Regulations Open Doors for Telehealth Services in FQHCs

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June 1, 2022

Originally published at AAPC.com
https://www.aapc.com/blog/85111-regulations-open-doors-for-telehealth-services-in-fqhcs/

Make sure your facility is aware of all the Medicare policy changes that permit payment for expanded services.

Telehealth as a healthcare delivery platform has been in existence since the late 1960s. It was first introduced through projects initiated by the National Aeronautics and Space Administration (NASA) and the Nebraska Psychology Institute. The declaration of the public health emergency (PHE) for COVID-19 in 2020 launched telehealth front and center as a mainstream healthcare delivery system.

The Coronavirus Aid, Relief and Economic Security (CARES) Act, signed into law on March 27, 2020, in response to the PHE, provided certain flexibilities that made it possible for federally qualified health centers (FQHCs) to provide telehealth services. This article will walk you through what an FQHC is, the evolution of telehealth coverage, and FQHC coding for telehealth services.

Telehealth Pre-COVID

Prior to implementation of the CARES Act, telehealth services were covered under very limited circumstances. The following requirements had to be met before the CARES Act took effect:

- Only established patients could receive telehealth services.
- Patients had to be in a remote or rural area.
- Patients had to be at an approved originating site.
- Patient deductible and coinsurance applied.
- Service provided had to be one of the limited covered services.

- Services had to be performed using HIPAA-approved technology for interactive audio-video (AV) communication.
- Providers had to be licensed in the state where the service was provided as well as the state where the patient was located, if different.
- Providers had to be located at an approved distant site.

An approved distant site refers to the location of the provider when delivering a telehealth service. FQHCs and rural health centers (RHCs) were not approved qualified distant sites prior to the CARES Act. This meant that providers employed by FQHCs could not perform a telehealth service when they were located at their place of employment. The CARES Act waives the Section 1834(m) restriction on FQHCs and RHCs that prohibits them from serving as a distant site. To understand the significance of this, you need to know more about FQHCs and who they serve.

FQHC vs. RHC

FQHCs are community-based centers that serve at-risk or medically underserved populations. They generally offer comprehensive care in an outpatient setting, although FQHCs can take many shapes, including but not limited to migrant health centers, healthcare for the homeless centers, and outpatient programs or facilities operated by a tribe or tribal organization. Since one of the major goals of telehealth services is to enhance the delivery of healthcare to medically underserved and geographically disadvantaged patients, thereby reducing costs through improved quality of care, the flexibilities for FQHCs through the CARES Act are a win all the way around.

Designated FQHCs, as defined by the Health Resources and Services Administration, an agency of the Department of Health and Human Services, must *:

- Qualify for funding under Section 330 of the Public Health Service Act
- Qualify for reimbursement from Medicare and Medicaid
- Serve an underserved area or population
- Offer a sliding fee scale
    - Provide comprehensive healthcare services including:
    - Preventive health services
    - Dental services
    - Mental health and substance abuse services
    - Transportation services necessary for adequate patient care
    - Hospital and specialty care

- Have an ongoing quality assurance program

** Not an all-inclusive list.*

According to the Centers for Medicare & Medicaid Services (CMS), there are approximately 1,400 FQHCs and similar health centers in the United States. These centers service roughly 25 million patients. Because many of the patients who receive care at FQHCs are at-risk or underserved, expanded telehealth services provide a vehicle for patients to receive care who may not otherwise be able to for a variety of reasons.

RHCs are similar to FQHCs but are located in rural areas that have been designated as a health professional shortage area or medically underserved areas. FQHCs can provide care in rural as well as suburban areas. RHCs provide outpatient care, emergency care, and basic lab services. There are many differences between RHCs and FQHCs, but one of the main differences is that FQHCs provide the same services as RHCs but more comprehensively by formal arrangement, meaning the services are generally by appointment. While the services are similar, there are many differences including the level of federal funding available. Additionally, RHCs are not required to provide services to all community members, where FQHCs are required to provide services for all patients within their jurisdiction.

FQHC Coding and Coverage

In the Calendar Year (CY) 2022 Medicare Physician Fee Schedule (MPFS) final rule, effective Jan. 1, 2022, CMS issued several provisions that affect telehealth services provided by FQHCs.

Telehealth services provided to Medicare beneficiaries generally require an interactive real-time telecommunication system that permits AV communication. FQHCs with this capability can provide and be paid for telehealth services to patients covered by Medicare for the duration of the COVID-19 PHE which, unless renewed, is set to expire on July 15, 2022. As a result of the CY 2022 MPFS final rule, FQHCs may also provide audio-only telehealth services to Medicare patients for the duration of the PHE.

Distant site telehealth services can be furnished by healthcare providers working for a FQHC provided that the services are within their scope of practice. Providers can perform approved distant site telehealth services under the MPFS. Approved distant site includes the provider's home.

When services on the CMS-approved telehealth services list are performed, claims are submitted with HCPCS Level II code G2025 *Payment for a telehealth distant site service furnished by a rural health clinic (rhc) or federally qualified health center (fqhc) only*. HCPCS Level II code G2025 is paid a flat rate of $99.45 for CY 2021 and $97.24 for CY 2022. For additional information, please reference CMS MLN Matters SE20016, article release date Jan. 13, 2022.

Additionally, the 2022 MPFS final rule allows mental health visits provided by a FQHC to be furnished using interactive, real-time telecommunications technology. The change also allows FQHCs to receive payment for audio-only visits when the beneficiary does not consent to or is incapable of using video

technology. As part of CMS' 2022 MPFS final rule, in-person mental health visits are required within six months prior to the patient receiving a telehealth mental health visit. Patients are required to have an in-person visit every 12 months while they are actively receiving services furnished via telehealth for diagnosis, evaluation, or treatment of mental health disorders.

Mental health telehealth services should ***not*** be billed with HCPCS Level II code G2025. RHC mental health visits provided via telehealth should be billed with CPT® code 90834 *Psychotherapy, 45 minutes with patient* or another qualifying mental health visit payment code.
FQHCs billing mental health visits via telecommunications should use HCPCS Level II code G0470 *Federally qualified health center (FQHC) visit, mental health, established patient; a medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit* and CPT® code 90834 or another qualifying mental health visit payment code.
For both RHCs and FQHCs, append modifier 95 *Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system* for mental health services furnished via AV technology and modifier FQ *The service was furnished using audio-only communication technology* for services that were furnished via audio-only.

No Turning Back

Legislators, payers, healthcare providers, and patients alike agree that leveraging telehealth will reduce healthcare costs by increasing patient compliance and access to healthcare. The flexibilities under the CARES Act for FQHCs to serve as approved distant sites create a unique opportunity for these community-based centers to further address patient needs through telehealth services. Looking to the future, several pieces of legislation have been introduced related to telehealth services in the last couple of years, married with CMS' expansion of telehealth services for FQHCs in the CMS CY 2022 MPFS final rule, as well as reports on several telehealth-related Office of Inspector General's work plan items due for release in 2022 and 2023, the efficacy of telehealth as a mainstream healthcare delivery platform is obvious.

Article Resources

- www.ncbi.nlm.nih.gov/pmc/articles/PMC3881125
- www.aafp.org/journals/fpm/blogs/gettingpaid/entry/FQHC_covid_telehealth.html
- https://mhealthintelligence.com/news/study-touts-fqhc-success-at-integrating-telehealth-mental-health-services

- https://ahima.org/media/myelojho/133_21_advocacy_summit_21_handouts_telehealth.pdf?utm_medium=email&_hsmi=125827590&_hsenc=p2ANqtz-_oFSZ5TQJqG15rSGcRBkh-8NEv1017kmAFPfwQiA0uLoEDrfMNjY38WYF8AgrgYlVHDJoODE-LZZyXMdBtEI9ksZNhkg&utm_content=125827590&utm_source=hs_email
- www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center
- www.cms.gov/files/document/se20016-new-expanded-flexibilities-rhcs-fqhcs-during-covid-19-phe.pdf
- www.differencebetween.net/science/health/difference-between-fqhc-and-rhc

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About Jessica Whitney, CPC, CPMA

Jessica Whitney, CPC, CPMA, is an audit manager with AAPC Audit Services Group. She performs revenue cycle audits and trains a variety of clients. Whitney began her healthcare career over 20 years ago at Blue Cross of Idaho, working in provider relations and claims. After several years, she transitioned to practice management, where she oversaw small, privately owned practices and large multispecialty hospital-owned organizations. Whitney also has in-depth knowledge of the credentialing and contracting processes and reimbursement analysis.