



**Federally Qualified Health Center Version**

## **KEY CONCEPTS OUTLINE**

### **Module 6: Coverage and Billing of FQHC Services Provided Outside the Federally Qualified Health Center**

#### **I. Virtual Communication Services (VCS)**

1. Effective for dates of service on or after January 1, 2019, an FQHC may receive an additional payment for the costs of certain communication technology-based services or remote evaluation services that are not already captured in the FQHC PPS payment when the following conditions are met.  
<See *Medicare Benefit Policy Manual*, Chapter 13 § 240; see Virtual Communication Services in Rural Health Clinics (FQHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions December 2018; >
  2. An FQHC practitioner must provide at least 5 minutes of certain communications-based technology or remote evaluation services to a patient who has been seen in the FQHC within the previous year.
  3. Face-to-face requirements are waived.
    - i. The medical discussion or remote evaluation must be for a condition that is not related to an FQHC service provided within the previous seven days and does not lead to an FQHC service within the next 24 hours or at the soonest available appointment.
    - ii. If the discussion between the patient and the FQHC practitioner is related to a prior billable visit furnished by the FQHC within the previous seven days or within the next 24 hours or at the soonest available appointment, the cost of the FQHC practitioner's time would be included in the FQHC PPS payment for the visit and is not separately billable as VCS.
- b. VCS services performed by FQHCs are reported with HCPCS code G0071.

- i. G0071 - Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only
- c. Initially, VCS services billable by FQHC with G0071, included only those services described by HCPCS codes G2010 or G2012. For dates of service on or after January 1, 2021, CMS added HCPCS codes G2250, G2251 and G2252, to the list to describe the services reportable by FQHCs with VCS HCPCS code G0071:
  - i. HCPCS G2010 – Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
  - ii. HCPCS G2012 - Brief communication [technology](#)-based service, e.g. [virtual](#) check-in, by a [physician](#) or other qualified [health care professional](#) who can report evaluation and management services, provided to an established [patient](#), not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or [procedure](#) within the next 24 hours or soonest available appointment; 5-10 minutes of [medical](#) discussion
  - iii. HCPCS G2250 - Remote assessment of recorded video and/or images submitted by an established patient, including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment
  - iv. HCPCS G2251 - Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available, 5-10 minutes
  - v. HCPCS G2252 – Same definition as G2251, except 11-20 minutes

d. PHE Exceptions

- i. VCS may be provided to new and established patients, as long as patient consent has been obtained.

**(a) New Patient PHE Expansion Expired – As of May 12, 2023, VCS may only be reported for established patients.**

- ii. For dates of service on or after March 1, 2020, and throughout the duration of the COVID-19 PHE, CMS is also expanding VCS (reportable by FQHCs with HCPCS G0071) to include certain additional online digital evaluation and management services using patient portals.

**(a) For dates of service after the end of the PHE, G0071 will no longer include the additional online digital E/M and other VCS codes.**

- e. Online digital evaluation and management services are non-face-to face, patient-initiated, digital communications using a patient portal, that require a clinical decision that otherwise typically would have been provided in the clinic by an FQHC practitioner.
  - i. A patient portal is a secure online website that gives patients 24-hour access to personal health information from anywhere with an Internet connection by using a secure username and password.
- f. The following codes describe the expanded VCS services which are reportable with HCPCS code G0071 during the PHE:
  - i. 99421 (Online digital evaluation and management service, for established patient, for up to 7 days, cumulative time; 5-10 minutes);
  - ii. 99422 (Online digital evaluation and management service, for established patient, for up to 7 days, cumulative time; 11-20 minutes); and,
  - iii. 99423 (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time; 21 or more minutes).

An FQHC practitioner can respond from any location during the time they are scheduled to work in the FQHC.

- g. Although an FQHC service, VCS services are paid under the MPFS, not the FQHC PPS.
  - i. For CY 2023, the payment rate for G0071 is \$23.72.
  - ii. MPFS coinsurance applies.
- b. Because these codes are for a minimum 7-day period of time, FQHCs cannot bill G0071 more frequently than once every seven days.

***Link: Rural Health Clinics Center under Medicare Related Sites – Rural Health***

*Select COVID-19 Frequently Asked Questions (FAQs) for Rural Health Clinics (FQHCs) and Federally Qualified Health Centers (FQHCs) under the Frequently Asked Questions section.*

## II. Telehealth Services

### 1. Originating site telehealth services

- a. Although telehealth is not an FQHC benefit, the clinic may serve as an originating site for telehealth services. Originating site refers to the location of the patient at the time the service is being furnished via telecommunications systems. <See *Medicare Benefit Policy Manual*, Chapter 13 § 200>
- b. The originating site facility fee is reported with revenue code 0780 and HCPCS code Q3014.
  - i. The payment rate for originating site telehealth services is made under the MPFS and is updated annually.
  - ii. For CY 2023, the payment rate for HCPCS code Q3014 is the lesser of \$28.64 or billed charges. <*Medicare Claims Processing Manual* Transmittal 10505>
- iii. The MPFS deductible applies
  - a) Given that the telehealth originating site facility fee is not an FQHC service, the MPFS deductible applies.

- iv. The MPFS coinsurance applies
- c. Exception for telehealth services during the COVID-19 PHE
  - i. Effective for dates of service on or after March 6, 2020, an eligible originating site location includes the patient's home. <MLN Matters SE20016, revised January 13, 2022>
  - d. An originating site facility service may be billed as the only billable service provided or in addition to a qualifying visit billed with revenue code 052X and/or 0900. <Medicare One Time Notification Transmittal 1540>
  - e. Although the charges for originating site services are reported on the claim, they are reported in a special section in the cost report and are not taken into consideration in the calculation of the PPS payment.
- 2. Distant site telehealth services
  - a. Usually, an FQHC may not serve as a distant site for telehealth services. Distant site refers to the location of the practitioner at the time of the service. <See Medicare Benefit Policy Manual, Chapter 13, § 200>
  - b. Exception during the COVID-19 PHE
    - i. **This exception will continue through December 21, 2024.**
    - ii. Prior to January 27, 2020, distant site services could not be billed by an FQHC. This includes telehealth services that are furnished by an FQHC practitioner who is employed by or under contract with the FQHC or a non-FQHC practitioner furnishing services through a direct or indirect contract. <MLN Matters SE20016, revised November 22, 2022>
    - iii. Section 3704 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) authorizes FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. <CARES January Act>
      - a) Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. <MLN Matters SE20016, revised November 22, 2022>
      - b) Distant site telehealth services can be furnished by any health care practitioner working for the FQHC within their scope of practice from any location, including their home, during the time that they are working for the FQHC and can furnish any telehealth service that is approved as a distant site telehealth service under the Medicare Physician Fee Schedule

(MPFS). <MLN Matters SE20016, revised November 22, 2022; see CMS Rural Health Clinic Center website at [Rural Health Clinics Center | CMS](#)>

- c) For distant site telehealth services beginning January 27, 2020, FQHCs must report HCPCS code G2025 for any covered service on the CMS telehealth list.
- d) Initially, CMS provided the following additional billing guidance for FQHC telehealth services. For dates of service from January 27 - June 30, 2020, that describe qualifying visits.
  - 1) The FQHC Prospective Payment System (PPS) specific payment code (G0466, G0467, G0468, G0469, or G0470)
  - 2) The HCPCS/CPT code that describes the services provided via telehealth with modifier -95
  - 3) G2025 with modifier -95
- 3. For COVID-19 testing-related services and preventive services not subject to cost sharing, FQHCs must waive collection of coinsurance from beneficiaries and attach modifier –CS to receive full payment from Medicare.
- 4. Effective March 1, 2020, CMS included CPT codes 99441, 99442, and 99443 (which are audio-only telephone evaluation and management (E/M) services) in the list of covered telehealth services. FQHCs can also furnish and bill for these services using HCPCS code G2025, as long as the following requirements are met.
  - i. 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 are provided to a new or established patient, parent, or guardian.
    - a) These services do not 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. <COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing, updated 09/11/20>

- b) All otherwise applicable billing requirements for distant site telehealth services are met, including the reporting of modifiers (-95) when appropriate. <See *MLN Matters SE20016*, revised November 22, 2022>

*Telehealth Visit Example*

Revenue Code	HCPCS Code	Modifier	Service Date
052X	G2025	-95	01/25/2022

**Note:** Initially, payment was based on the actual FQHC rate, not the lesser of the FQHC rate or billed charges. Coinsurance for distant site services was 20% of billed charges and payment was 80% of the FQHC rate (\$92.03) minus coinsurance. The intent, however, was for coinsurance and payment to be based on the lesser of the FQHC rate or billed charges.

5. For dates of service during CY 2023, FQHC payment for HCPCS code G2025 is based upon the updated national rate of \$95.88, utilizing the "lesser of" methodology. <See *MLN Matters SE20016*, revised November 22, 2022>
6. Cost reporting for telehealth services during the COVID-19 PHE
  - a. Costs for furnishing distant site telehealth services will not be used to determine the FQHC PPS rate; however, the costs must be reported on the appropriate cost report form. <*MLN Matters SE20016*, revised November 22, 2022> FQHCs must report both originating site and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled "Cost Other Than FQHC Services."

*Telehealth Services – Cost Sharing Waived Example*

*July 1, 2020*

Revenue Code	HCPCS Code	Modifier	Service Date
052X	G2025	CS, -95 (optional)	01/25/2022

### III. Virtual Mental Health Services

1. Beginning January 1, 2022, CMS allows FQHCs to report and receive payment for virtual mental health visits in the same manner as if the visit were provided in-person. <See *MLN Matters* SE22001; 86 Fed. Reg. 39229;>
  - a. Generally, these visits are furnished using two-way (audio/video) interactive real-time telecommunications technology. There is an exception that permits audio-only visits when the beneficiary is not capable of, or does not consent to, use of video technology.
    - i. When furnished using two-way technology, FQHCs should attach modifier -95.
    - ii. When furnished with audio only, FQHCs should report modifier -FQ.
  - b. An initial in-person, non-telehealth visit is required within six months prior to initiation of virtual mental health services. At least one additional in-person, non-telehealth visit is required every 12 months thereafter.
  - c. An exception to the 12-month in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient's medical record).
  - d. More frequent visits are allowed, as driven by clinical needs on a case-by-case basis.

#### *Virtual Mental Health Service Example*

Revenue Code	HCPCS Code	Modifier	Service Date
0900	G0470  (Or other appropriate FQHC specific Mental Health Visit Payment Code)	-95 (audio-video) or  -FQ (audio-only)	01/25/2022



0900	90834 (Or other FQHC PPS Qualifying Mental Health Visit Payment Code)	N/A	01/25/2022
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#### IV. Services Provided to a Hospice Patient

1. An FQHC may provide care to a hospice patient for any medical condition that is not related to their terminal illness. <See *Medicare Benefit Policy Manual*, Chapter 13 § 210.2>
2. In most cases, if the patient receives care from an FQHC practitioner during clinic hours for a condition that is related to the terminal illness, the FQHC cannot separately bill for or be reimbursed for the face-to-face visit, even if it is medically necessary.
3. Two exceptions
  - a. The FQHC has a contract with the hospice provider to furnish core hospice services when extraordinary circumstances exist within the hospice such as temporary staffing shortages, unanticipated high census, or temporary travel by the patient outside of their hospice's service area. <42 C.F.R. 418.64; see *Medicare Benefit Policy Manual*, Chapter 13 § 210.2>
  - b. The FQHC has a contract with the hospice provider to furnish highly specialized nursing services that are not usually provided by the hospice and for the hospice to employ a nurse with that skill would be impractical and expensive. <42 C.F.R. 418.64; see *Medicare Benefit Policy Manual*, Chapter 13 § 210.2>
  - a) Costs associated with these hospice exceptions should not be reported on the clinic's cost report since the FQHC is reimbursed by the hospice under its contract.
2. Unless prohibited by their employment contract or scope of practice, a practitioner who is employed by the FQHC can provide hospice services when he or she is not working at the FQHC. <See *Medicare Benefit Policy Manual*, Chapter 13 § 210.1>

*Any service provided to a hospice patient by an FQHC practitioner must comply with the prohibition on commingling and the practitioner would bill the hospice service to Part B under his or her own provider number.*

3. Effective January 1, 2022, FQHCs can bill and receive payment under the FQHC PPS payment, when a designated attending physician, NP, or PA who is employed by or working under contract with the FQHC furnishes hospice attending services during the patient's hospice election. <See *Medicare Claims Processing Manual*, Chapter 9 § 60.6; see *Claims Processing Transmittal 11029 and MLN Matters 12357*>
  - a. Modifier --GV must be reported on the claim line each day a hospice attending physician services are furnished.

#### Hospice Service Example

Revenue Code	HCPCS Code	Modifier	Service Date
0521	G0466/G0470 FQHC Payment	-GV	01/25/2023
0521	Hospice Qualifying Visit		01/25/2023

- i. When the FQHC furnishes a hospice attending physician service that has a technical component, the technical component must be billed separately to the hospice for payment.
- b. Coinsurance applies.

#### V. Visiting Nurse Services

1. The following requirements must be met for a visiting nurse service to be considered a covered FQHC visit. <See *Medicare Benefit Policy Manual*, Chapter 13 §§ 190.2, 190.3, 190.4>
  - a. There is a shortage of home health agencies in the area where the FQHC is located, as determined by CMS.
    - i. An FQHC located in an area that does not have a current home health shortage may make a written request to the CMS Regional Office for authorization to provide visiting nurse services.

- b. The patient is confined to the home. <Social Security Act § 1835(a)>
  - c. The services are furnished under a written plan of treatment and under the supervision of a physician, NP, PA, CNM, or CP. <See Medicare Benefit Policy Manual, Chapter 13 § 190.5>
    - i. The supervising practitioner must review the plan of treatment at least once every 60 days.
    - ii. If the patient does not receive at least one covered nursing visit in a 60-day period, the plan is considered terminated unless:
      - a) The supervising practitioner has made a recertification within the 60-day period and the lapse of visits is part of the treatment plan; or,
      - b) The documentation supports that visiting nurse services are required at predictable intervals that occur less than once every 60 days (i.e., once every 90 days).
  - d. The nursing services are furnished on a part-time or intermittent basis only.
  - e. Drugs and biological products are not provided during the visit.
2. A visiting nurse may provide skilled nursing services in a patient's home as determined by an FQHC practitioner to be medically necessary for the diagnosis and treatment of an illness or injury based on the patient's unique medical condition. <See Medicare Benefit Policy Manual, Chapter 13 § 190.1>
- a. The determination of whether visiting nurse services are reasonable and necessary is made by the FQHC practitioner, based on the condition of the patient when the services were ordered and what is reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.
3. For the duration of the COVID-19 PHE, CMS is revising certain requirements for coverage of visiting nurse services. <COVID-19 Frequently Asked Questions (FAQs) for Rural Health Clinics (FQHCs) and Federally Qualified Health Centers (FQHCs)>
- a. CMS will assume that the area typically served by the FQHC has a shortage of home health agencies, and no explicit shortage determination is required.
    - i. Expires at the end of the PHE (May 11, 2023)

- (a) If the FQHC is not located in an HHA shortage area, FQHCs will have to make a written request and justification that the area it serves meets the required conditions and that the definition of “homebound” will not apply to patients receiving their visiting nursing services.
- b. However, an FQHC 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.
- c. Visiting nurse services are only billable as an FQHC visit when they require skilled nursing services.
  - i. For example, a nurse’s collection of specimen to test for Covid-19 would not be a billable visit since no skilled services were provided.

***Link: Rural Health Clinics Center under Medicare Related Sites – Rural Health***

*Select COVID-19 Frequently Asked Questions (FAQs) for Rural Health Clinics (FQHCs) and Federally Qualified Health Centers (FQHCs) under the Frequently Asked Questions section.*



## Medicare Fee-for-Service Response to the Public Health Emergency on COVID-19

MLN Matters Number: SE20011 **Revised**

Related Change Request (CR) Number: N/A

Article Release Date: **May 12, 2023**

Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: N/A

**Note: The COVID-19 public health emergency (PHE) ended on May 11, 2023. View [Infectious diseases](#) for a list of waivers and flexibilities that were in place during the PHE.**

### Affected Providers

- Physicians
- Providers
- Suppliers

### Provider Information Available

The Secretary of the HHS declared a PHE in the entire United States on January 31, 2020. On March 13, 2020, HHS authorized waivers and modifications under [Section 1135 of the Social Security Act](#) (the Act), retroactive to March 1, 2020. **The COVID-19 PHE ended on May 11, 2023. View [Infectious diseases](#) for a list of waivers and flexibilities that were in place during the PHE.**

CMS is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for patients affected by the emergency. You don't need to apply for an individual waiver if a blanket waiver is issued.

For more Information, refer to:

- [Coronavirus Waivers and Flexibilities](#) webpage
- [Instructions](#) to ask for an individual waiver if no blanket waiver exists

### Background

#### **Section 1135 and Section 1812(f) Waivers**

As a result of this PHE, apply the following to claims for which Medicare payment is based on a "formal waiver" including, but not limited to, [Section 1135](#) or [Section 1812\(f\)](#) of the Act:

1. The “DR” (disaster related) condition code for institutional billing, that is, claims you submit using the ASC X12 837 institutional claims format or paper Form CMS-1450.
2. The “CR” (catastrophe/disaster related) modifier for Part B billing, both institutional and non-institutional, that is, claims you submit using the ASC X12 837 professional claim format or paper Form CMS-1500 or, for pharmacies, in the NCPDP format.

### Clarification for Using the “CR” Modifier and “DR” Condition Code

When HHS declares a PHE and invokes Section 1135 authority, we have the authority to take proactive steps through 1135 waivers as well as, where applicable, authority granted under Section 1812(f) of the Act, to approve blanket waivers of certain Social Security Act requirements. These waivers help prevent gaps in access to care for patients affected by the emergency. In prior emergencies, we issued waivers for the Medicare Fee-for-Service program. To allow us to assess the impact of prior emergencies, we needed modifier “CR” and condition code “DR” for all services provided in a facility operating per CMS waivers that typically were in place, for limited geographical locations and durations of time.

For the COVID-19 PHE, we added many blanket waivers, flexibilities, and modifications to existing deadlines and timetables that apply to the whole country. See the [full list](#) of waivers and flexibilities. Due to the large volume and scope of these new blanket waivers and flexibilities, we are clarifying which need the usage of modifier “CR” or condition code “DR” when submitting claims to Medicare. The chart below identifies those blanket waivers and flexibilities for which CMS requires the modifier or condition code. Submission of the modifier or condition code isn’t needed for any waivers or flexibilities not included in this chart.

Please note that we wouldn’t deny claims due to the presence of the “CR” modifier or “DR” condition code for services or items related to a COVID-19 waiver that aren’t on this list, or for services or items that aren’t related to a COVID-19 waiver. There may be potential claims implications, like claims denials, for claims that don’t contain the modifier or condition code as identified in the below chart, but providers don’t need to resubmit or adjust previously processed claims to conform to the requirements below, unless claims payment was affected.

Waiver/Flexibility	Summary	CR	DR
Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital	Allows acute care hospitals with excluded distinct part inpatient psychiatric units to move inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit as a result of a disaster or emergency.		X
Housing Acute Care Patients in the IRF or Inpatient Psychiatric Facility (IPF) Excluded Distinct Part Units	Allows acute care hospitals to house acute care inpatients in excluded distinct part units, like excluded distinct part unit IRFs or IPFs, where the distinct part unit’s beds are appropriate for acute care inpatients.		X

Waiver/Flexibility	Summary	CR	DR
Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital	Allows acute care hospitals with excluded distinct part inpatient rehabilitation units to move inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit as a result of this PHE.		X
Supporting Care for Patients in Long Term Care Acute Hospitals (LTCHs)	We decided to issue a blanket waiver to long-term care hospitals (LTCHs) where an LTCH admits or discharges patients to meet the demands of the emergency from the 25-day average length of stay requirement at § 412.23(e)(2), which allows these hospitals to take part in the LTCH PPS. Also, during the applicable waiver period, we decided to issue a blanket waiver to hospitals not yet classified as LTCHs, but seeking classification as an LTCH, to exclude patient stays where the hospital admits or discharges patients to meet the demands of the emergency from the 25-day average length of stay requirement, which must be met in order for these hospitals to be eligible to take part in the LTCH PPS.		X
Care for Patients in Extended Neoplastic Disease Care Hospital	Allows extended neoplastic disease care hospitals to exclude inpatient stays where the hospital admits or discharges patients to meet the demands of the emergency from the greater than 20-day average length of stay requirement, which allows these facilities to be excluded from the hospital inpatient prospective payment system and paid an adjusted payment for Medicare inpatient operating and capital-related costs under the reasonable cost-based payment rules.		X
Skilled Nursing Facilities (SNFs)	Using the authority under Section 1812(f) of the Act, we are waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who experience dislocations, or are otherwise affected by COVID-19. Also, for certain patients who exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (this waiver will apply only for those patients who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their up-to-date benefit period and renewing their SNF benefits that would have occurred under normal circumstances).		X

Waiver/Flexibility	Summary	CR	DR
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	When DMEPOS is lost, destroyed, irreparably damaged, or otherwise unusable, allow the DME MACs to have the flexibility to waive replacements requirements so the face-to-face requirement, a new physician's order, and new medical necessity documentation aren't needed. Suppliers must still include a narrative description on the claim explaining the reason why they are replacing equipment and we remind them to keep documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise unusable or unavailable as a result of the emergency.	X	
Modification of 60-Day Limit for Substitute Billing Arrangements (Locum Tenens)	Modifies the 60-day limit to allow a physician or physical therapist to use the same substitute for the entire time he or she is unavailable to provide services during the COVID-19 emergency, plus an added period of no more than 60 continuous days after the PHE expires. On the 61st day after the PHE ends (or earlier), the regular physician or physical therapist must use a different substitute or return to work in his or her practice for at least 1 day to reset the 60-day clock. Physicians and eligible physical therapists must continue to use the Q5 or Q6 modifier (as applicable) and don't need to begin including the CR modifier until the 61st continuous day.	X	
Critical Access Hospitals	Waives the requirements that Critical Access Hospitals limit the number of inpatient beds to 25, and that the length of stay, on an average annual basis, be limited to 96 hours.		X
Replacement Prescription Fills	We allow Medicare payment for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise unusable by damage due to the disaster or emergency.	X	
Hospitals Classified as Sole Community Hospitals (SCHs)	Waives certain eligibility requirements for hospitals classified as SCHs before the PHE, specifically the distance requirements and the "market share" and bed requirements (as applicable).		X



Waiver/Flexibility	Summary	CR	DR
Hospitals Classified as Medicare-Dependent, Small Rural Hospitals (MDHs)	For hospitals classified as MDHs before the PHE, waives the eligibility requirements that the hospital has 100 or fewer beds during the cost reporting period and that at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits during the specified hospital cost reporting periods.		X
IRF 60 Percent Rule	Allows an IRF to exclude patients from its inpatient population for purposes of calculating the applicable thresholds associated with the requirements to get payment as an IRF (commonly referred to as the "60 percent rule") if an IRF admits a patient solely to respond to the emergency. Also, during the applicable waiver period, we would also apply the exception to facilities not yet classified as IRFs, but that are trying to obtain classification as an IRF.		X
Waivers of certain hospital and Community Mental Health Center (CMHC) Conditions of Participation and provider-based rules	Allows a hospital or Community Mental Health Center (CMHC) to consider temporary expansion locations, including the patient's home, to be a provider-based department of the hospital or extension of the CMHC, which allows institutional billing for certain outpatient services provided in temporary expansion locations. If the entire claim falls under the waiver, the provider would only use the DR condition code. If some claim lines fall under this waiver and others don't, then the provider would only append the CR modifier to the particular line(s) that falls under the waiver.	X	X
Billing Procedures for ESRD services when the patient is in a SNF/NF	To keep patients in their SNF/NF and decrease their risk of being exposed to COVID-19, ESRD facilities may temporarily provide renal dialysis services to ESRD patients in the SNF/NF instead of the offsite ESRD facility. The in-center dialysis center should bill Medicare using Condition Code 71 (Full care unit. Billing for a patient who got staff-assisted dialysis services in a hospital or renal dialysis facility). The in-center dialysis center should also apply condition code DR to claims if all the treatments billed on the claim meet this condition or modifier CR on the line level to identify individual treatments meeting this condition.	X	X

Waiver/Flexibility	Summary	CR	DR
Clinical Indications for Certain Respiratory, Home Anticoagulation Management, Infusion Pump and Therapeutic Continuous Glucose Monitor national and local coverage determinations	In the interim final rule with comment period (CMS-1744-IFC and CMS-5531-IFC) we state that clinical indications of certain national and local coverage determinations wouldn't be enforced during the COVID-19 PHE. We wouldn't enforce clinical indications for respiratory, oxygen, infusion pump and continuous glucose monitor national coverage determinations and local coverage determinations.	X	
Face-to-face and In-person Requirements for national and local coverage determinations	In the interim final rule with comment period (CMS-1744-IFC) we state that to the extent a national or local coverage determination would otherwise need a face-to-face or in-person encounter for evaluations, assessments, certifications or other implied face-to-face services, those requirements wouldn't apply during the COVID-19 PHE.	X	
Requirement for DMEPOS Prior Authorization	We paused the requirement to send a prior authorization request for certain DMEPOS items and services. Suppliers were given the choice to voluntarily continue to send prior authorization requests or to skip prior authorization and have the claim reviewed through post payment review at a later date. Claims that would normally need prior authorization, but were submitted without going through the process should be submitted with a CR modifier.	X	
Signature requirements for proof of delivery	We waived the signature requirement for Part B drugs and certain Durable Medical Equipment (DME) that need a proof of delivery and or a patient signature. You should use a CR modifier on the claim and document in the medical record the right delivery date and that a signature couldn't be obtained because of COVID-19.	X	
Part B Prescription Drug Refills	MACs may exercise flexibilities about the payment of Medicare Part B claims for drug quantities that exceed usual supply limits, and to allow payment for larger quantities of drugs, if necessary. MACs may require the CR modifier in these cases.	X	

Waiver/Flexibility	Summary	CR	DR
Services provided by the hospital in the patient's home as a provider-based outpatient department when the patient is registered as a hospital outpatient.	During the COVID-19 PHE, hospitals may send clinical staff services in the patient's home as a provider-based outpatient department and bill and be paid for these services as Hospital Outpatient Department (HOPD) services when the patient is registered as a hospital outpatient. Hospitals should bill as if they provided the services in the hospital, including appending the PO modifier for excepted items and services and the PN modifier for non-excepted services. The DR condition code should also be appended to these claims.		X
Ground Ambulance Services: Treatment in Place	CMS waived the requirements that an ambulance service include the transport of an individual to the extent necessary to allow payment for ground ambulance services furnished in response to a 911 call (or the equivalent in areas without a 911 call system) in cases in which an individual would have been transported to a destination permitted under Medicare regulations but such transport did not occur as a result of community-wide emergency medical service (EMS) protocols due to the COVID-19 PHE.	X	

Medicare FFS, FAQs available on the [Waivers and Flexibilities webpage](#) apply to items and services for Medicare patients in the current emergency. We display these FAQs in these files:

- [COVID-19 FAQs](#)
- FAQs that apply [without any Section 1135](#) or other formal waiver.
- FAQs apply only [with a Section 1135](#) waiver or, when applicable, a Section 1812(f) waiver.

### **Blanket Waivers Issued by CMS**

View the [complete list](#) of COVID-19 blanket waivers.

### **Counseling and COVID-19 Testing**

To prevent further spread of COVID-19, a key strategy includes quarantine and isolation while patients wait for test results or after they get positive test results – regardless of showing symptoms.

Health care providers who counsel patients during their medical visits have an opportunity to decrease the time between patient-testing and quarantine or isolation, especially when this counseling happens concurrent with COVID-19 testing. Working in partnership with public health personnel, you could speed the counseling, testing, and referrals for case tracing

initiation to reduce potential exposures and added cases of COVID-19. By having patients isolated 1-2 days earlier, you can reduce the spread of COVID-19 significantly. Modeling shows early isolation can reduce transmission by up to 86 percent.

Through counseling, you can discuss with patients:

- The signs and symptoms of COVID-19
- The immediate need to separate from others by isolation or quarantine, particularly while awaiting test results
- The importance of informing close contacts of the person being tested (for example, family members) to separate from the patient awaiting test results
- If the patient tests positive, the patient will be contacted by the public health department to learn the names of the patient's close contacts. The patient should be encouraged to speak with the health department
- The services that may be available to help the patient in successfully isolating or quarantining at home

This early intervention of counseling steps and isolation can reduce spread of COVID-19.

### How to Bill for Counseling Services

Medicare covers these counseling services. Health care providers providing counseling services to people with Original Medicare should use existing and applicable coding and payment policies to report services, including [evaluation and management](#) visits.

When providing these services during 2020, when you spend more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) providing counseling or coordination of care, you may use that time to select the level of visit reported.

Please review the following provider resources:

- [Provider Counseling Q&A](#)
- [Provider Counseling Talking Points](#)
- [Provider Counseling Check List](#)
- [Handout for Patients to Take Home](#)

Please also review the following information from CDC:

- [Overall COVID-19 Information](#)
- [Testing](#)
- [Symptoms](#)
- [Self-Care](#)
- [Care at Home](#)

Contact Tracing:

- [Contact Tracing webpage](#)
- [Investigation Contact Tracing](#)

### Billing for Professional Telehealth Distant Site Services During the PHE

We are expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

View a [complete list](#) of services payable under the Medicare Physician Fee Schedule when provided via telehealth.

When billing professional claims for all telehealth services with dates of services on or after March 1, 2020, and for the duration of the PHE, bill with:

- Place of Service (POS) equal to what it would have been had the service been provided in-person
- Modifier 95, indicating that you provided the service via telehealth

As a reminder, we aren't requiring the CR modifier on telehealth services. But, consistent with current rules for telehealth services, 2 scenarios where modifiers are needed on Medicare telehealth professional claims are:

- Provided as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier
- Provided for diagnosis and treatment of an acute stroke, use G0 modifier

There are no billing changes for institutional claims. Critical access hospital method II claims should continue to bill with modifier GT.

CMS released a video providing answers to common questions about the Medicare telehealth services benefit.

[Video](#)

### Teaching Physicians and Residents: Expansion of CPT Codes that You May Bill with the GE Modifier

Teaching physicians and residents: Expansion of CPT codes that you may bill with the GE modifier under [42 CFR 415.174](#) on and after March 1, 2020, for the duration of the PHE:

- Residents providing services at primary care centers may provide an expanded set of services to patients, including levels 4-5 of an office/outpatient Evaluation and

Management (E/M) visit, telephone E/M, care management, and some communication technology-based services

- This expanded set of services are CPT codes 99204-99205, 99214-99215, 99495-99496, 99421-99423, 99452, and 99441-99443 and HCPCS codes G2010 and G2012
- Teaching physicians may send claims for these services provided by residents in the absence of a teaching physician using the GE modifier

MACs automatically reprocessed claims billed with the GE modifier on or after March 1, 2020, that were denied. You don't need to do anything.

### **Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Added COVID-19 Related Services**

The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients who got COVID-19 testing-related services. These services are medical visits under the HCPCS E/M categories described below when outpatient providers, physicians, or other providers and suppliers who bill Medicare for Part B services order or administer COVID-19 lab tests regardless of the HCPCS codes they use to report the tests.

Cost-sharing doesn't apply for COVID-19 testing-related services, which are medical visits that: are provided between March 18, 2020 and the end of the PHE that result in an order for or administration of a COVID-19 test; are related to providing or administering such a test or to the evaluation of an individual for purposes of determining the need for a test; and are in any of the following categories of HCPCS E/M codes:

- Office and other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home, or custodial care services
- Home services
- Online digital E/M services

Cost-sharing doesn't apply to the above medical visit services for which payment is made to:

- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
- Physicians and other professionals under the Physician Fee Schedule
- Critical Access Hospitals (CAHs)
- RHCs
- FQHCs

We provided the CS modifier for the gulf oil spill in 2010, but we recently repurposed the CS modifier for COVID-19 purposes. Now, for services provided on March 18, 2020, and through the end of the PHE, you should use the CS modifier on applicable claim lines to show the service is subject to the cost-sharing waiver for COVID-19 testing-related services. Don't charge Medicare patients any co-insurance and deductible amounts for those services.



Use these HCPCS codes for billing:

- [Health care practitioners](#)
- [Outpatient Prospective Payment System \(OPPS\)](#)
- [RHCs and FQHCs](#)
- CAHs: use OPPS codes
- Method II CAHs: use the OPPS list or the health care practitioner list, as appropriate

### **COVID-19: Expanded Use of Ambulance Origin/Destination Modifiers**

During the COVID-19 PHE, Medicare will cover a medically necessary emergency and non-emergency ground ambulance transportation from any point of origin to a destination that is equipped to treat the condition of the patient consistent with state and local Emergency Medical Services (EMS) protocols where you provide services. On an interim basis, we're expanding the list of destinations that may include but aren't limited to:

- Any location that is an alternative site determined to be part of a hospital, CAH, or SNF
- CMHCs
- FQHCs
- RHCs
- Physicians' offices
- Urgent care facilities
- Ambulatory Surgery Centers (ASCs)
- Any location providing dialysis services outside of an End-Stage Renal Disease (ESRD) facility when an ESRD facility isn't available
- Patient's home

We expanded the descriptions for these origin and destination claim modifiers to account for the new covered locations:

- Modifier D - CMHC, FQHC, RHC, urgent care facility, non-provider-based ASC or freestanding emergency center, location providing dialysis services and not affiliated with ESRD facility
- Modifier E – Residential, domiciliary, custodial facility (other than 1819 facility) if the facility is the patient's home
- Modifier H - Alternative care site for hospital, including CAH, provider-based ASC, or freestanding emergency center
- Modifier N - Alternative care site for SNF
- Modifier P - Physician's office
- Modifier R - Patient's home

For the complete list of ambulance origin and destination claim modifiers see [Medicare Claims Processing Manual Chapter 15](#), Section 30 A.

## New Specimen Collection Codes for Laboratories Billing for COVID-19 Testing

To identify and pay for specimen collection for COVID-19 testing, we provide 2 Level II HCPCS codes, effective with line item date of service on or after March 1, 2020:

- G2023 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
- G2024 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a SNF or by a laboratory on behalf of a home health agency, any specimen source

Note that G2024 applies to patients in a non-covered stay in a SNF and not to those residents in Medicare-covered stays (whose bundled lab tests would be covered instead under Part A's SNF benefit at Section 1861(h) of the Act).

These codes are billable by clinical diagnostic laboratories.

## Medicare Coverage of COVID-19 Testing for Nursing Home Residents and Patients

We instructed MACs and notified Medicare Advantage plans to cover COVID-19 laboratory tests for nursing home residents and patients. This instruction follows the CDC recent update of COVID-19 [testing guidelines for nursing homes](#) that give recommendations for testing of nursing home residents and patients with symptoms consistent with COVID-19 as well as for asymptomatic residents and patients who have been exposed to COVID like in an outbreak. Starting on July 6, 2020, and for the duration of the PHE, consistent with sections listed in the CDC guidelines titled, "Interim SARS-CoV-2 Testing Guidelines for Nursing Home Residents and Healthcare Personnel," original Medicare and Medicare Advantage plans cover diagnostic COVID-19 lab tests:

### Diagnostic Testing

- Testing residents with signs or symptoms of COVID-19
- Testing asymptomatic residents with known or suspected exposure to an individual infected with SARS-CoV-2, including close and expanded contacts (for example, an outbreak in the facility)
- Initial (baseline) testing of asymptomatic residents without known or suspected exposure to an individual infected with SARS-CoV-2 is part of the recommended reopening process
- Testing to determine resolution of infection

Original Medicare and Medicare Advantage Plans don't cover non-diagnostic tests.

## SNF Qualifying Hospital Stay (QHS) and Benefit Period Waivers - Provider Information

CMS recognizes that disruptions arising from a PHE can affect coverage under the SNF benefit:

- Prevent a patient from having the 3-day inpatient QHS



- Disrupt the process of ending the patient's current benefit period and renewing their benefits

The emergency SNF QHS and benefit period requirements under [Section 1812\(f\)](#) of the Social Security Act help restore SNF coverage that patients affected by the emergency would be entitled to under normal circumstances. By contrast, these emergency measures don't waive or change any other existing requirements for SNF coverage under Part A such as the SNF level of care criteria, which remain in effect under the emergency.

Using the authority under Section 1812(f) of the Social Security Act, CMS doesn't require a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services (including SNF-level swing-bed services in rural hospitals and CAHs) without a QHS, for those people who experience dislocations, or are otherwise affected by COVID-19. At the same time, we're monitoring for any SNF admissions under Section 1812(f) that don't meet the SNF level of care criteria (which, as noted above, remain in effect during the emergency), and we'll take appropriate administrative action in any instances that we find. See [SNF Billing Reference](#) for more information on SNF eligibility and coverage requirements.

Also, for certain patients who recently exhausted their SNF benefits, the waiver authorizes a one-time renewal of benefits for an added 100 days of Part A SNF coverage without first having to start a new benefit period (this waiver will apply only for those patients who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).

For the QHS waiver:

- All patients qualify, regardless of whether they've SNF benefit days remaining
- The patient's status of being "affected by the emergency" exists nationwide under the current PHE. (You don't need to verify individual cases.)

In contrast, for the Benefit Period Waiver:

- Patients who exhaust their SNF benefits can get a renewal of SNF benefits under the waiver *except* in one particular scenario: that is, those patients who are receiving ongoing skilled care in a SNF that is unrelated to the emergency, as discussed below. To qualify for the benefit period waiver, a patient's continued receipt of skilled care in the SNF must in some way be related to the PHE. One example would be when a patient who had been receiving daily skilled therapy, then develops COVID-19 and requires a respirator and a feeding tube. We would also note that patients who don't themselves have a COVID-19 diagnosis may nevertheless be affected by the PHE (for example, when disruptions from the PHE cause delays in obtaining treatment for another condition).
- Wouldn't apply to those patients who are receiving ongoing skilled care in the SNF that is *unrelated to the emergency* - a scenario that would have the effect of prolonging the current benefit period and precluding a benefit period renewal even under normal circumstances. For example, if the patient has a continued skilled care need (such as a

feeding tube) that is unrelated to the COVID-19 emergency, then the patient can't renew his or her SNF benefits under the Section 1812(f) waiver as it's this continued skilled care in the SNF rather than the emergency that is preventing the patient from beginning the 60 day "wellness period."

- In making determinations, a SNF resident's ongoing skilled care is considered to be emergency-related unless it is altogether unaffected by the COVID-19 emergency itself (that is, the patient is receiving the very same course of treatment as if the emergency had never occurred). This determination basically involves comparing the course of treatment that the patient has actually gotten to what would have been provided *absent* the emergency. Unless the two are exactly the same, the provider would determine that the treatment has been affected by and related to the emergency.
- **Providers should use the above criteria in determining when to document on the claim that the patient meets the requirement for the waiver.**

In this situation, we would also ask those providers to work with their respective MACs to provide any documentation needed to prove that the COVID-19 emergency applies for the benefit period waiver under §1812(f) for each benefit period waiver claim. We also recognize that during the COVID-19 PHE, some SNF providers may haven't yet submitted the PPS assessments for the benefit period waiver. In these limited circumstances, providers may use the Health Insurance Prospective Payment System (HIPPS) code that was being billed when the patient reached the end of their SNF benefit period.

### Billing Instructions

The following guidance provides specific instructions for using the QHS and benefit period waivers, as well as how this affects claims processing and SNF patient assessments.

To bill for the QHS waiver, include the DR condition code.

To bill for the benefit period waiver:

- Submit a final discharge claim on day 101 with patient status 01, discharge to home
- Readmit the patient to start the benefit period waiver

For ALL admissions under the benefit period waiver (within the same spell of illness)

- Complete a 5-day PPS Assessment. (The interrupted stay policy doesn't apply.)
- Follow all SNF Patient Driven Payment Model (PDPM) assessment rules
- Include the HIPPS code derived from the new 5-day assessment on the claim
- The variable per diem schedule begins from Day 1

For ALL SNF benefit period waiver claims, include the following (within the same spell of illness):

- Condition code DR - identifies the claims as related to the PHE
- Condition code 57 (readmission) - this will bypass edits related to the 3-day stay being within 30 days

- COVID100 in the remarks - this identifies the claim as a benefit period waiver request

Note: Providers may use the added 100 SNF benefit days at any time within the same spell of illness. Claims must contain the above coding for ALL benefit period waiver claims.

**Example:** If a benefit waiver claim was paid using 70 of the added SNF benefit days and the patient either was discharged or fell below a skilled level of care for 20 days, the patient may subsequently use the remaining 30 added SNF benefit days as long as the resumption of SNF care occurs within 60 days (that is, within the same spell of illness).

If you submitted a claim for a one-time benefit period waiver that rejected for exhausted benefits, take either of the following actions:

1. If you billed the discharge and readmission correctly:
  - Cancel the rejected claim to remove it from claims history. DON'T send an adjustment to the rejected claim
  - Once the cancel has completed, resubmit the first claim
  - If you send a claim without COVID100 in the remarks, we can't process it for an added 100 benefit days
2. If you didn't send a bill for a discharge on the last covered day to start a new admission with the benefit period waiver days:
  - Cancel the paid claim that includes the last covered coinsurance benefit day
  - Once the cancel is processed, resubmit as a final bill with patient status equal to 01
  - Cancel the first benefit period waiver claim that rejected for exhausted benefits. You can send this concurrently with the cancel of the paid claim
  - Once the rejected claim is cancelled, send the first bill for the benefit period waiver following the same instructions as #1 above

CAH Swing-bed providers don't have to follow 1 and 2 since they aren't paid according to the SNF PPS. They must submit separate claims for the one-time benefit period waiver claims with the DR condition code. These claims shouldn't contain both benefit period waiver days and non-benefit period waiver days.

Please note, as previously stated, ongoing skilled care in the SNF that is **unrelated** to the PHE doesn't qualify for the benefit period waiver. You must decide if the waiver applies following the criteria set forth above. If so:

- Fully document in medical records that care meets the waiver requirements. This may be subject to post payment review.
- Track benefit days used in the benefit period waiver spell and only send claims with covered days 101 – 200.

- Once the added 100 days have been exhausted, follow existing processes to continue to bill Medicare no-pay claims until you discharge the patient.
- Identify no-pay claims as relating to the benefit period waiver by using condition code DR and including “BENEFITS EXHAUST” in the remarks field. This remark is only necessary when the full extra 100 days have been exhausted.

MACs must manually process claims to pay the benefit period waiver but will make every effort to make sure of timely payment. Please allow enough time before inquiring about claims in process.

**Note:** You must abide by all other SNF billing guidelines. CAH Swing bed providers aren’t subject to PPS and so aren’t required to send assessments.

### Beneficiary Notice Delivery Guidance in Light of COVID-19

If you’re treating a patient with suspected or confirmed COVID-19, we encourage you to be diligent and safe while issuing the following beneficiary notices to patients receiving institutional care:

- Important Message from Medicare (IM)\_CMS-10065
- Detailed Notices of Discharge (DND)\_CMS-10066
- Notice of Medicare Non-Coverage (NOMNC)\_CMS-10123
- Detailed Explanation of Non-Coverage (DENC)\_CMS-10124
- Medicare Outpatient Observation Notice (MOON)\_CMS-10611
- Advance Beneficiary Notice of Non-Coverage (ABN)\_CMS-R-131
- Skilled Nursing Advance Beneficiary Notice of Non-Coverage (SNFABN)\_CMS-10055
- Hospital Issued Notices of Non-Coverage (HINN)

Due to concerns related to COVID-19, current notice delivery instructions give flexibilities for delivering notices to patients in isolation. These procedures include:

- Hard copies of notices may be dropped off with a patient by any hospital worker able to enter a room safely. A contact phone number should be provided for a patient to ask questions about the notice, if the individual delivering the notice is unable to do so. If you can’t drop off a hard copy of the notice, you can deliver notices to patients by email if the patient has access in the isolation room. Annotate the notices with the circumstances of the delivery, including the person delivering the notice, and when and where you sent the email.
- Notice delivery may be made via telephone or secure email to patient representatives who are offsite. Annotate the notices with the circumstances of the delivery, including the person delivering the notice via telephone, and the time of the call, or when and to where you sent the email.

We encourage you to review all of the specifics of notice delivery, as in [Chapter 30 of the Medicare Claims Processing Manual](#).

## More Information

See the complete list of [COVID-19 blanket waivers](#).

You may also want to view the [Survey and Certification FAQs](#).

For more information, contact your [MAC](#).

## Document History

Date of Change	Description
May 12, 2023	We revised the Article to show the COVID-19 PHE ended on May 11, 2023. View <a href="#">Infectious diseases</a> for a list of waivers and flexibilities that were in place during the PHE. All other information remains the same.
September 8, 2021	We revised this Article to add more information about the SNF waivers. All other information remains the same.
May 12, 2021	We revised the article to add waiver information about ground ambulance services at the end of the table on page 7. All other information remains the same.
November 9, 2020	We revised the article to clarify the billing instructions in the SNF Benefit Period Waiver - Provider Information section. All other information remains the same.
October 16, 2020	We revised the article to clarify the HCPCS codes that Critical Access Hospitals (CAHs) should use in the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section. Also, we clarified the Skilled Nursing Facility (SNF) Benefit Period Waiver - Provider Information section to show the SNF waiver applies to swing-bed services in rural hospitals and CAHs. All other information remains the same.
August 26, 2020	We revised the article to add information about the HCPCS codes for OPPS, RHC, FQHC, and CAH billers in the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section. All other information remains the same.
August 20, 2020	We revised the article to add information about the HCPCS codes in the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section. All other information remains the same.
July 30, 2020	We revised the article to add the section, "Counseling and COVID-19 Testing." All other information remains the same.



Date of Change	Description
July 24, 2020	We revised the article to add clarifying language to the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section to show it applies to lab tests regardless of the HCPCS codes used to report those tests. All other information remains the same.
July 17, 2020	We revised the article to: - Update information on CDC nursing home patients or /residents testing - Add clarifying language to the SNF Benefit Period Waiver - Provider Information section All other information remains the same.
July 8, 2020	We revised the article to add a row at the end of the Waiver/Flexibility table (page 7) to discuss services provided by the hospital in the patient's home as a provider-based outpatient department when the patient is registered as a hospital outpatient. Also, we added the section on Teaching Physicians and Residents: Expansion of CPT Codes that May Be Billed with the GE Modifier. All other information remains the same.
July 1, 2020	We revised the billing instructions on page 12 of this article. Changes include instructions to readmit the patient on day 101 to start the SNF benefit period waiver. All other information remains the same.
June 26, 2020	We revised the article to add the section, "Skilled Nursing Facility (SNF) Benefit Period Waiver - Provider Information" and related billing instructions. All other information remains the same.
June 19, 2020	We revised the article to add the section, "Medicare Coverage of COVID-19 Testing for Nursing Home Residents and Patients." All other information remains the same.
June 1, 2020	We revised the article to add a section on Clarification for Using the "CR" Modifier and "DR" Condition Code. All other information remains the same.
April 10, 2020	Note: We revised this article to: • Link to all the blanket waivers related to COVID-19 • Provide place of service coding guidance for telehealth claims • Link to the Telehealth Video for COVID-19 • Add information on the waiver of coinsurance and deductibles for certain testing and related services • Add information on the expanded use of ambulance origin/destination modifiers • Provide new specimen collection codes for clinical diagnostic laboratories billing • Add guidance about delivering notices to patients. All other information is the same.

Date of Change	Description
March 20, 2020	We revised the article to add a note in the Telehealth section to cover _ modifiers on telehealth claims and to explain the DR condition code isn't needed on telehealth claims under the waiver. All other information is the same.
March 19, 2020	We corrected a typo in the article. One of the e-visit codes was incorrectly stated as 99431 and we corrected it to show 99421.
March 18, 2020	We revised this article to include information about the Telehealth waiver. All other information remains the same.
March 16, 2020	Initial article released.

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## New & Expanded Flexibilities for Rural Health Clinics & Federally Qualified Health Centers

MLN Matters Number: SE20016 **Revised**

Related Change Request (CR) Number: N/A

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Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: N/A

**What's Changed:** We updated this Article to show the impact of the end of the COVID-19 public health emergency (PHE). You'll find substantive content updates in dark red on pages 1-4.

### Affected Providers

- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

### What You Need To Know

To provide as much support as possible to you and your patients during the COVID-19 PHE, both Congress and CMS made several changes to RHC and FQHC requirements and payments. **The COVID-19 PHE ended on May 11, 2023. View [Infectious diseases](#) for a list of waivers and flexibilities that were in place during the PHE.**

**Also, view the latest [COVID-19 information for RHCs and FQHCs](#).**

### Background

#### New Payment for Telehealth Services

On March 27, 2020, Congress signed into law the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). [Section 3704 of the CARES Act](#) authorized RHCs and FQHCs to provide distant site telehealth services to Medicare patients during the COVID-19 PHE.

**Section 4113 of the [Consolidated Appropriations Act, 2023](#), extended this authority through December 31, 2024.**

Any health care practitioner working for you within your scope of practice can provide distant site telehealth services. Practitioners can provide distant site [telehealth services](#) – approved by Medicare as a distant site telehealth service under the physician fee schedule (PFS) – from any location, including their home, during the time that they're working for you.



The statutory language authorizing RHCs and FQHCs as distant site telehealth providers requires that we develop payment rates similar to the national average payment rates for comparable telehealth services under the PFS.

**Table 1. RHC and FQHC Telehealth Payment Rates**

Date of Service	Payment
January 27-December 31, 2020	\$92.03
January 1-December 31, 2021	\$99.45
January 1-December 31, 2022	\$97.24
January 1-December 31, 2023	\$98.27

These rates are the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS during the given timeframes. Because we made these changes in policy on an emergency basis, we made changes to claims processing systems in several stages.

#### Claims Requirements for RHCs and FQHCs

Starting July 1, 2020, RHCs and FQHCs should submit G2025 and you may append modifier 95, but it isn't required. Table 2 shows these reporting instructions.

**Table 2. RHC and FQHCs Claims for Telehealth Services starting July 1, 2020**

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

#### Cost-Sharing Related to COVID-19 Testing

For services provided between March 18, 2020, through May 11, 2023, which is the end of the COVID-19 PHE, we'll 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 supply or administration of such test or to the evaluation of a person for purposes of deciding the need for such test. For the specified E/M services related to COVID-19 testing, including when provided via telehealth, you must waive the collection of coinsurance from patients. For services in which Medicare waives the coinsurance, you must put the "CS" modifier on the service line. **Don't collect coinsurance from patients if the coinsurance is waived.**

#### Claims Example

**Table 3. RHC and FQHC Claims for Telehealth Services when we waive cost sharing starting July 1, 2020**

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

## Other Telehealth Flexibilities

For dates of service through December 31, 2024, you can provide any [Medicare-approved telehealth services](#) under the PFS. Also, effective March 1, 2020, these services included CPT codes 99441, 99442, and 99443, which are audio-only telephone E/M services. You can provide and bill for these services using HCPCS code G2025. To bill for these services, a physician or Medicare provider who may report E/M services must provide at least 5 minutes of telephone E/M service to an established patient, parent, or guardian. You can't bill for these services if they start 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 with Cost Sharing

For the CPT and HCPCS codes included in the list of telehealth codes at the link above, we'll adjust the coinsurance and payment calculation for distant site telehealth services you provided to show the method used to calculate coinsurance and payment under the PFS. The coinsurance for these services will be 20% of the lesser of the allowed amount in Table 1 or actual charges. The payment will be 80% of the lesser of the allowed amount in Table 1 or the actual charges.

Before the adjustment, the coinsurance for distant site services you provided was 20% of the actual charges and the payment was the allowed amount in Table 1 minus the coinsurance.

## Telehealth Services with Cost Sharing Waived

The list of telehealth codes at the link above includes several CPT and HCPCS codes that describe preventive services that have waived cost sharing. As stated earlier in this Article, bill telehealth services on this list using HCPCS code G2025. To distinguish those telehealth services that don't have cost sharing waived from those that do, like some preventive services, also report modifier CS. We've 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 an order for or administration of a COVID-19 test and/or used for cost-sharing waived preventive services provided via telehealth in RHCs and FQHCs during the COVID-19 PHE.

For preventive services provided via telehealth that have cost sharing waived, RHCs must report G2025 on claims with the CG and CS modifiers, and FQHCs must report G2025 with the CS modifier on or after July 1, 2020 – December 31, 2024.

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.

## More Information

Visit the [coronavirus waivers](#) and the [current emergencies](#) webpages.

View [RHC](#) and [FQHC](#) booklets.

For more information, [find your MAC's website](#).

## Document History

Date of Change	Description
May 12, 2023	We updated this Article to show the impact of the end of the COVID-19 PHE. You'll find substantive content updates in dark red on pages 1-5.
February 23, 2023	We corrected the 2023 payment rate for distant site telehealth services. You'll find substantive content updates in dark red on pages 2, 3, and 5. Note that Medicare systems have been paying the correct amount.
November 22, 2022	We revised this article to add the 2023 payment rate for distant site telehealth services. You'll find substantive content updates in dark red (pages 2, 3, 5, and 6). All other information is the same.
January 13, 2022	We revised this article to add the 2022 payment rate for distant site telehealth services and information on RHC payment limits. You'll find substantive content updates in dark red font (see pages 2, 3, 5, 6, and 7). All other information is the same.
February 23, 2021	We revised this article to provide the updated rate effective January 1, 2021, for G2025. You'll find substantive content updates in dark red font (see pages 2, 3, and 5). We also updated the rate for G0071 on page 6.
December 3, 2020	We revised this article to provide additional guidance on telehealth services that have cost-sharing and cost-sharing waived. You'll find substantive content updates (see pages 5-6). We also made other language changes for clarity, but these changes didn't change the substance of the article.
July 6, 2020	We revised this article to provide: <ul style="list-style-type: none"> <li>- Additional guidance on telehealth services that have cost sharing waived and additional claim examples</li> <li>- An additional section on the RHC Productivity Standards</li> </ul> All other information remains the same.

Date of Change	Description
April 30, 2020	We revised this article to provide: <ul style="list-style-type: none"><li>- Additional claims submission and processing instructions</li><li>- Information on cost-sharing related to COVID-19 testing</li><li>- Additional information on telehealth flexibilities</li><li>- Information on provider-based RHCs exemption to the RHC payment limit</li></ul> All other information remains the same.
April 17, 2020	Initial article released.

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## **Virtual Communication Services in Rural Health Clinics (RHCs) and**

### **Federally Qualified Health Centers (FQHCs)**

#### **Frequently Asked Questions**

**December 2018**

1. What are “virtual communication services” for RHCs and FQHCs?

**Answer:** In the 2019 Physician Fee Schedule (PFS) Final Rule, CMS finalized a policy that, effective January 1, 2019, RHCs and FQHCs can receive payment for virtual communication services when at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC or FQHC practitioner to a patient who has had an RHC or FQHC billable visit within the previous year, and both of the following requirements are met:

- The medical discussion or remote evaluation is for a condition not related to an RHC or FQHC service provided within the previous 7 days, and
- The medical discussion or remote evaluation does not lead to an RHC or FQHC visit within the next 24 hours or at the soonest available appointment.

2. What is the payment rate for the new code G0071 (Virtual Communication Services)?

**Answer:** HCPCS code G0071 is set at the average of the national non-facility PFS

payment rates for HCPCS code G2012 (communication technology-based services) and HCPCS code G2010 (remote evaluation services) and is updated annually based on the PFS national nonfacility payment rate for these codes. For 2019, the payment amount for code G0071 will be \$13.69 (average of HCPCS codes G2012 and G2010).

3. Will claims submitted with HCPCS codes G2012 or G2010 be paid?

**Answer:** No. RHCs and FQHCs are required to bill for virtual communication services using G0071.

4. Are telehealth and virtual communication services the same thing?

**Answer:** No. Although both telehealth and virtual communication services use technology to communicate, these are separate and distinct services. Telehealth services are considered a substitute for an in-person visit, and are therefore paid at the same rate as it would have been had it been furnished in person. With some exceptions, telehealth services require the use of interactive audio and digital telecommunication systems that permit real-time communication between the practitioner at the distant site and the beneficiary at the originating site. The communication technology-based and remote evaluation services that we finalized are not a substitute for a visit, but are instead brief discussions with the RHC or FQHC practitioner to determine if a visit is necessary. If the discussion between the RHC or FQHC practitioner and the Medicare beneficiary results in a billable visit, then the usual RHC or FQHC billing would occur. The virtual

communication G-code would only be separately payable if the discussion between the RHC or FQHC practitioner does not result from or lead to an RHC or FQHC billable visit. The payment rate for communication technology-based services are valued based on the shorter duration of time and the efficiencies associated with the use of communication technology.

5. Are there any limitations on the number of times HCPCS code G0071 (Virtual Communication Services) can be billed for a single beneficiary?

**Answer:** No, there are no frequency limitations at this time.

6. What types of practitioners can furnish virtual communication services?

**Answer:** Communication technology-based and remote evaluation services are billable by RHCs and FQHCs only when the discussion requires the skill level of an RHC or FQHC practitioner. RHC and FQHC practitioners are physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers. If the discussion could be conducted by a nurse, health educator, or other clinical personnel, it would not be billable as a virtual communication service.

7. Does coinsurance apply to HCPCS code G0071?

**Answer:** Coinsurance and deductibles apply to RHC claims for G0071 and coinsurance

applies to FQHC claims for G0071. Coinsurance is 20 percent of the lesser of the charged amount or the payment amount for code G0071. We are aware that coinsurance can be a barrier for some beneficiaries, but we do not have the statutory authority to waive the coinsurance requirement. RHCs and FQHCs should inform their patients that coinsurance applies, and provide information on the availability of assistance to qualified patients in meeting their cost sharing obligations, or any other programs to provide financial assistance, if applicable.

8. Is beneficiary consent required before virtual communication services can be furnished?

**Answer:** Beneficiary consent should be obtained before virtual communication services are furnished in order to bill for the service.

9. Do virtual communication services have to occur with the same RHC or FQHC practitioner that has previously treated the patient?

**Answer:** No. As long as the patient has had an RHC or FQHC billable visit within the previous year, virtual communication services can be furnished by any RHC or FQHC practitioner.

10. Will payment of this new code affect the RHC or FQHC payment rates?



**Answer:** No, the RHC AIR and the FQHC PPS would not be impacted by these changes. Services that are currently being furnished and paid under the RHC AIR or FQHC PPS payment methodology will not be affected by the ability of the RHC or FQHC to receive payment for additional services that are not included in the RHC AIR or FQHC PPS.

11. What types of communication technology can be used in order to bill for code G0071?

**Answer:** Virtual communication services would be initiated by the patient contacting the RHC or FQHC by a telephone call, integrated audio/video system, or through a store-and-forward method such as sending a picture or video to the RHC or FQHC practitioner for evaluation and follow up within 24 hours. The RHC or FQHC practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

12. If the RHC or FQHC practitioner contacts the patient to monitor their condition, could G0071 be billed?

**Answer:** No. Virtual communication services are initiated by the patient in order to determine if an RHC or FQHC visit or other care is necessary. If an RHC or FQHC practitioner contacts the patient to follow up on a previous visit, the cost of this contact would be included in the RHC AIR or FQHC PPS payment.

13. Can RHCs and FQHCs bill virtual communication services for Medicare Advantage patients?

**Answer:** RHCs and FQHCs should consult the MA plan for billing information.

14. Will secondary payors recognize HCPCS code G0071?

**Answer:** HCPCS codes are recognized by all secondary payors. In some cases, there may be a delay if the secondary payor has not yet updated their systems to accept new codes.

15. Are virtual communication services considered RHC and FQHC services?

**Answer:** Yes, virtual communication services are RHC and FQHC services.

16. Are RHCs and FQHCs required to provide virtual communication services? Is there a penalty if these services are not provided?

**Answer:** No, RHCs and FQHCs are not required to furnish virtual communication services and there is no penalty if they are not provided.

17. Do RHCs and FQHCs have to enroll and be approved in order to furnish and bill for virtual communication services?

**Answer:** No, there is no enrollment or approval process for virtual communication services. Any RHC or FQHC can bill for virtual communication services if all requirements are met.

18. Can RHCs and FQHCs bill G0071 during the same month that the patient is receiving care management services?

**Answer:** Yes, if all requirements for billing G0071 are met.

19. Can RHCs and FQHCs bill G0071 on the same claim as a billable visit?

**Answer:** G0071 can be billed either alone or on the same claim as a billable visit.

However, virtual communication services are not billable if an RHC or FQHC visit was furnished within the previous 7 days or the next 24 hours or soonest available appointment.

20. Can virtual communication services costs such as software or management oversight be included on the cost report?

**Answer:** Yes. Any cost incurred as a result of the provision of RHC and FQHC services, including virtual communication services, is a reportable cost and must be included in the Medicare cost report. Direct costs for virtual communication services are reported in the

*“Other than RHC/FQHC Services”* section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate.

21. Where can I find more information on virtual communication services?

**Answer:** Information is available in section 240 in Chapter 13 of the CMS Benefit Policy Manual, which is located on the RHCs and FQHCs webpages at

<https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html>, and

<https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>.

The 2019 PFS proposed and final rule is located at:

[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html)

[Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html).