Improving Access to Quality Medical Care Webinar Series

Presented by

The Southwest Telehealth Resource Center, Arizona Telemedicine Program, and the Arizona Department of Health Services

Welcome

- SWTRC region - AZ, UT, CO, NM & NV
- Fellow HRSA Grantees
- All other participants

The **Arizona Department of Health Services, the Arizona Telemedicine Program,** and **the Southwest Telehealth Resource Center** welcome you to this free webinar series.

The practice & deliver of healthcare is changing, with an emphasis on **improving quality, safety, efficiency, & access to care**.

Telemedicine can help you achieve these goals!

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Carol Yarbrough

“CAHs, FQHCs and RHCs, Oh My!”

Disclaimer

- The opinions expressed in this presentation and on the following slides are solely those of the presenter and not necessarily those of the organizations sponsoring this webinar. The organizations do not guarantee the accuracy or reliability of the information provided herein.

AGENDA

- Where did they come from and for what purpose?
- The Payors: Medicare and Arizona
- PHE Telehealth and Post PHE Telehealth

- REFERENCES
- QUESTIONS

CMS List Followed by All Payors – the designation goes on the CMS 1500 (Pro Fee Bill)

Place of Service	Description
11	Office
19	Off Campus-Outpatient Hospital
21	Inpatient Hospital
22	On Campus-Outpatient Hospital
31	Skilled Nursing Facility
50	Federally Qualified Health Center
72	Rural Health Clinic

https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

Critical Access Hospital

What is the Prospective Payment System?

- In 1983, the payment methodology for inpatient acute hospital care (Medicare Part A) changed from cost-based reimbursement to a prospective payment system (PPS). In this new payment system, all of the various clinical diagnoses are classified into groups, called “Diagnosis Related Groups” or DRGs.
- You get paid one reimbursement amount based on diagnoses.

What is a CAH? POS 21

- During the 1980s and 1990s, hospitals closed across the U.S. because of financial losses from the PPS system. In 1997, the Balanced Budget Act created the Medicare Rural Hospital Flexibility (Flex) Program and Critical Access Hospital provider type.
- CAHs receive cost based reimbursement for inpatient and outpatient services provided to Medicare patients (and Medicaid patients depending on state policy).
- Cost based reimbursement provides significant financial advantage to CAHs by allowing them to get paid at 101% of costs on all of their hospital Medicare business.

How do Swing Beds work?

- Hospitals with 100 beds or less can provide both acute care treatment and skilled nursing treatment to patients without having to physically move the patient to another bed.
- The hospital discharges patients from acute care beds and admits them to skilled nursing beds when the patient meets the coverage guidelines for skilled care.
- The skilled nursing bed is referred to as a “swing” bed, because the hospital swings a bed from an acute care designation to a skilled nursing designation.
- Patients must be in the medically necessary acute care bed for at least 72 hours before they can be discharged to a swing bed.

Optional II Billing – Setting Specific

- A CAH may elect the Optional (Method II) Payment Method under which it bills the fiscal intermediary (FI) or Medicare Administrative Contractor (MAC) for both facility services and professional services to its outpatients on a single claim.
- These services include when a CAH physician reassigns outpatient billing services to the CAH, for example in pathology, radiology, emergency room, outpatient surgery and outpatient clinics. This payment does not include services provided at a rural health clinic and only applies to the CAH outpatient services.

Payment

- For facility services:
  - 101% of reasonable costs, after applicable deductions, regardless of whether the physician or practitioner has reassigned his or her billing rights to the CAH; and
- For professional services:
  - If reassigned billing rights, physician pro fees: 115% of the allowable amount, after applicable deductions, under the MPFS.
  - For non-physician providers: 115% of the of allowed amount

Telehealth

- CMS is waiving the requirement for CAHs that a doctor of medicine or osteopathy be physically present to provide medical direction, consultation, and supervision for the services provided in the CAH at § 485.631(b)(2). CMS is retaining the regulatory language in the second part of the requirement at § 485.631(b)(2) that a physician be available "through direct radio or telephone communication, or electronic communication for consultation, assistance with medical emergencies, or patient referral." Retaining this longstanding CMS policy and related longstanding subregulatory guidance that further described communication between CAHs and physicians will assure an appropriate level of physician direction and supervision for the services provided by the CAH. This will allow the physician to perform responsibilities remotely, as appropriate. This also allows CAHs to use nurse practitioners and physician assistants to the fullest extent possible, while ensuring necessary consultation and support as needed.
- Page 10: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

TH – Originating Site

- Question: Should hospitals submit a separate 012x type of bill (TOB) for the telehealth originating site facility fee charges during an inpatient stay?
- Answer: Yes, hospitals and critical access hospitals should bill their A/B/MAC for the originating site facility fee on a 12x TOB using the date of discharge as the line item date of service.
  - New: 10/20/20
- Page 89: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

Outpatient Therapy Services

- Question: Can outpatient therapy services that are furnished via telehealth and separately paid under Part B be reported on an institutional claim (e.g., UB-04) during the COVID-19 PHE?
- Answer: Yes, outpatient therapy services that are furnished via telehealth, and are separately paid and not included as part of a bundled institutional payment, can be reported on institutional claims with the "-95" modifier applied to the service line. This includes:
  - Critical Access Hospital (CAH) – 85X (CAHs may separately provide and bill for PT, OT, and SLP services on 85X bill type);

How to Bill – Two Options – Option 1

Question: How do hospitals bill for outpatient therapy services furnished by employed or contracted therapists using telecommunications technology on the UB-04 claim form during the COVID-19 PHE?

Answer: There are two options available to hospitals and their therapists.

1) A hospital could choose to bill for services furnished by employed/contracted PTs, OTs, or SLPs through telehealth, meaning that they would identify furnished services on the telehealth list (https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes), they would bill these services on a UB-04 with a "-95" modifier on each line for which the service was delivered via telehealth. No POS code is required (and there is no location for it on the UB-04).

2nd option

2) A hospital could, instead, use the flexibilities available under the Hospital Without Walls initiative. The hospital would register the patient as a hospital outpatient, where the patient's home acts as a provider-based department of the hospital. The hospital's employed/contracted PT, OT, SLP would furnish the therapy care that the hospital believed could be furnished safely and effectively through telecommunications technology. The hospital is not limited to services included on the telehealth list (since these would not be considered telehealth services), but must ensure the care can be fully furnished remotely using telecommunications technology. The hospital would bill as if the therapy had been furnished in the hospital and the applicable PO/PN modifier would apply for the patient's home since it would be serving as an off-campus department of the hospital. The option to bill for telehealth services, along with the -95 modifier, furnished by employed/contracted PTs, OTs, and SLPs using applicable audio-visual telecommunications technology applies to the following types of hospitals and institutions:

- Critical Access Hospital (CAH) – 85X (CAHs may separately provide and bill for PT, OT, and SLP services on 85X bill type)

RPM billed from CAH?

- CPT code 99453 & 99454 could be billed on the UB and receive cost based reimbursement.
- CPT code 99091 can only be furnished by a physician or other qualified healthcare professional. CPT 99457 and 99458 can be furnished by a physician or other qualified healthcare professional, or by clinical staff under the general supervision of the physician.
  - All three of these codes are only billable as professional codes as the status indicator assigned to these codes is B (not allowed to be submitted on an outpatient hospital Part B bill type).
- Because much of the services described by codes 99457/99458 may be performed by clinical staff under general supervision, it would not be appropriate to split and bill a technical.
- These codes would be paid under the physician fee schedule. There is no method to bill them as a facility service.
- Providers may report CPT code 99091 for work & time outside of services performed for CPT code 99457 & 99458. This may provide additional revenue.
- Professional work could be billed out of the hospital setting if that is where it occurred. As this is outpatient, if method II it would be billed on the UB, method I would be billed on the 1500.

Federal Qualified Health Center

What is a FQHC? POS 50

- Est. in 1991, community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas.
- They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients.
- Federally Qualified Health Centers may be Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing.
- The defining legislation for Federally Qualified Health Centers (under the Consolidated Health Center Program) is Section 1905(l)(2)(B) of the Social Security Act.
- https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html

Continued -

- Strictly speaking, a FQHC is a reimbursement model, not a place. To achieve this recognition, the organizations must meet rigorous governance, access, quality of care, service and cost standards, and in exchange for meeting these requirements, Medi-care and Medicaid pay these organizations on a cost-based or cost-derived (usually higher) basis than published fee schedules.

https://static1.squarespace.com/static/53023f77e4b0f0275ec6224a/t/5776bfac44024370023c78a7/1467400108978/2015SoYouWantToStartAHealthCenter.pdf

The Only Codes (on CMS 1500)

- G0466 – FQHC visit, new patient
- G0467 – FQHC visit, established patient
- G0468 – FQHC visit, Initial Preventative Physical Exam (IPPE) or Annual Wellness Visit (AWV)
- G0469 – FQHC visit, mental health, new patient
- G0470 – FQHC visit, mental health, established patient

And Exceptions

- Technical component of FQHC services
- Certain laboratory services
- Durable medical equipment
- Ambulance services
- Telehealth distant-site services
- Hospice services
- Group services.

Rural Health Clinics

What is a RHC? POS 72

- The Rural Health Clinic Service Act of 1977 addressed an inadequate supply of physicians serving Medicare beneficiaries in rural areas and increased the use of nurse practitioners (NPs), physician assistants (PAs), and certified nurse-midwives (CNMs) in these areas. Medicare pays RHCs an all-inclusive rate (AIR) for medically necessary, face-to-face primary health services and qualified preventive health services furnished by an RHC practitioner. RHC practitioners are physicians, NPs, PAs, CNMs, clinical psychologists (CPs), and clinical social workers (CSWs).

Billed on CMS UB-04 w Revenue Codes

- **0521**: Clinic Visit at RHC by qualified provider
- **0522**: Home visit by RHC provider
- **0524**: Visit by RHC provider to a Part A SNF bed
- **0525**: Visit by RHC provider to a SNF, NF or other residential facility (non-Part A)
- **0527**: Visiting Nurse service in home health shortage area
- **0528**: Visit by RHC provider to other non-RHC site
- **0900**: Service subject to Medicare outpatient mental health treatment limitation
- **0780**: Telehealth from originating site

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Telehealth During PHE

For FQHCs and RHCs

Telehealth – Only During PHE

- Pages 64-71 of the Covid-19 PHE FAQs apply to FQHCs and RHCs
- Changes are not permanent
  - Billing Codes
    - HCPCS code G2025 for both audio/visual and audio only (if specified on telehealth list)
      - Payment = $92.03
      - (the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS. Please also refer to https://www.cms.gov/files/document/se20016.pdf
    - HCPCS code G0071 for online digital evaluation and management
      - The new payment rate is $24.76.
      - Bill once every 7 days
      - New and established patients

Telephone Documentation

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

FAQs I've heard more than twice!

Question: Can a medical visit and a mental health visit be reported on the same day when furnished as a distant site telehealth service?

Answer: Yes. A medical visit and a mental health visit can be furnished on the same day as distant site telehealth services for the duration of the COVID-19 PHE.

Question: How do we report distant site telehealth services when a mental health visit is furnished on the same day as a medical visit?

Answer: Distant site Telehealth services should be billed with HCPCS code G2025 and the appropriate revenue code, 052X for a medical visit or 0900 for mental health. Please see SE20016 for billing guidance, available at https://www.cms.gov/files/document/se20016.pdf.

Cost Report Requirements

Question: How should distant site telehealth services be reported on the cost report?

Answer: RHCs and FQHCs should report distant site telehealth service costs on their cost report along with costs for furnishing originating site telehealth services. RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on l i ne 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”

Providers and Supervision

Question: Which health care providers are permitted to furnish distant site telehealth services for RHCs and FQHCs during the COVID-19 PHE?

Answer: … physicians and certain non-physician practitioners such as nurse practitioners, physician assistants and certified nurse midwives. Other practitioners, such as certified nurse anesthetists, licensed clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals may also furnish telehealth services …

Question: Are there changes to the direct supervision requirements for RHCs and FQHCs?

Answer: In general, the requirements for direct supervision have been modified for the duration of the COVID-19 PHE to include the use of a virtual supervisory presence through the use of interactive audio and video telecommunications technology.

In a nutshell for FQHCs and RHCs

- Providers can perform distant site services
- Providers do not need to be in a facility – can be at home
- Patients can be at home
- Coinsurance and deductibles apply

What’s next, post-PHE?

News on the Horizon

- Recent Congressional staffers' conversation indicates even if other PHE telehealth extensions are revoked, keeping the ability to act as distant site providers is highly sought

RHC – possible funding to reclass as ER

- The measure requires small rural hospitals to shutter their in-patient operations, which often lose money, and revamp as standalone emergency rooms with some outpatient services. Hospitals that receive the status get increased funding.
- [H]ospitals could receive around $750,000 in additional funding under the program, on average, adding that the amount could vary widely depending upon how CMS calculates payments.
  - https://www.nny360.com/communitynews/healthmatters/rural-hospitals-may-get-federal-aid-to-reshape-as-standalone-ers/article_59b9d385-93c8-53ba-86eb-361b7117ace9.html

Resources

- Critical Access Hospital
  - Billing 101 Location: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiDnrvej5XxAhUXt54KHfdnCZsQFjAAegQIAxAD&url=https%3A%2F%2Fwww.ruralcenter.org%2Fsites%2Fdefault%2Ffiles%2FCAH%2520Replacement%2520Manual.pdf&usg=AOvVaw102h6NvMPolZOu4BhHhoKt
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CritAccessHospfctsht.pdf
- Federal Qualified Health Center
  - https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html
  - https://static1.squarespace.com/static/53023f77e4b0f0275ec6224a/t/5a29875a0d92972420c91437/1512671067129/fqhcfactsheet.pdf
  - Billing 101: https://physicianservicesusa.com/fqhc-billing-101/
- Rural Health Clinic
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf
  - Billing 101: https://physicianservicesusa.com/rhc-billing-101/
- Chapter 13 of the Medicare Benefits Manual
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

Other helpful links

- Broadband mapping paper: https://fas.org/sgp/crs/misc/R45962.pdf
- Mapping site: https://broadbandusa.ntia.doc.gov/resources/data-and-mapping
- Nurse billing tip sheet/article: http://stdtac.org/wp-content/uploads/2016/05/RN-Billing-FAQ_STDTAC-1.pdf

QUESTIONS

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