



Questions & Answers: Reimagining Reimbursements



NCTRC Webinar Series hosted by HTRC

Reimagining Reimbursements: Planning for Sustainability for Telehealth Practice

Questions from the session answered by Richelle Marting, JD, MSHA, RHIA

Question: How are reimbursements impacted by provider roles that may not be recognized by CMS, particularly if billing submissions are being denied?

Medicare Advantage plans may recognize a greater range of provider specialty taxonomies, and specialty designations impact if multiple providers can bill and be paid for services on the same day. In the instances you're seeing denials, it's possible that the providers' enrollment with the MCOs are showing the same subspecialty designation. When that happens, only one provider gets to report an evaluation and management service per day, per patient, per specialty/subspecialty, per group practice. However, the work of the two providers can be combined to determine the total level of service that has been provided to the patient on that date. Also consider discussing the issue with the state medical society and the professional associations these physicians are members of. If those organizations representing large numbers of providers begin to hear similar provider needs, it helps justify the resources to consider changes like this. Medicare also has statutory restrictions on specialty-specific payment variations that could present a barrier to implementation, and in developing a proposal those limitations should be considered to understand if the proposal is within CMS's statutory authority. (see discussion at [83 Fed. Reg. 59643, Nev. 23, 2018 here, page 192](#), about halfway down the third column).

Where to Go for More Information:

The Healthcare Provider Taxonomy Code Set is available from the Washington Publishing Company (www.wpc-edi.com) and is maintained by the National Uniform Claim Committee (www.nucc.org). Traditional Medicare's crosswalk from those detailed specialty taxonomies to the narrower Medicare Specialty codes **can be found here**. These are developed by the CMS Center for Program Integrity, Provider Enrollment Oversight Group, Division of Enrollment Operations. The current contacts in this enrollment division are Alisha Sanders and Joseph Schultz ([see page 43 here](#)). The division's email address is providerenrollment@cms.hhs.gov

Question: Do you have information on FQHC reimbursement for telehealth and if it will still be at the reduced rate?

FQHCs qualify for payment for the originating site fee for a telehealth service, pre- during- and after- the COVID Public Health Emergency. See [IOM 100-04 Chapter 9 Section 80, page 36-37 here](#). These are the only FQHC services that are subject to a Part B deductible, so amount paid by Medicare may be lower

than the allowable amount if patient still has a deductible amount to which the charges are being applied.

Comment: Under the PHE, FQHC's are reimbursed now as the distant site. We could not do that before. We are reimbursed \$170, but for telemedicine (Medical) it is \$99.

FQHCs have been eligible to bill as distant site telehealth providers since 1/27/2020, and will continue to be eligible for at least 151 days after the PHE ends. The CARES Act, Section 3704, that created this ability for FQHCs to bill as distant site telehealth providers required CMS to develop FQHC distant site telehealth rates that are similar to the national average payment rates for comparable telehealth services under the Physician Fee Schedule. CMS averaged its payments for all Physician Fee Schedule telehealth services to arrive at a \$92 amount for 2020, that has been adjusted upward each year since. That annual adjustment will continue, albeit lower than the total PPS rate, unless Congress makes a legislative change to make FQHCs eligible as permanent distant site telehealth providers, and that's likely the time that the amount of telehealth service payment would be established either by Congress, or delegated to CMS to develop that methodology.

Question: Are states paying the PPS to FQHCs/RHCs post PHE for audio only telehealth services? Maybe the better question is, do states have the authority to pay PPS to FQHCs/RHCs for audio only telehealth based upon federal regulations?

Each state's Medicaid payment for FQHCs/RHCs will depend upon their individual program rules, and potentially any PHE waivers that were issued by CMS during the PHE. Some states simply modified their state Medicaid program telehealth payment on a permanent basis. One our local states under the HTRC, Missouri, increased telehealth flexibilities during the PHE through waivers with CMS and because they were granted by CMS, only CMS could agree to revoking the waiver. This benefitted providers in the state when Missouri's state emergency declaration ended – rather than any state-created Medicaid flexibilities going away due to their contingency on the state emergency declaration, they've had to await CMS approval to withdraw those flexibilities.

States do have authority to develop policies on when/how to pay for telehealth services and FQHC/RHC payments.

Question: During the Public Health Emergency our agency could provide behavioral services to clients across state lines however this is no longer possible. Is there talk of bringing this back? We are in western Massachusetts and share borders with NY and CT, with several other states close by. Not to mention college students!

At the Medicare level, there is still a *payment* policy waiver that permits providers to render telehealth to patients in any state regardless of licensure in that state and will remain until the PHE ends. ***But***, providers need to be aware of their individual state's rules for licensure. Some states may still waive the requirement to be licensed in the state where the patient is located for telehealth services, and some – Kansas in our HTRC region is an example – have an expedited limited licensure process limited to telehealth services in the state. Those are great questions for the licensing boards for the disciplines that are impacting your organization, within the individual state(s) where they practice. Also look to see if

your state participates in licensing compacts that make it quicker and more efficient to become licensed across state lines. We may need to extend this question to our Outreach Partner that has extensive knowledge regarding licensure and practice that extends across states.

Question: Do you think they will extend the PHE in October?

Just minutes after our session, I received an announcement that yes, HHS is *expected* to renew the PHE in October for an additional 90 days, and that would take the next renewal date to January 11, 2023. That also gives assurance that many of the telehealth flexibilities such as FQHCs/RHCs billing as distant site telehealth providers will continue for 151-days after January 11, 2023.

Source: https://www.beckershospitalreview.com/finance/hhs-expected-to-renew-covid-19-phe-for-11th-time.html?origin=BHRE&utm_source=BHRE&utm_medium=email&utm_content=newsletter&oly_enc_id=1827D4612990E9P&utm_source=PayerE&utm_medium=email&utm_content=newsletter

HHS has also committed to providing 60-days' advance notice before revoking or allowing the PHE declaration to expire. Source: <https://aspr.hhs.gov/legal/PHE/Pages/Letter-to-Governors-on-the-COVID-19-Response.aspx>

With that in mind, **mark your calendars for 11/12/2022 which marks 60 days before the anticipated January 11 renewal date** when we should hear if HHS is intending to allow the PHE to expire.

Question: Are there discussions for FQHC's behavioral health MD, DO and NP's (providers) that would be considered under the FQHC PPS rate like the LICSW? Currently it falls under the medical reduced rate.

This may be a good question to gather more detail. Are the services by behavioral health MD/DO and NP's being billed under revenue code 0900 and with G0469 or G0470? CSWs can provide services covered under the FQHC mental health visit codes only, and not medical codes. But any FQHC practitioner can render a service that qualifies as a mental health visit to be paid at the mental health visit rate.

Source: See [CMS IOM 100-02, Chapter 13, Section 17](#) (beginning at p. 37)

Question: Can you speak to seeing new patients in person for mental health care and yearly in-person visits when the PHE ends versus virtual initial visits and virtual continued care? Is it going to be required to see new patients in-person and current patients in-person yearly? We are a psychiatry and therapy outpatient clinic. Our primary payers are Medicaid and other private insurance such as Medica and BCBS.

Great question, and it's probably the most common question we get about PHE flexibilities. The requirement refers to a recent expansion of telehealth coverage for mental/behavioral health services. This occurred as a permanent expansion before COVID, and allowed patient to be seen from their home for the evaluation or treatment of mental/behavioral conditions that do not co-occur with substance

use disorder. When the telehealth service would only be covered by using this expanded coverage option – namely when the patient was at home --- the patient was required to have an in-person, face to face visit within 6 months of the first telehealth visit and annual in person visits thereafter. There are exceptions to the annual visit requirement, but not to the initial 6-month in person visit requirement.

The initial in-person visit *would not apply* if 1) the patient presented to an eligible originating site and all regular telehealth requirements were met; 2) the patient’s mental/behavioral conditions co-occur with substance use disorder.

During the PHE declaration, those in-person visit requirements have been waived. Under the Consolidated Appropriations Act of 2022, they will also be waived for 151-days after the federal PHE ends. If HHS does in fact renew the PHE in October, then, the very earliest they would apply is 6/11/2023.

You raise a great question, and frankly, an unaddressed ambiguity in CMS policy. CMS has informally suggested to me that when the PHE ends, and when those in-person visit requirements go back into effect, even patients who have been established and receiving mental/behavioral telehealth since the beginning of the PHE would still need an in-person visit within 6 months of the first telehealth service that is to occur once requirements are reinstated.

But, again, that won’t apply if the patient is presenting from an eligible originating site or has co-occurring substance use disorder. And, *this is only a Medicare payment policy*. Your state Medicaid program and commercial payors can develop their own policies on whether they require similar in-person visit requirements.

For additional questions, contact the Heartland Telehealth Resource Center at htrc@kumc.edu.