Emily DeMent (00:01):

This is "Everything FQHC Medicare" webinar, which is part three of our new series Finance Office Hours: Strategies to Manage Operations During COVID-19. Thank you all for joining us. My name's Emily DeMent, Program Associate in the Training and Technical Assistance Department here at NACHC, and I'm pleased to bring you this webinar along with my colleagues, Ted Henson, Director of Health Center Performance and Innovation, and Gervean Williams, Director of Finance Training, who you'll get to hear from in a few minutes. Without any further delay, let's get started and I'll turn things over to Ted.

Ted Henson (00:35):

Thank you, Emily. And I want to welcome everyone to NACHC's third installment of the Finance Office Hours for Health Centers During COVID-19. But first of all, I just want to stop for a second and on behalf of NACHC thank everyone out there in the field for the incredible work that you do, day in and day out, at community health centers around the country. Whether that's in person or now virtually to serve your patients, your communities, it's not an exaggeration to say that all of you and healthcare workers nationwide are our true heroes. So, thank you. As Emily mentioned the focus of today's Office Hours is Everything FQHC Medicare. And today's webinar we'll provide an in-depth overview of Medicare telehealth coverage, other Medicare COVID related policies and FTCA coverage and telehealth during the COVID-19 emergency.

Ted Henson (01:23):

We have a really strong panel of experts to walk us through today's presentations. From NACHC, we're going to be joined by Susan Sumrell, Deputy Director of State Affairs and my colleague, Gervean Williams, Director of Financial Training, TTA. I want to personally thank Susan and Gervean for all the great work and all things Medicare, CMS, telehealth and for putting this Finance Office Hours together. They will be joined or followed by Marty Bree and Molly Evans who are partners at Feldesman Tucker Leifer Fidell. And after Marty and Molly, we are excited to hear from Corinne Axelrod, who is the Acting Deputy Director of the Division of Ambulatory Services within the Center for Medicare, CMS, and her colleague Tracy Mackey, who's the technical advisor for Center for Medicare Provider Billing Group, Division of Institutional Claims Processing. So without further ado, I'll turn things over to Susan.

Susan Sumrell (02:13):

Thank you very much, Ted. I was double muted. But I hope you all can hear me now. I want to thank you all for joining us today for this Office Hours and an echo Ted's thanks for all of the work that you are doing out in the field and for taking the time to join us for the webinar. I'm very excited that we're joined by Captain Corinne Axelrod and Tracey Mackey both at CMS. They have been wonderful to work with and just really great advocates for health injury within the Center for Medicare and Medicaid Services and for the Medicare beneficiaries at community health centers. Gervean and I are going to walk through some of the new policies from CMS. And then like Ted said, we'll hear from Marty and Molly about some FTCA issues and then please bring all of your questions because Corinne and Tracy will be able to help us walk through some of the technical details and any answers to the questions that you may have.

Susan Sumrell (03:20):

I'm going to go ahead and get started on the telehealth policy. I want to I jump right in. And I think you all know this, but prior to the coven emergency health centers were somewhat limited in their telehealth services that they were able to provide to their Medicare patients. They were limited to only

being able to serve as an originating site, which is the site where the patient is and they could not be reimbursed or provide the services as a distant site, which is where the provider is. This has been a long standing issue that we've worked on for a number of years and talked with the folks at CMS and talked on Capitol Hill to try and get fixed and we're really thankful that they were able to make some changes, especially in light of the current emergency.

Susan Sumrell (04:11):

I'm going to go over a couple of... because there has been a lot of action in this space actually and Congress has had several bills that has included telehealth provisions and I want to talk about which ones are most relevant to health centers and how they really opened up a lot of doors for health insurers to provide more telehealth services for their Medicare patients. So the very first stimulus bill that one eased geographic originating site restrictions. And I said that we were able to provide through as originating site, it was really only the rural health centers, rural FQHCs that we're able to provide services as originating sites. The very first stimulus bill wanted to open up those restrictions. They removed the geographic restrictions so anyone can the originating site, any FQHC can, and also allowed for services to be provided in a patient's home and the types of technology that were needed there.

Susan Sumrell (05:08):

So that was a really big hurdle, but still there was a limitation on the types of services that FQHC could provide a distant site providers. It wasn't until the CARES Act was passed that included a provision to allow us to provide and be reimbursed for distant site services through the end of the public health emergency. And on April 17th, 2020 CMS released guidance on this provision. What I think a lot of folks were filling up our inboxes on is what will the payment be and how will it work? So here are some of the details that came out of the CMS MLN matters article on April 17th. FQHC is going to be reimbursed $92 and that is an average of all the physician fee schedule rates for distant site services. Now through July 1, health centers will be paid PPS, but on July 1 that will be reconciled back to the $92 and then from July through the end of the emergency, it will be just the $92.

Susan Sumrell (06:11):

That provision is retroactive to January 27th, 2020 and goes through the end of the public health emergency. So as long as that public health emergency is opened health centers will be able to provide these distant site services. The guidance says, and I'm guessing there will be several questions on this particular piece for the folks at CMS, that any healthcare provider can provide telehealth services from any location including his or her home as long as he or she is working for the FQHC. I know historically, and we got a lot of questions about this before this guidance came out on whether or not the provider would have to actually physically be in the FQHC to provide those services. And we know that that is really difficult, especially in this time. And so allowing the provider to be working from his or her home or an offsite location is very important. It also includes the entire list of distant-site approved telehealth services, not just FQHC services. So there's a list that you can find in that MLN matters articles, and we can share that link in the chat if you've not already seen it, of all the services that are open for you all to provide and be reimbursed forth as a distant site provision.

Susan Sumrell (07:34):

So that was distant site, but there are also a couple of other things that have happened in Medicare specific to FQHCs and specific to the public health emergency. There have been some changes to the virtual check-in code. CMS added E-visit to this code. And just a reminder, virtual check-ins have been

around for about a year now, and it allows Medicare patients to have a brief communication service with practitioners via a number of communication technologies including a telephone call or a video call if that was appropriate. The one thing about this is that these services must be initiated by the patient, and I pulled this language from a CMS fact sheet linked below, pulled the language straight there from it. It does note that practitioners may need to educate beneficiaries on the availability of the service prior to patient initiation.

Susan Sumrell (08:33):

Through the public health emergency, CMS has also added an E-visit code, which is when an established Medicare patient can I have a non-face-to-face patient-initiated communication with their providers using an online patient portal. So it's communication initiated through the patient portal and while the virtual check-in is communication over the phone or through video. With the addition of the E-visit to this G0071 code, there was an increase to the G0071 payment rate, which bumped it up to $24.76. I think it was right around $13 prior to the emergency. So we're very thankful and I know that a lot of folks have been really quite interested in both the virtual check-in and E-visit codes especially during the emergency.

Susan Sumrell (09:29):

I want to flag a couple of other things that CMS has done. I noted for the virtual communication services that it's a patient-initiated and that you have to obtain consent. Throughout the emergency CMS has noted that for virtual communication services and chronic care management, CCM, the beneficiary consent may be obtained at the same time the services are initially furnished. So specifically I think for RHCs and FQHCs as it says in the bullet, this means that beneficiary consent can be obtained by someone working under general supervision of the RHC or FQHC practitioner. And direct supervision is not required to obtain consent. So that is through the duration of the emergency and I think is a really helpful provision that CMS included to allow more timely access to these services.

Susan Sumrell (10:25):

I also wanted to flag, for those of you that provide Visiting Nurse Services to your Medicare patients, effective March 1st, 2020 through the end of the emergency, there's no requirement for a request for determination of shortage of home health agency that has been waived through the duration of the emergency. And that FQHCs must check the HIPAA eligibility transaction system before providing Visiting Nurse Services to ensure the patient is not already under a home health care home health plan of care. With that, I want to turn it over to Gervean to walk through a couple of the... So I gave you the very high-level policy overview, Gervean's going to walk through a little bit of the how-tos then on these. Gervean, I'm going to hand it over to you.

Gervean Williams (11:13):

Thanks so much Susan. So this is FQHCs Distant Site Telehealth Services. From January 27 to June 30th, you will be able to bill for these visits by putting on the FQHC G-code and qualifying visit and the G2025, that's the code to identify that this is the telehealth service. After July 1st you will be able to just use strictly the G2025 code in order to get reimbursed for your telehealth services. And then also all this information needs to be put on your cost report when you submit it, so any additional costs and services added onto your cost report on CMS form 224-14. And here are the couple of links to some CMS great resources to walk you through all these individual details.

Gervean Williams (12:10):

So here is example of a claim layout for January to June 30th. You will have your revenue code, you'll have your HCPCS codes for the FQHC Specific Payment Code. And on that line you won't need a modifier. In the next line, you'll see you have your revenue code, you'll have your qualifying visit code 99214, what level of visit you have, and then add the modifier 25. And then the last line to identify this as a telehealth service will be the revenue code, the G2025 and the modifier 95.

Gervean Williams (12:52):

So I just want to talk about the Medicare accelerated and advanced payment briefly. The program now is being reevaluated so you can't submit for Medicare Accelerated or Advanced Payments. But if you have received those advanced payments, please make sure you think about the repayment time. The MACs have been very good about getting the money out to the providers and the recoupment process is going to take place 120 days after you receive your payment. And please make sure you still submit your claims because there will be a netting process. So your repayment amount will be decreased by the claims you submit. So please make sure you look at those timelines, look at when you receive, receive that advanced payment and look at when you're going to be recouped and follow that paper trail to make sure that everything reconciled appropriately. So before we go into the FTCS coverage... Oh. When do we have Marty on the line? Marty, are you on the line? Ted, do we have any questions so far?

Ted Henson (14:10):

We do. It does look like Marty is waiting to connect right now. So, hopefully he'll be live in just a minute, but one second. Okay. So there are a lot of questions coming in related to just the clarification around the payment. Ann Loeffler, are you there and to read them for us?

Ann Loeffler (14:39):

Hi Ted. Sure. So, we have a question, "If our PPS rate is higher than $92 for telehealth services, would it be advantageous to hold off on submitting those charges until after July 1st, or should we financially plan for a "clawback" of any payments over $92? Thank you for all your hard work."

Gervean Williams (15:08):

Tracey would you like to answer that?

Tracey Mackey (15:10):

I think I'm going to allow Corinne to address it. I think, Corinne, the caller's asking if they hold their claims will the payment rate change because $92 is lower than their PPS rate.

Martin Bree (15:27):

This is Corinne. Tracey, did you want me to start? Can you hear me Tracey?

Tracey Mackey (15:47):

Yes. Yes. Can you please start because I think the caller's asking if they wait to submit their claims, would they can be paid the PPS rate for the telehealth service.

Corinne Axelrod (15:59):

Yes. Okay. Thank you. And if you don't mind, I'm going to give you a long answer. But first, again, to start out by thanking you all because we know that you guys are doing really amazing work right now and it's really hard and we're trying to be as supportive as we can. But we have our laws and regulations and things that we have to follow. But we're trying to make things as easy for you as possible, I know it doesn't always seem that way. Thank you for the work that you're doing.

Corinne Axelrod (16:29):

Now, I just want to back up and say that I know some people are a little disappointed in the $92 rate, and we have to follow the law. The way that Congress wrote the statute, it didn't give us a lot of wiggle room every which way to see what we can do and when it came down to it, the decision was that if Congress wanted to pay you at your APS rate that's what they would have said. And what they said was that we needed to pay you in a manner similar to the Physician Fee Schedule. So that's what we did. It's $92, which is the average... it's actually $92.03, but what we've done is made it as expansive as possible. So as Susan was saying earlier, any provider that is working under their scope of practice for the FQHC can furnish a telehealth service. It doesn't have to be one of the authorized at FQHC practitioners. So, as you know, that's an MD, MP, PA, certified nurse midwife, clinical psychologist, clinical social worker. So, for telehealth services, we've widened that door a lot. Any practitioner that is working under their scope of practice for the FQHC can furnish the service. And, also as Susan said earlier, any service that is on the Physician Fee Schedule list of telehealth services that can be furnished during COVID can be furnished by the FQHC.

Corinne Axelrod (18:05):

Another thing that I don't think was mentioned is that there are no frequency limitations. So you can build as many services as appropriate in a day, it doesn't mean that you can do a telehealth service and then say, "Well let's hang up and we'll reconnect," and then bill for two visits. No. You can't do that. But if it's medically appropriate and meets the requirements, you can bill for more than one telehealth visit a day for the beneficiary. So we hope that that mitigates some of the concerns about the payment rate. I do want to get back to the question about the $92, that is the rate. We are temporarily paying at the PPS rate just because our systems need to be reprogrammed for this and it's a very complicated and difficult thing to do that quickly.

Corinne Axelrod (19:05):

And so the choices were either we have you all hold your claims and you don't get paid, or we pay you more now and then take that money back later. So that's what we decided to do. You certainly can hold your claims if you want and Tracy is going to talk about this in just a minute. But that's the reason that we did it this way is because we know that for many FQHCs, holding the claims and not getting paid is really not an option right now. But I don't want you to think that you're going to get the PPS rate for telehealth. It's going to be $92 and that is for the duration of the COVID-19 public health emergency. So let me stop there. And Tracey did you want to add to that?

Tracey Mackey (19:53):

Thanks Corinne. I think you covered the caller's question, and I don't have anything else to add.

Susan Sumrell (19:58):

Corinne. Can I have a question.

Ann Loeffler (19:58):

Okay. Since we have-

Susan Sumrell (20:07):

Oh. No. Go ahead. Sorry. This is Susan. I saw a question come in on the chat box but also have had this question come in as well. I just was going to ask you to clarify a little bit further about any practitioner. In the chat box it says, "Can LPCs bill for telehealth services to Medicare?" And I've had a question about nurses billing services, if that's appropriate within their scope of work. Could you clarify that a little bit more about any practitioner?

Corinne Axelrod (20:36):

Sure. Happy to do that. So, any practitioner means that anybody like a nurse or a therapist or any type of practitioner that is working within their scope of practice. So for instance, an FQHC could bill a telehealth visit if a nurse furnishes a 99211 E&M visit. So 99211 is not normally an FQHC billable visit because it doesn't require the skill level of an FQHC practitioner. But for the telehealth services during the PHE, the public health emergency, that would be a billable telehealth visit. So we don't have a list of practitioners, and that may actually vary by state. But the practitioner must be working for the FQHC, either as a employee are under a direct contract, either one. And so any practitioner that is authorized to furnish the service can do so. And that would be a billable service if it's on the telehealth list.

Susan Sumrell (22:00):

Thank you, Corinne.

Ted Henson (22:04):

We have a lot of questions coming in asking for clarification around whether or not telehealth is still only video, audio. Can it be audio only?

Corinne Axelrod (22:16):

We have also gotten a lot of questions about that. So the only options that are available right now are the telehealth, which is audio and visual or the virtual communications which are really a little bit different. As you know they're patient-initiated, they're not quite as extensive as an actual visit. We are continuing to look at this situation and I'm hoping that we can provide more flexibilities soon. But for right now, the only things that are available are the virtual communication codes and the telehealth, which is both audio-visual.

Ted Henson (23:04):

Great. Thanks. Gervean, do you want to take a break from Q&A and transition to Marty Bree now? If Marty's still on the line.

Martin Bree (23:16):

Yes. I'm on the line.

Ted Henson (23:20):

Great. Marty we will hand you the ball so you can advance your own slides. Let us know if you'd like us to advance your slides for you.

Martin Bree (23:28):

Alrighty. Let's see. I am having a little trouble advancing the slides.

Ted Henson (23:49):

Marty, hit the down arrow.

Martin Bree (23:52):

Yeah. Oh. There we go. Okay. Now they work. Okay. Thank you. All right. I know I've got 10 minutes, and that's all the time I want to take off all of you to talk about FTCA coverage and telehealth during the current COVID-19 emergency. Let's start with a general statement right now with this question about immunity from lawsuits during this period of time. Many of you are probably aware that there are a variety of laws out there right now that provide a host of immunity to lawsuits for providers during this period of time. The recently passed Federal Cares Act has an immunity for volunteers who are providing services on the COVID-19 emergency declaration. There is the older Federal Prep Act that was implemented when the HHS Secretary declared the public health emergency and that created certain kinds of immunities under certain circumstances for all practitioners who are involved in the COVID-19 response. Many states have created new immunities under law for those who are providing responses to the COVID-19 emergency, be it volunteers or employed practitioners. So there's a whole host of things out there. But remember, your coverage under the Federal Tort Claims Act program is your best coverage. And that's what you want to rely on. Don't want you to think you have to rely on some other coverages that are newly available to you we want to you. We want you to be protected under the Federal Tort Claims Act program.

Martin Bree (25:51):

So, these are the required disclaimers that lawyers always put up in front of their slides. And so here we go with common questions related to the COVID-19 situation. The first one is, "Can health centers engage in activities with non-health center patients to prevent, prepare for and respond to the coronavirus?" And what we mean by a non-health center patient is, if you remember, the FTCA manual that HRSA published in 2011, that was the first time they defined the health center patient. And in order to have the protection of the FTCA program, you've got to be caring for a health center patient, with some exceptions. So, in this current environment, you may be outside the health center and you may be doing screenings in another location, you may be caring for patients in a temporary facility set up by a health department, all sorts of environments where you can be providing services to non-health center patients. And HRSA's definition have has traditionally been "Someone who accesses care at one of your sites is a health center patient." If someone hasn't accessed care at a health center site, they're generally not a health center patient. So can health center patients engage in activities with non-health center patients? And the answer is yes.

Martin Bree (27:21):

Clearly, the particularized determination that was published by HRSA, signed by Jim Macrae about two weeks ago, it's up on the slide, the language. It basically talks about you can provide services screening, triage, testing, diagnosis, treatment to individuals who are not established patients of the health center, in-person or through telehealth. So now you can provide that care via telehealth to a non-health center patient that's clear. Can providers provide telehealth services from their home and still be protected by the FTCA program? And the answer there is yes. And if you look back at that language in the particularized determination. It says off-site. So, yes, you can provide services off-site from your home.

There's no prohibition, no language in there that would prohibit you from doing that. But if you're providing a telehealth service from your home, so you're a physician and you're working from home, nurse practitioners working from home, things you want to be aware of. And the most important I believe is the question of scope of employment. That's probably going to be a key issue on how these decisions about coverage are going to be made in the future, if and when claims are filed.

Martin Bree (28:55):

Remember, you've got basically two tests around coverage. One is "What are you providing? Is it a medical, surgical, dental or related function?" And two "Were you acting in your scope of employment?" Scope of employment is determined by the Department of Justice, not by HRSA. So the person doesn't have a say in that, it's the Department of Justice who makes that call. One. Two, they have to apply state law. So it could vary from state to state. One fact situation state A may end up being in the scope of appointment, same fact situation state B, may not. Okay. So it's state-based law. So when we're talking about the practitioner being at home, if a claim arises, DOJ is going to want to see your employment agreement, your position description. Whatever that document is that describes your scope of your work. They want to see your privileging docs. So, you're going to want to make sure that we have some writing that shows that your work from home is part of your scope of employment. It's possible you could amend your employment agreement. You might write an email. It might be via an email to direct the individual to work from home or approve working from home. But the bottom line here is that we want something in writing to show that working from home and providing telehealth services from home is in your scope of employment.

Martin Bree (30:30):

Second. Licensing. And this is a kind of a two way street. There may be a chance that your home is in another state. It's not out of the realm of the possible. If you're in state A and you're providing services to an individual who's in state B, you have to be licensed to state B. But do you have to be licensed in state A to provide that telehealth service to the patient in state B? We need to know what the licensing laws of the states that you're involved with are. Now, know that a lot of states have temporarily changed their licensing requirements just For this reason, so that practitioners can provide telehealth service more easily. So you need to be familiar with that. If you go to the Federation of State Medical boards, their website has a lot of information on that. I may have a link to it here. Sir, don't forget you need to get informed consent, even if it's a telehealth visit. You need to informed consent to the actual mechanism and informed consent to provide the treatment. For record keeping. You need record keeping for your third party payers. You need record keeping in order to provide a defense for any claim that may arise. If you're caring for non-health center patients, that we talked about previously, you subsequently would need to register them and create a record for them.

Martin Bree (32:07):

Okay. Another question. "Can we see, via telehealth means, a new patient for screening for COVID-19 for the first time from the patient's home?" An the answer to that question is yes. You can be covered under the FTCA for screening of a non-health center patient via the phone when the patient is at their home. This particularized determination granted as broad abilities to provide care to non-health center patients. Let's see. "Can we see, via telehealth, a new patient for healthcare services other than COVID-19?" And again, yes. You can see a new patient for healthcare services for other than COVID-19 screening via telehealth. And the reason for this is a little more complicated. But if you just back to the FTCA manual and look at the definition of a health center patient, you'll see there's a third way that you become a health center patient and that's via triage. Services are provided in-person or over the phone.

And HRSA uses that language "To provide triage services in-patient or over the phone." And then you intend to register the patient, and that makes that person a patient of the health center. Even though they haven't physically come into the health center.

Martin Bree (33:35):

Okay. Let's go down here. "Can we provide services via telehealth to patients who are in a different state?" Sometimes, and I know this question has come up, we've received this question from clients. That patients have gone back to another state to be with their parents during this period of time or to care for their relative or whatever, and they're not in the state where they live and where the health center is. Can you provide services via telehealth? Again, you've got to know the laws of the state where the patient is. Okay? And to see if they would require that you have a license in that state to provide that service. And again, many states, many states, a majority, probably, have loosened their requirements around that question. So check with those states. When we talked about this with HRSA, it wasn't really an issue for HRSA. Their position is "How do you know where the patient is on a telehealth visit? And while that makes some sense, my bigger concern is two years from now when DOJ gets their hands on a claim and you have an enterprising young assistant US Attorney who's trying to save the government money and he's looking for ways to deny coverage. So we want to make sure that we're following the licensing laws of the state where the practitioner is and the state where the patient is.

Martin Bree (35:06):

Okay. So those are the big issues around telehealth and FTCA. It's a complex, ever-evolving arena. HRSA's putting out FAQs, they've revised the policy on getting temporary sites approved, so it's kind of a dynamic process here. Let me conclude by saying that we believe that much, if not all of what you're going to be doing during this emergency period, should be covered by the FTCA. The statute is very simple, it says you got to be providing medical, surgical, dental or related functions, acting within the scope of project. That's what the statute says. The only regulation that's relevant say that the activities that you're engaging in must be related to the grant program. Okay. And that's how basic that is. So, we're fairly confident that much of what you're going to do will be covered. Just keep in mind documentation is going to be important in this going forward, because if a claim arises in the future, we need to have records of what occurred during the encounter. Be it screening or otherwise. And here's some contact information. I apologize Molly couldn't be with us. We had just finished up a webinar that we had been doing and she's cleaning up some questions on that right now. So, there we go.

Gervean Williams (36:48):

Thanks so much, Marty.

Martin Bree (36:49):

All right.

Gervean Williams (36:50):

We're going to turn it over to Ann to manage our Q&A.

Martin Bree (36:52):

Okay. And I've got a few more minutes-

Ann Loeffler (36:59):

Okay. Great. I think this question is for CMS. "Can you please clarify about when to use the modifier and when to use the G-code? And how will payments be adjusted?" I'm just going to read one more question in that similar category, "In the SE0016, it says to use 95 mod and bill as usual then after July 1 is the G225. Is there an FAQ of billing examples or reference guide you can share a directive to?

Tracey Mackey (37:36):

This is Tracey. Can you hear me? So I'll take that one and I just want to say-

Ann Loeffler (37:41):

I can,

Tracey Mackey (37:41):

... Thank you. I just want to say that we are in the process of updating our FAQs in that Med Learn Matters article to put some examples. But I think earlier someone had a slide up with the billing examples. I don't know if we could pull that up again for illustrative purposes? From January 27th until June 30th, until the systems are updated, we will be paying the PPS rate. And in order to pay that, you would bill as normal. You would bill the FQHC G-code with a qualifying visit. On the visit line, you will put 95 and that would let us know that you're billing for telehealth services until the system is updated. And then you would bill an additional line with your G2025 code. After the system is updated in July, your MAC will go back automatically and reprocess that claim. What'll happen is on that FQHC G-code line, where you give the FQHC payment, they will not uncover that line and then your claim will pay for the telehealth G-code. I know that's kind of confusing but that's what's going to happen. They're going to take the claim, mass adjust it and take the PPS payment off and give you the $92.

Ann Loeffler (39:02):

Great. Thank you. Anyone else on the panel want to chime in? Okay. Great. So we were just talking about providing telehealth visits from the providers home. We're getting a lot of questions about "What location do you submit on the claim?"

Tracey Mackey (39:22):

This is Tracey again. So on institutional claims, there is not a place of service code. So you don't have to indicate a location, you would just bill it on your 77X type of bill, which is the FQHC type of Bill.

Ann Loeffler (39:44):

Great. And, "Should the patient's location, city and state, be documented in the patient visit record?"

Corinne Axelrod (39:58):

I don't think that we have any guidance on that, but it's probably a good idea.

Ann Loeffler (40:08):

Thank you. And we're getting a lot of questions about phone visits versus audio plus video. Just gonna read a few. "Is the G2025 required for phone visits?'

Corinne Axelrod (40:31):

So G2025 is it for telehealth visits? Which is both audio and visual at this time. As I said earlier, right now the only things that are available are telehealth visits and the virtual communication codes. But we are looking at what we can do regarding payment for telephone... I don't know if you'd call it visits or whatever and we're hoping to have more information out on that soon, but there's not a whole lot that we can say at this point.

Ann Loeffler (41:13):

Okay. So there's a similar question "What fee should we associate to the G2025?

Corinne Axelrod (41:22):

I'm sorry. Can you repeat the question?

Ann Loeffler (41:25):

Sure. "What fee should we associate to the G2025?

Corinne Axelrod (41:33):

Tracey, did you want to answer that?

Tracey Mackey (41:38):

Can we get a little clarification on that? I don't know if you mean the submitted charges, but the fee for G2025 will be $92. That will be the fee rate.

Corinne Axelrod (41:55):

I they're asking how should they set-

Ann Loeffler (41:57):

Okay. Yeah. I think that answers the question.

Corinne Axelrod (42:05):

Yeah. Okay.

Ann Loeffler (42:06):

We have a question about technology issues using video applications. "If the visit isn't completed successfully because of video problems, will Medicare still pay if it's documented correctly?"

Corinne Axelrod (42:22):

This is Corinne. I think that there's some FAQs that are being developed that will address that question. So I don't have the answer now, but I think we will have an answer hopefully soon on that. Because it's probably a not uncommon occurrence.

Ann Loeffler (42:45):

Okay. Great. We have a question about undocumented patients. "Are undocumented immigrants eligible for the new COVID-19 on insured program?" Giving you a break, CMS. So this one's for you, Marty. If you're still on.

Corinne Axelrod (43:16):

This is Corinne. Speaking for Tracy and myself, this is sort of not in our area so it's not something we could answer.

Ann Loeffler (43:26):

Marty Are you still on?

Martin Bree (43:30):

Yes. Yes I-

Ann Loeffler (43:31):

Okay. Oh. There you are. Okay. Great. Did you hear the question?

Martin Bree (43:38):

Could you repeat it for me?

Ann Loeffler (43:40):

Yeah. Sure. So the question is, "Are undocumented immigrants eligible for the new COVID-19 uninsured program?"

Martin Bree (43:49):

I do not know the answer to that. That's a little bit out of my ballpark.

Ann Loeffler (43:56):

Okay. One more question for you, Marty. We're giving you a break CMS. "Are uninsured patients who qualify for Sliding Fee Scale eligible for the new COVID-19 uninsured program?"

Martin Bree (44:12):

That's kind of another variation on the same question. And I think that the questions I'd have to defer over to Marcie. I wouldn't want to I wouldn't want to opine on that, without consulting with her. I do want to know-

Gervean Williams (44:32):

This is Gervean at NACHC. Feldesman Tucker and NACHC are working on research in that, so stay tuned to our COVID-19 web page for updated information regarding that.

Ann Loeffler (44:43):

Great. Thanks. "If the employment agreements or position descriptions are updated after provision of telehealth services from home has started, will that be an issue? Sometimes the official approval process takes time."

Martin Bree (45:02):

That depends on where you are and what state you're in. Typically, employment agreements don't have to be in writing. Most states don't necessarily require employment agreements to be in writing.

Typically, real estate agreements must be in writing. Real estate contracts must be in writing to be enforceable, but not employment agreements. So, in theory, you could modify your employment agreement via conversation between the two individuals. The difficulty you have there is then in the future, arguing that "Yes. We had this conversation and it modified the employment agreement." That's why we always tell you writing is more important, so an email between the health center and the physician and the physician's agreement via email that, "Yeah. I'll work from home. Yes. I'll work from home." That should be enough to show that a contract existed. That there was an agreement, a meeting of the minds. If you have a system that that requires that the changes to any contract has to be approved in such a fashion that it takes a long period of time, that might be a problem.

Ann Loeffler (46:25):

Right. Thank you. And we'll do one more question and then I'll turn it back to your Gervean. "Are FQHCs required to utilize approved software such as Skype or Zoom for telehealth services?"

Corinne Axelrod (46:42):

This is Corinne. And I don't know the answer to that. I think in the past that was true, but I'm not sure that that's required at this point. But we certainly can try to follow up on that.

Ann Loeffler (46:57):

Great. Thanks. And Ted I'll turn it back to you.

Ted Henson (47:03):

Thanks, Ann. There were a couple more questions related to same-day billings. That's for CMS. I'll just read them to you as well. "Can you bill a regular face-to-face visit as well as telehealth on the same day?" And then another question was, "If we have a patient that has a telehealth appointment with a medical provider and then an appointment with the behavioral health provider on the same day, are we able to build both services and be reimbursed for both services?"

Corinne Axelrod (47:19):

So in your first question, was that the same patient that would have both an in-person visit and a telehealth visit? Or are you talking about two different patients?

Ted Henson (47:19):

I interpreted as the same patient.

Corinne Axelrod (47:19):

Okay. So I don't think we've thought about that, but that's a great question. So, I'm writing it down and we'll try to get an answer back for that.

Ted Henson (47:19):

Great. And then the other question was, "If we have a patient as a telehealth appointment with the medical provider and then an appointment with behavioral health provider on the same day." So, both are telehealth, not one telehealth and one in-person. Can they be reimbursed for both services?

Corinne Axelrod (48:13):

So that's yes, because there's no limits to how many telehealth visits they can have on one day.

Ted Henson (48:25):

Okay. Great. Well, we are coming up on the hour. Seems like we still have questions coming in. One more actually, sorry, for CMS. "Can we get clarification again on the G2025 code, what charged to put for that? Is it the $92?"

Tracey Mackey (48:52):

So this is Tracy. The fee is $92. We generally don't tell providers what charges to bill, but the fee that CMS will pay is $92.03. So the charge is for their discretion.

Ted Henson (49:07):

Okay.

Gervean Williams (49:09):

So I would say they'd need to take in consideration, look at the different telehealth services, look at the cost and looking at prevailing rates is a kind of a challenge right now, but I will look at your health centers call and use that to figure out what you're going to set that charge at for.

Ted Henson (49:31):

Thanks, Gervean. And closing minutes, one more question. I feel like this has come up a couple times, "If a patient is seen by a doctor or nurse practitioner via telehealth, then the patient comes back later that day to have labs drawn. How does the health center bill for that?"

Corinne Axelrod (49:51):

So I think they would bill for that the same way they would always bill for the labs. The labs are included in a visit, but they're not separately billable. If there's no billable visit, then there's no payment for the lab collection. So it's really the same as it's always billed. I don't think there's any difference.

Ted Henson (50:18):

Mm-hmm (affirmative). Thank you.

Gervean Williams (50:28):

I know-

Ted Henson (50:29):

So we have a lot of questions we'll continue to-

Gervean Williams (50:36):

We'll gather all the questions and make sure we respond to those with the FAQs. I know Corrine had a hard stop at three. And I do want to take a moment to recognize her and thank her for all of her hard work and supporting of FQHCs throughout her career at CMS. She will truly be missed.

Corinne Axelrod (50:53):

Thank you very much. It's been a pleasure to work on FQHCs. I'm going to be retiring in a couple of days, so I'm very excited about that. But I will definitely miss working with the FQHCs, I've been very fortunate in my career to be able to do so. And it's really always been inspiring to me to see the work that you do and the passion that you have, so I feel very lucky that I've been able to work on FQHCs in the federal government. And I wish you all well and hope everybody stays healthy. Thank you.

Gervean Williams (51:32):

Thank you so much, Corinne and Tracy and Marty and Susan and all of our presenters today. And thank you guys out in the trail, we really appreciate you. And anything we can do at NACHC to help you, just reach out and let us know. Everybody have a good rest of the day. Take care.