33. BILLING PROVIDER INFO & PH # ( ): Pro fee group information

<u>Example 6</u>: An RHC provider either located in the clinic or at their residence performs a **medical audio-visual telehealth service** to a patient who is located at home. The RHC bill type is 711. The use of modifier 95 is optional. G2025 is reported instead of the 99214. The RHC is reimbursed $95.27 for G2025. No -CG modifier is used since the AIR is not paid.



Example 7: The patient is located inside the RHC where they are being hosted for a distant site telehealth service with an outside provider who does not practice in the RHC. The revenue code is the RHC. Q3014 is reported. The RHC will be reimbursed $ 29.96. The RHC does not report an encounter for the remote provider. The revenue code is 0780 for telehealth



RHC Distant Site Medical Telehealth Example

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0521	Telehealth	G2025 95	05/15/2022	1	100.00
0001	Total Charge				100.00

Optional

Effective January 1, 2024, the payment rate for distant site medical telehealth services is $95.27. This is a composite fee schedule amount. G2025 is reported on the UB-04 claim.

Add the -CS Modifier if G2025 is reporting a preventive service that would not be subject to deductible and coinsurance.

No –CG Modifier since this does not reimburse at the AIR. Not an encounter.

Medicare Mental Health Telehealth

2022 Mental Health Telehealth Example

These visits are different from telehealth services provided during the Public Health Emergency (PHE). Don't bill HCPCS code G2025 for a mental health visit you provide via telecommunications. See MLN Matters Article SE20016 for information on billing G2025 for professional telehealth distant site services other than mental health visits during the PHE.

RHC Claims for Mental Health Visits via Telecommunications Example

Revenue Code	HCPCS Code	Modifiers
0900	90834 (or other Qualifying Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only) CG (required)

- Mental Health Codes on the QVL
- Revenue Code = 900
- MORE GUIDANCE FROM CMS IS NEEDED!
- New Modifiers for Medicare: 95 for audio/visual and FQ for audio only
- SE22001 Revised on 05/05/2022 : -CG now required
- Is an encounter; pays at the AIR.

RHC Mental Health Telehealth Example

FL 42 Rev Code	FL43 Description	FL44 HCPCS	FL 45 Date of Service	FL46 Units	FL47 Total Charge
0900	Telehealth	90791 CG and either FQ or 95	05/05.2022	1	100.00
0001	Total Charge				100.00

Mental Health Services	
HCPCS Code	**Short Descriptor**
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

- Mental Health Codes on the RHC QVL
- Do NOT use –CG on medical telehealth visits-Only on mental health
- MORE GUIDANCE FROM CMS IS NEEDED!
- New Modifiers for Medicare: 95 for audio/visual and FQ for audio only
- SE22001 MLN
- Reimburse at the AIR; permanent status with CMS.

Telehealth Questions/Comments?

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Patty Harper is CEO of InQuiseek Consulting, a healthcare consulting company based in Louisiana. She has over 26 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. Patty holds a B.S. in Health Information Administration (cum laude) from Louisiana Tech University. She is credentialed through AHIMA as a RHIA, CHTS-IM, and CHTS-PW. Patty successfully completed AHIMA's ICD-10 Academy and has previously been recognized as an ICD-10 Trainer. She is also Certified in Healthcare Compliance (CHC®) thorough the Compliance Certification Board. Patty is a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other reimbursement-related topics. Patty proudly served on the NARHC Board for six years.