

Phillip Stringfield (00:00):

Awesome, and thank you so much Olivia. As she stated, my name is Phillip Stringfield and I serve as the Manager of Health Interoperations Training here within NACHC Training and Technical Assistance Division. And I'm glad to be here with you to kick off this season of our NACHC Telehealth Office Hour. You can go ahead and move to the next slide.

(00:19):

As we get started, I just wanted to go ahead and put a quick plug in for the NACHC supported EHR user groups. As you all are aware of, these groups meet on a monthly and a quarterly basis and they do also meet in person at some of our NACHC conferences as well, but you'll see the current six providers that we currently support. If you do have questions or if you would like to actually join one of these groups and start joining our user group meetings, you can always email me at pstringfield@nachc.org and I'll make sure to point you in the right direction.

(00:55):

Next slide. And then also just wanted to put in a quick reminder of our upcoming 2022 Finance, Operations Management and IT Conference, better known as FOM/IT, happening October 30th to 31st in Las Vegas. This will also be a hybrid conference, so if you're not comfortable traveling just yet, you can also spend some time with us virtually and have that virtual experience. It's been pretty great either way and we definitely hope to see you there.

(01:28):

All right, and to dive into now what we all came here for, I'm glad to see there's over 200 folks already in today's session and we'll be talking about optimizing telehealth reimbursement. We have with us today our theme panelists, Christina Quinlan, with Christina Rose Consulting, was going to go through some of the top reimbursement tips that you really should be considering. It's going to be helping you to, like we say, optimize telehealth reimbursement. Christina's also been helpful in providing additional resources for us and we will be sure to share those with you at the end of today's session. So with that, I'm going to go ahead and hand it over to Christina to get us started today. Thank you so much.

Christina Quinlan (02:06):

Thank you, Phil. So Olivia, do you want to pass the controls to me please? Thank you. Hi everyone, I'm Christina Quinlan. I'm an executive healthcare consultant, I've been working with FQHCs for the past 16 years. Most recently, I spent 16 years as chief operating officer for an FQHC off the coast of Maine. I'm so glad to be here and we're going to kick into top 10 reimbursement tips to optimize telehealth reimbursement and strategy. And thank you for having me.

(02:44):

The disclaimer, today's discussion is for informational purposes. It's not to be regarded as legal advice, nor I have any financial interest arrangement or affiliation with any organizations or vendors or services related to today's discussion.

(03:01):

So we're going to kick right in with reimbursement tip one. So the first tip that I always start with is that what type of service are you providing? And the reason why that this is important is that we know when the public health emergency hit and COVID hit, the definition of telehealth sort of changed. And we're all trying to understand the harmonization of these terms. What is telehealth versus telecommunications, versus telemedicine, versus CTBS? And they all come with different reimbursement and different coverage, so I always say you have to have a clear understanding of the

type of telehealth services or telecommunication services that you're providing so that you can compare that type of service that you're provided to individual payer reimbursement, Medicare and Medicaid coverage and policy. So you want to determine, you want to navigate Medicare, defining that originating site and distant site post public health emergency. Of course it's waived, we could talk a little bit about that later.

[\(04:07\)](#):

Is the patient in a HPSA, Health Professional Shortage Area? Which if you look at the 2023 proposed changes, it looks like that is going to be changed where a patient can be in any location in any state or protectorate of the United States, so that's going to go away once that's approved. Only certain CPT and HCPCS codes are eligible for reimbursement and the billing department should be keeping you up to date using that proper modifier, when to build that facility fee, these are all important. And that facility fee, again, is a type, that's the technical component of a telehealth service. And then the private payers. So determining it, navigating Medicare, going through those private payers, identify the coverage, and then reviewing your state policy.

[\(05:02\)](#):

Tip two, this is a big one. So Telehealth FQHC Mental Health Services. So post the public health emergency, even now, but from now moving forward, again, they put a little spin on it. Before, it would take an Act of Congress for FQHCs to be able to provide telehealth services as a distance provider. So what they did was they sort of switched it up. They're not saying, you notice, right? They're not saying that we can furnish mental health services via telehealth, they switched it up sort of to telecommunications, which was interesting. And it sort of bypasses that sort of legislation that says it's going to take an Act of Congress, you've got to change this, it's going to be in the Social Security Act for us to do. So they kind of switched it up. So post-public health emergency, actually January one and forward, FQHCs may continue to furnish mental health services via telecommunication for all CPT component services listed under the PPS Mental Health Visit code G0469 and G0470.

[\(06:07\)](#):

What's important in a comment that I made on the 2023 physician fee schedule is that we keep hearing, well FQHCs even when we talked about our legislature and we think about advocacy, but FQHC can provide mental health services and sub-services via telehealth. We can only provide the services listed under that PPS Mental Health Visit code, which means it's psychotherapy, there's seven codes listed. So any of your psychiatric nurse practitioners, which one would argue would be under mental health, could not because they bill E&M codes. So that all of the services, and sub-services, and med management services that are provided by your psychiatric nurse practitioners or even your nurse practitioners in PAs, they, post-public health emergency, would not be able to continue to provide those services. Only the seven codes listed under the mental health visit codes will continue to be allowed via telecommunications, audio only as well.

[\(07:05\)](#):

This is what the claim looks like now and how it will continue to look like post-public health emergency. However, that FQ modifier is going to change to a 93 for standardization if the proposed comments are in fact enacted. So what they want to do is pull out the FQ for behavioral health audio only and keep a standard 93 modifier across the board. Verify with your billing department that all claims that were processed January one forward, that are for your psychotherapy codes or your psychiatric intake, did not process with the G2025. So I know that we've changed our setup to sort of roll all of our telehealth services to the G2025 code, but as of January one, we get our full PPS reimbursement for any

component services that were provided via telehealth that fall under those G0469 or G470 codes, so that's super important.

[\(08:04\)](#):

And then here's a sample. So this would be an existing patient, G0470 and psychotherapy 45 minutes. And now the other change we want to make sure is that that 95 modifier goes, Oh, I think FQ goes on the PPS line. So all of the other examples previous to this time would show early on, even before the G2025, we appended that modifier to the component service line. So you want to make sure that your billing department is up to date on where that modifier falls and it falls on the PPS line. What's important too is that section 304 of the CAA Act 2022 is that they delayed that in-person visit requirement under Medicare during the public health emergency. And it goes until the 152nd day after the public health emergency, which we're going to talk about soon because today is the last day, but we know that it's going to be extended.

[\(09:11\)](#):

So reimbursement tip number three, knowing the specific place of service and modifier. This has been really interesting because each payer has changed their communication. I actually keep an updated list of all the major payers in New England and I check them monthly to see, "Hey, where are they going now?" Before it was, "Okay, we're going to use Place of Service 10 after January one." Then Anthem pops up and says, "You know what, we're not going to do it until April one." Then Cigna pulls it back and says, "You know what? We're just going to continue to use Place of Service 2 for all of our claims." So it's so important that you're staying up to date on that Place of Service and modify your code. And again, you're going to see that FQ more than likely disappear even though it just came out January one, and it's going to align with 93 for audio only to standardized.

[\(10:09\)](#):

Reimbursement tip number four, this is the big question, I get it all the time. I have one pagers on it that can be shared, telephonic E&M versus audio only telehealth. Here's some tips. Number one, a telephonic E&M, previous to the public health emergency was meant to be a triage call. If you look at the definition, which we can talk about it in a little bit, the definition, anything that is patient initiated cannot stem from a visit in the previous seven days, so it can't be a follow up visit, and the patient can't be seen in the next 24 hours. So a triage visit is meant to literally triage a patient so that they do not have to be seen that day or that very next day. Brief clinical advice, so here are some tips. Post-public health emergency, we say, "We're going to go ahead and add these telephonic E&M codes into the list of services. So that 99441 to 99443 and the 98966 and 98968, and we're going to use them as audio only."

[\(11:22\)](#):

However, not all payers wavered that global rule, so we're going to talk about that a little bit. So you have to know which payer is covering an audio-only office visit and audio only offices visit are your 99202s to 99205s, your 99211s to 99215s, but that may be delivered audio only. So it's the same visit as an in-person except for that it's being provided and delivered via telephonically. And then know what modifiers to use. Many of your private payers, you don't append modifiers for these telephonic E&M codes because they're not considered telehealth. So an audio-only telehealth is different than a telephonic E&M. And then educate your providers. Telephonic E&M codes should only be used for triage unless office visits delivered via audio only are not reimbursed. It's the only time.

[\(12:20\)](#):

Some payers have removed that global rule edit, some have not, so that's another big difference. FQHCs will only be reimbursed for telephonic E&M codes for Medicare, so Medicare audio only are not allowed for office visits. However, FQHCs can perform any service that's listed in CMS list of telehealth services and those telephonic E&M codes are listed so we can be reimbursed with the G2025. And then you want to check with your local telehealth resource center for updated payer telehealth coverages as well as the setup for connected health policy. And then you want to utilize your EHR and practice management system to assist with telehealth billing and coding requirements. For example, default modifiers by payer or by visit type, audio only versus audio and video. Flip to code G2025 for all FQHC Medicare services listed in that CMS telehealth list of allowed services except for the component services listed under G0469 and F0470, where we'll get our full PPS rate with that 95 modifier appendant to that line item, that PPS line item.

(13:36):

And Phillip, let me know if I'm going too fast. I know that they're going to reference these, but I'll take all of your questions, which I know we're going to need more time for Q&A.

(13:46):

Reimbursement tip number five, understanding the billing and documentation requirements for VCS services, Virtual Communication Services, and telephonic E&M. Why did I pair those two together? Well, previous to the public health emergency, as of January 1st, 2019, FQHCs were able to perform and be reimbursed for Virtual Communication Services. Telephonic E&M codes have the same requirements as VCS services, the G2012 when performed telephonically. What is the difference? The reimbursement. So we're going to talk about that in a little bit too. Don't bill a G2012, have it roll up to a G0071 and be paid less when the same qualifications, requirements, billing, and coding is for that 99441. I want to talk a little bit about that. Example scenario, again, telephonic E&M patient calls to be seen, patient initiated. Patient can be transferred to the triage line, including RNs during the public health emergency. A brief clinical discussion and advice is given greater than four minutes. It is determined the patient does not need to be seen in 24 hours, patient is okay with the plan, you build a telephone E&M. And then here are the documentation requirements that you must have, verbal consent, patient initiated, documented in the medical record. And again, not covered if the patient had an E&M visit in the last seven days or the next 24 hours, you want to document your time spent. And RN can bill for this, especially during the public health emergency. And I'm going to show you at the end the documentation where you don't just have to take my word for it, I'm going to go right back to the CARES Act, right back to the waivers, and there's a link that you can click, download it, show your team, show compliance, "Here are the regulatory guidelines by statute at this time."

Phillip Stringfield (15:51):

Awesome, you were just right on it. Someone had just asked who can bill for that telephone triage, a provider or RN? So thank you.

Christina Quinlan (15:57):

So well yeah, that's another reimbursement tip. We're going to take advantage of the flexibilities that FQHCs have now, particularly when we are getting a 40% decrease in our reimbursement when we provide telehealth services for all medical services outside those two mental health visit codes, so I made it my job to study that list and say, "Okay, what could we not bill for before that we can now? What's going to pay us more under that G2025 that we would not have seen reimbursement so that I

can sort of balance the AR leakage that I was going to have by increasing telehealth to almost 50% for medical services, right? That's a big hit.

[\(16:42\)](#):

So let's talk a little bit about that reimbursement tip number six, Virtual Communication Services or telephonic E&M. For all you FQHCs out there, that have been billing VCS services when it's been done telephonically, make sure that during the public health emergency that you're not doing that anymore and that you flip that and this is why. The physician fee schedule. Okay, so FQHCs receive reimbursement for all non-FQHC services listed in the 2022 physician fee schedule and to reimburse with the G2025. So when I say non-FQHC services, I think about things like group behavioral health performed via telehealth, not included as an FQHC core service, post-public health emergency, it's included in your list of allowed telehealth services by CMS and FQHCs can perform any service listed. I'm going to talk about that later too with those flexibilities.

[\(17:42\)](#):

So consider it this way, 99441 and 99443 are included in that list. Billing the G2025 instead of the VCS G0071 payment code will result in a higher reimbursement. Do you want to get \$97.24 for five minutes of discussion versus \$23.88? And if your health center hasn't been doing that, I would seriously correct all of those claims because this is a time where it would be worth it and to resubmit it with a G2025. And then let's look at them, the two definitions. We both have the previous a day. So FQHCs bill a G0071 for a G2012, which includes services delivered telephonically, so it could be delivered digitally by portal, but this is telephonically and it's included telephonically, that's why we're sort of matching it up. It's brief communication technology-based services, a virtual check-in by a physician or other qualified healthcare professional. So those NPPs are nurse practitioners and physician assistants.

[\(18:51\)](#):

However, during the public health emergency, they've added additional providers and we'll talk about that in a minute. So anyone who's qualified to provide an evaluation and management service, which we know RNs are qualified to provide a 99211 during the public health emergency and otherwise, and we'll going to talk about that. Previous seven days, previous seven days, next 24 hours, next 24 hours, five to 10 minutes of medical discussion over here and we have five to 10 minutes. They are essentially the same exact definition by AMA standards, except the difference in reimbursement is \$97.24 versus \$23.88.

[\(19:39\)](#):

And do not confuse those with audio-only telehealth. For example, in the state of Maine post-public health emergency, we got everything that we wanted, I think it was one of the best states, the best telehealth state policy, so everything that was included in the CARES Act we can do and then some. So for us audio only, any telehealth service that's delivered via telephone audio only is still considered a telehealth service, it's reimbursed at the same amount. So the 99212, we add our GT modifier, we get paid the same amount because it's allowed, so you want to determine that and your provider documents as they would.

Phillip Stringfield [\(20:23\)](#):

And Christina, I want to just stop you right here because we were getting a couple questions.

Christina Quinlan [\(20:28\)](#):

Yep.

Phillip Stringfield ([20:28](#)):

The first one was, "Are these subject to co-insurance?"

Christina Quinlan ([20:32](#)):

They are.

Phillip Stringfield ([20:35](#)):

And the next question is, "The reimbursement of \$97.24, should this be at the total reimbursement rate even after the sequestration?"

Christina Quinlan ([20:50](#)):

Yeah, sequestration was waived and now it's back. So the \$97.24 plus that 2% sequestration. So no, they're still going to take the two. This is the allowable amount, then you decrease it for the sequestration, because that's going away too in the 2023 physician fee schedule.

Phillip Stringfield ([21:09](#)):

Thank you.

Christina Quinlan ([21:10](#)):

Sure. Now, expansion of virtual communication services for all of you guys that are really taking advantage of your portal, your patient experience. So during the public health emergency online, digital E&M codes have now been added to VCS. So these codes are not separate, you can't build a G2025 because it's not listed in that CMS list of telehealth services, but it has been added to virtual communication services, so that two-way communication between the provider and the patient that's happening via a secure portal is now going to be reimbursed at this rate. So every time you'll get the 2388. So you want to make sure that you're capturing that, that verbal consent is required, the service must be documented, same global seven day.

([22:02](#)):

Well, the contact must be initiated using a digital platform and the time of work be cumulative over seven days, but only once in that seven day period. If the patient had services in the last seven days to not be used to report this, and this is for established patients, but it's been waived during the public health emergency. I will say when I proposed comments to CMS, I asked that this continued to be a part of the Virtual Communication Services, particularly since it aligns with the G2010 and we have store and forward, why wouldn't they add this? It just doesn't make sense that they wouldn't continue to add this as a component service under our G0071 code.

([22:48](#)):

Okay, here's the big one, the reimbursement tip number eight, the CMS list of allowed telehealth services during the public health emergency and you should be taken advantage of these flexibilities. So today would've been the end of the public health emergency, but we know the attorney general said that they were going to give us 60 days. Notice if they were not going to extend, so tomorrow we should be seeing, or even maybe even right now, as of this morning, it wasn't published. So we know that it's going to be extended another 90 days, which puts us into January. So then that's like January 13th, and so we know if the public health emergency ended on January 13th, we still have the rest of the year. So

the end of the year of which the public health emergency ends. So we have 12/31/2023 and then 151 days. Super important. So we're going to continue to be reimbursed for Medicare for these services.

[\(23:49\)](#):

And so what are on there? What are services that FQHCs do that they don't get reimbursed for, but during the public health emergency, are now reimbursable under that G2025 group therapy? If anybody's doing group behavior health therapy, you can bill it now during the public health emergency and it rolls up to the G2025 if it's performed via telehealth. Super bizarre if they're in person, no dice, right? That's so crazy to me. The 90833, psychotherapy with the patient, and audio only is allowed. The health behavioral assessment and reassessment, that's something health centers do often, we do it with community outreach, we do it with migrant outreach. Now, that can be done via telehealth audio only, and we can be reimbursed. Physical therapy services when it was in scope, when we have physical therapy in scope FQHCs, we know there's not a separate reimbursement, it's incident to a medical visit.

[\(24:54\)](#):

So for those of you that have physical therapy out of scope, it's you bill it fee for service part B, still can be done via telehealth and all of your physical therapy are audio and video unless it's a telephonic E&M code. So now we have an in scope. In scope, we couldn't get paid. Now we can. So any telehealth physical therapy that's been done, your therapeutic exercise, your neuromuscular reeducation, all of those visits will now be reimbursed under the G2025. And again, you have a year. So when you go back to your billing department or if your billing department is here, start running reports and say, "Hey, give me all of my PT services that were reimbursed by Medicare."

[\(25:43\)](#):

And if they're none, then we need to go ahead and pull these codes and see, did your system already adjust them off automatically because they were contractual, nobody went in and fixed it in your system? So that they would roll up to that G2025. So make sure that you're going back. I can't tell you how many health centers that are like, "We didn't even think of that." And they went back and build them all out because we have a year to submit claims, so that's super important.

[\(26:15\)](#):

Tip number nine, registered nurses. I love my RNs, I bill for all my RNs to commercial payers, I already have all of my RNs have their own NPI number and I get reimbursed with them as rendering, and then the supervising provider that's underneath them. So this is the big one, this people have gone back and forth, but I go straight to the FAQs, straight to CMS's FAQs. So that's what I've provided here. So registered nurses may bill a 99211 during the public health emergency via telehealth. So 99211 is listed in the list of allowable telehealth services. And again, FQHCs can furnish any service that's listed, including non-FQHC services by non-FQHC core servicing providers during that public health emergency. So if you look at the FAQs for Medicare, this was a big one, I thought I would cut it out for you. Who can furnish distance site telehealth services? Distance site telehealth services can be furnished by the RHC or FQHC practitioner or any care practitioner working within their state scope of practice.

[\(27:27\)](#):

An RN performing triage, an RN doing a nurse visit is within their state scope of practice. So that was great, it wasn't anyone that's listed under HRSA, anyone who's listed under chapter 11, it's anyone working within their state's scope of practice. So CPT 9921 is on the list, flip it to the G225 for reimbursement. You offer a triage line? Take advantage of the flexibilities. Telehealth triage? Set up the audio and video and get reimbursed the 97 bucks, it's worth it. We lose so much by the reduction of our

reimbursement for services other than now as of January one, the component services under that Medicare mental health G code.

Phillip Stringfield ([28:13](#)):

Would this also apply to an LPC?

Christina Quinlan ([28:21](#)):

You mean a Licensed Professional Counselor? Yes, so they can do that now. They couldn't before because LPCs weren't added as a core service and provider, but they can do it 100%. They've been listed, they're qualifying providers, they're also qualifying providers for most state Medicaid plans. And interesting enough that telehealth payer spreadsheet, Phillip, that I'm going to send you that metric, I actually have a whole column of each qualifying mental health provider, LADC for each of those payers. When an LADC can bill, an LMFT, and LPC, and then of course the LCSW.

([29:06](#)):

So reimbursement tip number 10, we all have to get involved. So we know today was the end, we know that they're going to extend it. I don't know how many FQHC participants are on here right now, I don't know how many. Of course NACHC works for us and they work hard for us, but we all should be proposing comments in the 2024 physician fee schedule because it is our last shot for us, one to be able to continue to furnish services via telehealth, post that 151 days, it's the time where we want payment parities. So I've got it here, all FQHCs should draft comments based on data extrapolation that supports FQHCs as a distance site provider. They're going to want proof, let's give it to them. And we want PPS payment parity.

([30:01](#)):

We don't just want parity, meaning if we can do something in person, we want to be able to do it telehealth. Also, FQHCs want to be able to get reimbursed at the same rate. And then we want FQHCs to be reimbursed for all communication technology-based services, including remote patient monitoring. 2023, they kept us out of that again for their proposed rule. FQHC should be reimbursed for community health workers, so CMS 2023 physician fee schedule is literally saying, "Hey we want to reimburse for community health workers." No mention of FQHCs being able to take advantage of hiring community health workers. I know that a lot of us already have them that are going out into the community, but again, we're not able to be reimbursed for treating our most vulnerable populations.

([30:51](#)):

FQHCs should be listed as telehealth servicing providers. This was a big problem for me. So essentially what they were going to do is buy place of service, CMS was going to create this database, this very large database so that anybody that is enrolling in Medicare could literally base their primary care services on whether or not telehealth services may be furnished at that site. Well, that's a problem for us because we don't bill Medicare with place of service code, we bill with revenue codes and with modifiers. So I made the comment that this should be modifier driven. And also, it should be CPT code driven, CPT and modifier. So that's another thing we should be commenting on. FQHC should be allowed to provide all component services listed under our FQHC PPS code via telecommunications and receive payment par date.

([31:49](#)):

So any code that's listed under our PPS, we should be able to do that via telehealth telecommunications. So benchmark, how are we going to make the case? The more we make the case, the more we push for

reimbursement and the more we drive usual and customary. So patient surveys, start adding. How do we determine if patients are better served via telehealth due to transportation barriers? We ask them. Patients better serve via telehealth due to child care limitations. If I'm home, my kids are sick, I am more apt to cancel an appointment if I have to pick up my sick kids and drive to a health center. Now, could I set them up with Cocomelon and do my call over here? Yes, I would. Patients wanting additional autonomy with limited interaction with the waiting room, particularly in small towns, very difficult. Do you really want to go and check into your mental health visit when you know everybody at the front desk, right? It's awkward.

[\(32:46\)](#):

Those patients with high anxiety, we need to start serving our patients and we need to start benchmarking this data. Patients with limited mobility find it less difficult to receive care via telehealth. Digital literacy, we need to talk about that and determine because that's one thing they're going to argue, whereas is their health equity in telehealth? Well, we don't really know unless we start surveying it. And then what do we do? We do what we always do, we start hiring digital health coach outreach just like we do to navigate a patient through enrollment. We need to push innovation, quality, and telecommunications forward.

[\(33:24\)](#):

Quality reporting, study data trends that support quality telehealth visits, no dip in measures. We should've no dip in measures because remember, a quality telehealth visit is as good or better than an in-person visit. And it could only be better than an in-person visit if you are reducing the list of those social determinants of health, because then it becomes better, because we reduced a social determinant and still provided that same quality of care. And then again, financial matrix, reduction in no-shows for patient utilizing telehealth with a comparison to in-person visits. Get them on your metrics, let's start getting this data, we have to start trending.

[\(34:08\)](#):

And then improve recruitment and retention. And can talk about that, I sent over licensing documentation. Now there's seven interstate compacts that providers can be licensed in the state of Maine, but Maine for one is a part of the interstate compact, so any other of those, I think like 29 states, you're able to treat patients via telehealth in any of those states that are a part of the compact. I know in Maine, there's a \$500 fee during your license renewal registration that says, "Yes, I want to perform these services and be a part of the interstate compact." Additional \$500 and then you're able to do that. And then the great thing about an interstate compact or even the nursing compact is that all you have to worry about is your state regulatory guidelines. This doesn't matter that you're treating somebody in other state, you don't have to know their state laws, their state chapter under prescription, under prescribing, or what's needed in a telehealth consent. You only have to worry about your state's regulatory license and guidelines, so that's what's important about being a part of that compact.

[\(35:16\)](#):

And now questions. A lot of information. Philip, you're going to share the slide deck. I've also added, there's some tip sheets and there's supporting documentation, and then I answered a lot of the registrants' questions previous to this in a summary document as well because I knew that we didn't have a ton of time.

Phillip Stringfield [\(35:45\)](#):

I really appreciate it, Christina, this is very informative. We have plenty of questions, so I'll try to get through them as much as we can with the time that we have. Christina answered one of the most

popular questions, you will receive the recording and you will receive a copy of the presentation as well, so don't fret, we'll make sure to get you those as the session concludes. So where to start? So folks, if you do have any remaining questions, I would really appreciate if you put it in the Q&A section. The chat is going to keep going, but if you can put them in the Q&A section, I'll be able to target them there. Okay, so we'll just start with the first question I have, it says, "What is the appropriate modifier to amend for the preventative exam?"

Christina Quinlan ([36:36](#)):

If it's performed via telehealth audio and video, and what payer? So if it's Medicaid, it could be a CT or a 95 depending on your Medicaid state plan. If it's Medicare, it's a 95 modifier. Okay.

Phillip Stringfield ([36:58](#)):

It says, "Do we need patient consent to bill 99211? Will the patient be responsible for copay?"

Christina Quinlan ([37:08](#)):

You don't need patient consent actually for Medicare, but your other payers you do. And yes, for those other payers, verbal consent, but all telehealth services should have a separate telehealth consent anyway. Of course again, it can be verbal and on the same day during the public health emergency. Actually, my health center had been furnishing telehealth services for 15 years previous because we were on an island off the coast of Maine. Telehealth consents should be driven right from your state requirements and you should find that under your state plan, it will tell you whether verbal or written and what language needs to be included in those consents.

Phillip Stringfield ([37:49](#)):

All right. Let's get one from the Q&A. So it says, "For behavioral health billing, what happens if you bill on a UB form and do not use 15 hundreds for billing?"

Christina Quinlan ([38:00](#)):

So I bill all of mine on a UB form. So if you're billing to all of your Medicare or your state Medicaid, if it was behavioral health, you would put like a T1015 and the appropriate modifier. And then underneath, you would put your CPT codes. So it would be a GT modifier or a 95. I see a lot of state plans using the GT one, the state Medicaid plans. If it's Medicare and you're behavioral health and you're doing say psychotherapy, you'd see on that first line, if it was a new patient, it would be a G0469. If it was 45 minutes of psychotherapy, you would see 90834, and then that 95 modifier will be appended to the first G line. And then of course your revenue codes are 0900.

([38:49](#)):

If you would do a behavioral health and medical on the same day, you would see one line for medical that had a G2025, modifiers are optional. Then you would see with a 0521, you'd see 0521 revenue code, G2025 optional modifier. Then you would see a 0900 with a G470 for an established mental health visit and you would have a modifier 95. If it was audio only, you'd have a modifier FQ. And then on that component line you'd have a 0900. And if it was a psychiatric intake, you'd have a 90791 and no modifier necessary.

Phillip Stringfield ([39:32](#)):

Okay. It looks like there were some discussions in the chat we need you to weigh in on. So the first question that stems from it says, "Do you have any supporting documentation for the LTC seeing patient through an FQHC, especially Medicare?" Some of the folks in the chat were saying that LPCC or LPC was not able to be credentialed through Medicare. And then another comment said, "LPCs are not Medicare-billable providers." So I didn't know if you wanted to weigh in on that.

Christina Quinlan ([40:07](#)):

So licensed professional coders are not Medicare providers, but neither were speech therapists, audio therapists, they're not core providers. But during the public health emergency, just like registered nurses, it's going back to your state scope. So I did do, there's a Q&A, and you'll be able to see the Q&A. And again, for licensed professional coders, number one, if they're dual eligible in their Medicaid, you would bypass Medicare anyway and go straight to your Medicaid plan. So that is a big one that a lot of people don't realize that you're dual eligible and if they're allowed by Medicaid, you can bypass Medicare, go straight to Medicaid and it would be reimbursed. You may need a UG modifier, you'd have to just check your state plan.

[\(40:51\)](#):

During the public health emergency, we know that registered nurses are not FQHC core services providers, but it literally says that all of these services, and go to your state plan, what your state is in scope with your state licensing board. So that's going to be important for you to distinguish.

Phillip Stringfield ([41:14](#)):

Awesome. And then we have a question from Pam. It says, "Could you please explain the difference between telephonic versus audio only?"

Christina Quinlan ([41:22](#)):

So audio only is all of your regular office visits, so you're 99212, so the same exact thing that you would do for an in-person visit, except it's audio only, there's no audio and video. Telephonic E&M codes come with one patient initiated, even though it's been waived during the public health emergency, it is meant to be a triage call to determine a brief clinical discussion to determine if the patient should be [inaudible 00:41:52]. So you don't have medical decision making requirements, you don't have those time component requirements that you would on a regular evaluation and management. It's four minutes plus. I mean, I guess the easiest way is that it's meant to be a triage call, a brief clinical discussion. So there's no requirements on whether an appropriate history or physical examination like your office visit codes are. So even though office visits are built on time and medical decision making, an appropriate history and physical exam must also be conducted not for those triage calls.

[\(42:35\)](#):

So it's the same, it's like a virtual check-in. If you look at your virtual communication services and you look under the G2012 CPT code that we've been able to do since January 1st, 2019, and you look at the definition for telephonic E&M codes, it is the same exact definition when that VCS service is being performed telephonically. But I have a cheat sheet, so Phillip's going to send that out too. So for the dual eligible-

Phillip Stringfield ([43:07](#)):

All right.

Christina Quinlan ([43:08](#)):

Go ahead. They're popping up, but I don't know-

Phillip Stringfield ([43:10](#)):

Oh, go ahead, go ahead. Yeah. No, go ahead, go ahead.

Christina Quinlan ([43:12](#)):

So for the dual eligible, it depends on the state that you're in. For Maine, it's a UG modifier. So what I would suggest is either look, notify your provider rep in your state for the dual eligible because it's kind of like in Maine when I want to bill a preventative visit for a dual eligible, but Medicare doesn't cover those annual physicals, that 99385, 386. We're allowed to bypass Medicare and be paid directly by our state Medicaid plan. So take advantage of what may not be covered by Medicare, but if they're dual, they're full dual eligible, what your state Medicaid plan will pick up.

([44:02](#)):

That was another big one, I think years ago when that sort of came to light, everybody's like, "I got to reprocess all my claims." Because essentially you set up your system sometimes to automatically adjust off those contractual adjustments, so it could be that in your system as soon as you put in a 99396, it's adjusting off a zero and it's automatically appending a CO45. If that was happening, then you couldn't send it to the secondary main care because it's already been adjusted off, so it wouldn't flag that. There are things that you can do to exclude those.

Phillip Stringfield ([44:39](#)):

Thank you and thanks everyone who are still submitting their questions. I'll just encourage you again to put them in the Q&A section and we'll make sure to get them answered for you. I just want you to also know there is over 250 people in here, so we're trying to get to as many questions as we can with the time. So the next question comes from Susan, and the question is, "Do you recommend that RNs obtain a NPI number? And if the expense of ancillary staff converted under the cost report, is it double billing to be paid for nurse visit and get the cost covered under the cost report?"

Christina Quinlan ([45:17](#)):

So that's Medicare specific. All of my RNs bill commercial insurances, so not just FQHC, so the only time, only right now can my FQ, only now what I bill my nurse, the G2025, but look at your cost report, telehealth services, those non-FQHC services are not on the same line. So those are carved out and it's on a separate line, so you can see that in your MLN Matters, NGS has it, Novitas and Noridian clearly state that the non-FQHC services are not on those same lines as we put all of our other costs and visits, so just make sure. So no, that's not double dipping. And then moving forward forever and always, I always say that FQHCs kind of get stuck in our FQHC status, although our FQHC status only relates to Medicare and Medicaid. So if you have nurses and you're not billing commercial for their services, I would start now. It's the same enrollment that, well, number one, they're supervised but they're listed under rendering, so there's no gray area, you're not trying to sneak a service in.

([46:30](#)):

Essentially, you're billing a 99211, the rendering says the nurse with the NPI, like I said, my nurses, all of them have had NPIs for years and years, we build a 99211, she's on there as rendering, we have the supervising provider and we get reimbursed like 28 bucks, sometimes 35. But if you're not, it's better than not. And we've always been able, the health centers that I work with early on, we had said our RNs

pay for themselves and then some, but they actually really do now because we can generate enough income. 99211 is not a non-billable code during the public health emergency, so if you go through the slides and you click on the list, regulatory guidelines and under the CARES Act, FQHCs can perform any service listed. A 99211 is listed under those services.

(47:32):

And then if you look at the Q&A section, I mean if you look at the slide and you click on, it comes right from CMS' FAQs where it says who can prefer for them, I build 99201s before the public health emergency and I'll continue to build them after. I can see them popping up, so I keep answering.

Phillip Stringfield (47:57):

You're speaking to their pain points here. So the next one-

Christina Quinlan (48:01):

Somebody had mentioned, "How do we know it's 151 days post the public health emergency?" Phillip, I know NACHC has regulatory guidelines, you guys have posted this everywhere. It's in the federal register. So it's 151 days. Well, the proposed 2023 physicians fee schedule proposes that FQHCs and RHCs continue to be reimbursed for these services 151 days post the public health emergency. We've also established that even if the public health emergency ended today, we would still have the end of the year of which the public health emergency ended and then 151 days. So that is just been nationally recognized. And Philip, you can send, I mean there's a ton. You could go back to the federal register, the CARES Act, if you look on MLN Matters, they have some supporting documentation on that as well. And then look at the 2023 proposed fee schedule, which should be finalized anytime now.

Phillip Stringfield (49:15):

Thank you. So moving onto the next one, it says, "Considering that most states have removed the licensing waivers, are these applicable only to providers who have multi-state license and conduct telehealth visits?"

Christina Quinlan (49:29):

Well, it depends if your state's also a part of those licensure compacts. So you could have, or you have your state-to-state compacts, like I know Massachusetts and New Hampshire and Maine are trying to build one, but if all three of those states were a part of the interstate compact, then you wouldn't need that separate arrangement. Now, you could also go through and get your multi-state license. I don't know what a provider has to do to get a multi-state license. From what I understand, the inter-pack licensure agreement means that that provider only has to maintain regulatory guidelines for that one state. That one state, that's all they need to know. They don't have to pay attention to the regulatory guidelines in those other states, particularly with prescribing, which is a big deal, and telehealth services. But again, some states, I know that I think it was maybe New York, there's another state where I know in Maine you have to pay an additional \$500 to be a part of the interstate compact. And then there's the nursing compact. I don't know what their fee is.

(50:31):

I'm more familiar with Maine only, but this is something super simple that you just call your state licensing board or who's ever in charge of your credentialing enrollment does that and has that communication and then shows your providers, "Hey, you can do this." Florida's a part of the interstate and you want to do it because I don't know how many times your patients have gone on vacation and

maybe called you, and maybe you call it a prescription or something like that. A lot of the times you're actually not allowed to do that, it just wasn't at the forefront as it is now because we're just treating so many patients outside of our state lines.

Phillip Stringfield ([51:15](#)):

I have a question here that says... Okay.

Christina Quinlan ([51:18](#)):

Phillip, you have that one pager on licensing though, that points to those compacts and where they can go, and it tells you what states are a part of which ones.

Phillip Stringfield ([51:27](#)):

Gotcha. And we'll get those resources out to you all in just a few minutes, but I wanted you go ahead and see if there were any restrictions to build chronic disease follow-up visits via telehealth?

Christina Quinlan ([51:41](#)):

Oh no, those are geared for it, especially if you have your recent labs. You can absolutely do chronic, like your diabetic population, your hypertension population. So I have a workflow preference for that. What we did even during the public health emergency is we had our drive-thru lab and what we did was we pulled all of our population health reports. So let's just say our diabetic population, we had them drive through, get their labs done, and then a two week follow-up telehealth appointment. So because the provider had all of the testing and he didn't need point of care testing because he had those recent labs, for me it's the same quality of telehealth as an in-person visit for what they needed for, unless they were due for a diabetic foot exam. And then maybe you would have them come in and I know those are done annually.

([52:34](#)):

So there are plenty of visits that have clinical appropriateness for telehealth. The only one for me I wasn't truly big on is an annual physical when you're kind of doing a full physical examination. And then I had a hard time with the well child because in the beginning you had to capture vitals at the next in-person visit, you couldn't just have the patient reported. And then I worried about the growth chart and then did that cause another sort of gap in care? So now I got to look at all my well child visits that are being done remotely and make sure that I get them in soon enough so that they didn't grow. You know what I mean? Quick enough. And that I'm actually capturing those vitals. That was a big one for me. But I think that's organizational preference, I think that's based on a team of physicians compliance and establishing a quality telehealth visit at your practice. And metric and your telehealth resource centers, they have CMEs on achieving quality in telehealth, I wrote a lot of the content for that on the billing and compliance section. "Could we bill a phone call to the patient by a clinician on the fly?" Well, the telephonic E&M codes, it all depends. If a payer allows audio only and they also allow telephonic E&M, so you could do like a 99212 audio only. They also allow the telephonic E&M, then that telephonic E&M has to be patient initiated. Some payers have just substituted and said, "Hey, we're not going to allow audio only." If you're going to do telephone only, no matter what the service is, you're going to build those telephonic E&M codes.

Phillip Stringfield ([54:34](#)):

And then can we just... I want to see if we could [inaudible 00:54:36].

Christina Quinlan ([54:36](#)):

Yes, FQHCs can build group behavioral therapy via telehealth only and build the G2025. So what I would suggest for everybody is, as like little bit of homework, is go ahead and search for 2022 CMS list of telehealth services. When you click on that, it's going to give you all of the telehealth services that are allowed. And then there's a column of what can be done audio only. FQHCs during the public health emergency can do any one of those and get paid and build the G2025 except all of our codes that are listed that are still on that list but are listed under our mental health PPS, we want to get our full PPS, so we bill with our PPS G code for mental health and the component service, but we can do all of them.

([55:30](#)):

So if you have speech, if you have physical therapy, if you have speech therapy, because remember, it clearly states that we can get reimbursed for our telehealth and our non-telehealth services if it's on that list. And the 90853 is on the list and it's on the list that's audio only. If it's in person, you can't.

Phillip Stringfield ([55:54](#)):

Awesome. Well, we are right at time. So I know that there is a plethora of questions still here. Seems like we might need to come back and do a part two or something with all of this that we have. But since we are at time, we want to thank you all for joining this session. And then of course thanking Christina Quinlan with Christina Rose Consulting for putting this presentation together in addition to all the tip sheets that you'll receive in just a few moments, but also just for spending some time and being able to answer some questions for us. We really appreciate the time that we spent.

([56:29](#)):

And I already see, "Please, part two, please do a part two." So we'll definitely try to get back in with Christina probably, thanks again. I'll try to also plug in Christina's email in case you wanted to connect with her as well. If not, you can also Google it and it'll be in the recording as well if we're not able to get it to you. So with that, I want to thank you all, hope you all have a great rest of your day and enjoy the rest of your week and we hope to see you at a future event.

Christina Quinlan ([56:57](#)):

Thank you so much. Thanks for having me. I appreciate it.

Phillip Stringfield ([57:01](#)):

Thank you.