



New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)

MLN Matters Number: SE20016 **Revised**

Related Change Request (CR) Number: N/A

Article Release Date: **July 6, 2020**

Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: N/A

Note: We revised this article to provide:

- **Additional guidance on telehealth services that have cost-sharing waived and additional claim examples**
- **An additional section on the RHC Productivity Standard**

All other information remains 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 provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

To provide as much support as possible to RHCs and FQHCs and their patients during the COVID-19 PHE, both Congress and the Centers for Medicare & Medicaid Services (CMS) have made several changes to the RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE, and we will make additional discretionary changes as necessary to assure that RHC and FQHC patients have access to the services they need during the pandemic. For additional information, please see 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, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was signed into law. Section 3704 of the CARES Act authorizes RHCs and FQHCs to furnish distant site telehealth services to Medicare beneficiaries 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 the patient. RHCs and

FQHCs with this capability can immediately provide and be paid for telehealth services to patients covered by Medicare for the duration of the COVID-19 PHE.

Distant site telehealth services can be furnished by any health care practitioner working for the RHC or the FQHC within their scope of practice. Practitioners can furnish distant site telehealth services from any location, including their home, during the time that they are working for the RHC or FQHC, and can furnish any telehealth service that is approved as a distant site telehealth service under the Physician Fee Schedule (PFS). 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 CMS develop payment rates for these services that are similar to the national average payment rates for comparable telehealth services under the PFS. RHCs and FQHCs must use HCPCS code G2025, the new RHC/FQHC specific G code for distant site telehealth services, to identify services that were furnished via telehealth beginning on January 27, 2020, the date the COVID-19 PHE became effective (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.

Payment to RHCs and FQHCs for distant site telehealth services is set at \$92.03, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS. Because these changes in policy were made on an emergency basis, CMS needs to implement changes to claims processing systems in several stages.

Claims Requirements for RHCs

For telehealth distant site services furnished between January 27, 2020, and June 30, 2020, RHCs must report HCPCS code G2025 on their claims with the CG modifier. Modifier "95" (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) may also be appended, but is not required. **These claims will be paid at the RHC's all-inclusive rate (AIR), and automatically reprocessed beginning on July 1, 2020, at the \$92.03 rate.** RHCs do not need to resubmit these claims for the payment adjustment.

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

RHC Claims for Telehealth Services from January 27, 2020 through June 30, 2020

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

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 furnished between January 27, 2020, and June 30, 2020, that are also FQHC qualifying visits, FQHCs must report three HCPCS/CPT codes for distant site telehealth services: the FQHC Prospective Payment System (PPS) specific payment code (G0466, G0467, G0468, G0469, or G0470); the HCPCS/CPT code that describes the services furnished via telehealth with modifier 95; and G2025 with modifier 95. **These claims will be paid at the FQHC PPS rate until June 30, 2020, and automatically reprocessed beginning on July 1, 2020, at the \$92.03 rate.** FQHCs do not need to resubmit these claims for the payment adjustment.

When furnishing services via telehealth that are not FQHC qualifying visits, FQHCs should hold these claims until July 1, 2020, and then bill them with HCPCS code G2025. Modifier 95 may be appended but it is not 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, FQHCs will only be required to submit G2025. Modifier 95 may be appended but it is not required.

Example of FQHC Claims for Telehealth Services January 27, 2020 through 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

FQHC Claims for Telehealth Services starting July 1, 2020

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

Payment Rate for 2021

Only distant site telehealth services furnished during the COVID-19 PHE are authorized for payment to RHCs and FQHCs. If the COVID-19 PHE is in effect after December 31, 2020, this rate will be updated based on the 2021 PFS average payment rate for these services, weighted by volume for those services reported under the PFS.

Cost Reporting

Costs for furnishing distant site telehealth services will not be used to determine the RHC AIR or the FQHC PPS rate but must be reported on the appropriate 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 are not paid under the RHC AIR or the FQHC PPS, the Medicare Advantage (MA) wrap-around payment does not apply to these services. Wrap-around payment for distant site telehealth services will be adjusted by the MA plans.

Cost-sharing Related to COVID-19 Testing

For services furnished on March 18, 2020 through the duration of the COVID-19 PHE, CMS will 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 determining 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 furnished via telehealth, RHCs and FQHCs must waive the collection of co-insurance from beneficiaries. For services in which the coinsurance is waived, RHCs and FQHCs must put the “CS” modifier on the service line. **RHC and FQHC claims with the “CS” modifier will be paid with the coinsurance applied, and the Medicare Administrative Contractor (MAC) will automatically reprocess these claims beginning on July 1, 2020. Coinsurance should not be collected from beneficiaries if the coinsurance is waived.**

Claims Examples:

RHC Claims for Telehealth Services from January 27, 2020 through June 30, 2020 when cost sharing is waived:

Revenue Code	HCPCS Code	Modifiers
052X	G205	CG, CS (required) 95 (optional)

RHC Claims for Telehealth Services with cost sharing waived starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G205	CS (required) 95 (optional)

FQHC Claims for Telehealth Services January 27, 2020 through June 30, 2020 when cost sharing is waived

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)
052X	G2025	CS, 95 (required)

FQHC Claims for Telehealth Services starting July 1, 2020 when cost sharing is waived

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

Additional Telehealth Flexibilities

During the COVID-19 PHE, RHCs and FQHCs can furnish any telehealth service that is approved as a Medicare telehealth service under the PFS. (See <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>.) In addition, effective March 1, 2020, these services include CPT codes 99441, 99442, and 99443, which are audio-only telephone evaluation and management (E/M) services. RHCs and FQHCs can furnish and bill for these services using HCPCS code G2025. To bill for these services, at least 5 minutes of telephone E/M service by a physician or other qualified health care professional who may report E/M services must be provided to an established patient, parent, or guardian. These services cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

Telehealth Services Cost Sharing Waived

There are several CPT and HCPCS codes included in the list of telehealth codes at the link above that describe preventive services that have waived cost-sharing. As stated earlier in this article, telehealth services on this list are billed using HCPCS code G2025. In order to distinguish those telehealth services that do not have cost sharing waived from those that do, such as certain preventive services, RHCs and FQHCs must also report modifier CS. CMS has 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 and order for or administration of a COVID-19 test and/or used for cost-sharing waived preventive services furnished via telehealth in Rural Health Clinics and Federally Qualified Health Centers during the COVID-19 public health emergency.

For preventive services that are furnished via telehealth and have cost-sharing waived, RHCs must report G2025 on their claims with the CS modifier and FQHCs must report G2025 with the CS modifier on

or after July 1, 2020.

Please 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 include 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 receive payment for the new online digital evaluation and management (CPT codes 99421, 99422, and 99423) or virtual communication services (HCPCS codes G2012 and G2010), RHCs and FQHCs 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. Claims submitted with G0071 on or after March 1, 2020 and for the duration of the COVID-19 PHE will be paid at the new rate of \$24.76, instead of the CY 2020 rate of \$13.53. **MACs will automatically reprocess any claims with G0071 for services furnished on or after March 1, 2020 that were paid before the claims processing system was updated.**

Revision of Home Health Agency Shortage Requirement for Visiting Nursing Services

RHCs and FQHCs can bill for visiting nursing services furnished by an RN or LPN to homebound individuals under a written plan of treatment in areas with a shortage of home health agencies (HHAs). Effective March 1, 2020, and for the duration of the COVID-19 PHE, the area typically served by the RHC, and the area included in the FQHC service area plan, is determined to have a shortage of HHAs, and no request for this determination is required. RHCs and FQHCs must check the HIPAA Eligibility Transaction System (HETS) before providing visiting nurse services to ensure that the patient is not already under a home health plan of care.

Consent for Care Management and Virtual Communication Services

Beneficiary consent is required for all services, including non-face-to-face services. During the COVID-19 PHE, beneficiary consent may be obtained at the same time the services are initially furnished. For RHCs and FQHCs, this means that beneficiary consent can be obtained by someone working under general supervision of the RHC or FQHC practitioner, and direct supervision is not required to obtain consent. In general, beneficiary consent to receive these

services may be obtained by auxiliary personnel under general supervision of the billing practitioner; and the person obtaining consent can be an employee, independent contractor, or leased employee of the billing practitioner. For RHCs and FQHCs, beneficiary consent to receive these services may be obtained by auxiliary personnel under general supervision of the RHC or FQHC practitioner; and the person obtaining consent can be an employee, independent contractor, or leased employee of the RHC or FQHC 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

RHCs that are provider-based to a hospital with fewer than 50 beds are 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. To prevent RHCs that are currently exempt from the national per-visit payment limit from losing their exemption due to the COVID-19 PHE, and to not discourage hospitals from increasing bed capacity if needed, CMS will 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 determining exemption to the payment limit. As such, RHCs with provider-based status that were exempt from the national per-visit payment limit in the period prior to the effective date of the COVID-19 PHE (January 27, 2020) will continue to be exempt from the national payment limit for the duration of the PHE for the COVID-19.

Exception to the Productivity Standards for RHCs

Productivity standards are used to help determine the average cost per patient for Medicare reimbursement in RHCs. Physicians, nurse practitioners, physician assistants, and certified nurse midwives are held to a minimum number of visits per full time employee (FTE) that they are expected to furnish in the RHC. Failure to meet this minimum may indicate that they are 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 public health emergency (PHE). As a result, these RHCs may have difficulty in meeting the productivity standards. To minimize the burden on RHCs, exceptions to the productivity standard may be granted by your MAC during the COVID-19 PHE. Further direction will be forthcoming from your MAC.

ADDITIONAL INFORMATION

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

Review information on the current emergencies webpage at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

DOCUMENT HISTORY

Date of Change	Description
July 6, 2020	<p>We revised this article to provide:</p> <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 <p>All other information remains the same.</p>
April 30, 2020	<p>We revised this article to provide:</p> <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 <p>All other information remains the same.</p>
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 2019 American Medical Association. All rights reserved.

Copyright © 2013-2020, 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.