

How & What Will Medicare Pay For RHC Telehealth Visits

Nathan Baugh:

0:06
Hello everyone. My name is Nathan Baugh. I'm going to do the operator today for today's webinar. I'm also the Director of Government Affairs for the National Association of Rural Health Clinics. Today's topic is how and what visits this series is sponsored by HRSAs Federal Office of Rural Health Policy and is done in conjunction with the National Association.

0:31
Of Rural Health Clinics were supported by Cooperative agreement as you can On your screen to the federal office of rural Health policy and that allows us to bring you these calls free of charge. The purpose of the series is to provide Our IT staff with valuable technical assistance and I see specific information today's call is ninety third in the series which began in 2004 and there have been over 26,000 combined participants. As you know, there's no charge to participate in these calls and we encourage you to refer others who might benefit from this information.

1:05
To sign up to receive announcements regarding dates topics and speaker presentations at the rhi website a couple of things before we get started. We are going to ask folks to not ask questions while we are presenting we will have a question-and-answer period but if you ask a question through the chat box during the presentation, we will not answer it. We're only going to answer.

1:35
Questions that we receive in the Q&A period just to makes it easier in it and less likely to repeat ourselves if we do it that way. So with that I'm going to turn it over to Bill Finerfrock who's the Executive Director of the National Association of Rural Health Clinics. There's going to get get us started.

Bill Finerfrock:

Thanks Nathan and thanks everyone for taking the time to be with us. I know that we have over 1,200 people on today's webinar.

2:04
And so and then that's an indication of how valuable this information is. I also want to mention that joining us today for the Q&A portion will be Karin Axelrod and Tracy Mackey with CMS. And so they have agreed to participate in the Q&A portion.

2:26
And so we look forward to working with them and getting even more information out to during the Q&A period before beginning I also Say thank you. Thank you to all of you who are out there on the front lines. I'm delivering care through this pandemic what you're doing and trying to deliver care is really critically important and we know that many of you are struggling financially based on the surveys we've done with the calls that we had and we just really appreciate everything you're doing to try and continue to provide care in your communities on we're going home for a second.

Nathan Baugh:

3:05
And so I think a lot of people are saying they have no sound here Cate. Can you verify that are we coming through for people who have found on this computer?

3:21

I held on for people who are presenters to if you could put your phones on mute. We're getting a lot of feedback. Yep.

Cate Visser:

The sound is coming through fine on my end. So I'm just going to respond to people that if you're having issues with sound you might need to jump out and back in. I know that's helped in the past.

Nathan Baugh:

Okay? Okay, so a lot of people okay.

3:46

Now I'm getting folks that are saying that they have sound so it's The folks that just don't have the sound on the computer turned up. Got it. Okay. All right.

Bill Finerfrock:

3:57

So on March 27th the coronavirus Aid we leave an Economic Security Act otherwise known as the CARES Act was signed into law and net legislation authorized rural health clinics furnish distant site Telehealth services to Medicare beneficiaries during the covid-19 public health emergency, and I've underlined that because I want to A size that right now this time this benefit is only available during the public health emergency. It is possible that Congress could extend it. But right now it is only during the time period of the public health emergency that you don't know obviously when that is going to be to end but throughout the public health emergency is Telehealth filling opportunity is available in order for Medicare to pay for a Telehealth visit. It's generally going to require you to use an Interactive.

4:49

Is audio and video telecommunication system that permits you to engage in real-time communication between your RHC practitioner and the patient this can include a smartphone that has video and audio capability a computer-based audio video communication that is not publicly facing. In other words. It has to at least maintain a private one-to-one communication cannot be a publicly.

5:19

Facing tool and also and we'll go into this a little bit later. But Telehealth visits are not the same as virtual check-ins or digital even visit.

5:31

So we're all health clinics with this capability committee can immediately provide and be paid for Telehealth services to patients covered by Medicare for the duration of the public health emergency, so you can be the distance site now there's some unique characteristics about this that Are a little bit different than what you may have been used to first and foremost is that during the Telehealth this period Services can be furnished by any any Healthcare practitioner working for the RHC working within their scope of practice.

6:06

So for example, a marriage and family therapist would not normally be a recognized provider in the world health clinic setting during this time period for a Telehealth visit you could use a marriage a family therapist to provide a Medicare-covered mental health service that is within the scope of practice of that marriage and family therapists in the state in which you are located. So you are not limited to just those providers who would normally be recognized in the rhc setting the position the pa the nurse practitioner the psychologist or the clinical social worker. You have an expanded capability to wreck to bring in other types of providers.

6:49

Again to the extent that they are legally recognized in your state acting within the scope of practice and providing what would have otherwise been a Medicare-covered service?

7:01

Practitioners can furnish this distance site from any location including their home. So if your physician your PA your nurse practitioner for whatever reason is not able or just chooses to engage in a Telehealth visit from a location other than your practice they can do.

7:21

So as long as they are being compensated by the rural health clinic at the time they are under contract or they're an employee of the rural health clinic and they Engaging with a rural Health Clinic patient for that Telehealth visit for additional information. You can go there's a link on your screen and you can download these slides from the website and you can see what are the full range of Telehealth codes that you could in theory bill for the most common codes that we find are the typical e/m codes new.

8:01

Patient E&M 99201 to 99205 or an established patient 99211 to 99215, but all the codes that you'll find listed under the link that I provided you with our codes for which you can build you have to be able to meet all the requirements to build for those codes, but you and you should be able or could be able to deliver those via Telehealth.

8:32

Now payment for rit's for distant site Telehealth Services has been set by Medicare at \$92 for Telehealth visit. This represents. The average amount Medicare will pay as all for all Telehealth services on the Telehealth list weighted by volume for those Services reported Under The Physician fee schedule. So it constitutes a single rate.

9:02

That is the Average of all those services so it'll be \$92 for you to engage whether you're an independent or provider-based rural Health Clinic. It will be the same rate the \$92 for each Telehealth visit.

9:19

When you submit the claim for services and it is retroactive if you engaged in a Telehealth visit going back to January 27th of 2020 and up through June 30th of 2020. You will build for those and you will you will bill for those using the appropriate CPT code and then use modifier 95 on the claim and that will identify it as a Telehealth visit rather than an in-person visit.

9:49

When you do that during this time period this January claims back to January 27th up through June 30th. You will be paid your all-inclusive rate. So whatever you're a IR is that is what you are going to be paid for your visit.

10:06

However is you'll see that is not what ultimately you will be able to retain because these claims will then be automatically reprocessed in July when care claims processing system is updated to reflect the new payment rate for Telehealth visits. Rhcs and then also fqhcs will not need to resubmit these claims for the payment adjustment. This will already this will be done automatically. And what does that mean? What does reprocessing mean for Telehealth visits in which the rhc per visit payment rate your AIR is less or more than 92 dollars. They will be reprocessed.

10:48

If the AIR is less than \$92 per visit Medicare will remit pay you an additional amount equal to the number of Telehealth visits the RAC conducted between January 27th, 2020 and June 30th, 2020 multiplied by the difference between the RHCs AIR and \$92. Excuse me, if the AIR is more than \$92 per visit.

11:17

Medicare will recoup an amount equal to the number of Telehealth visits the RHC conducted between January 27th, 2020 and June 30th, 2020 multiplied by the difference between the AIR and \$92. So what is that going to look like? So in this example, our RHC visit rate is \$86.31.

11:38

That's the cap and between January 27th and June 30th, the RAC provides 500 Telehealth visits the RHC was entitled to \$92 for each of the Telehealth visits, but they were subjected to the cap when you submit it using your AR. So at that time CMS will remit to the rural Health Clinic a check for or an amount of deposit for 2276 dollars. How do we get that you take the \$92 you do subtract the 86 31, which was what you were the allowable was for that that equal and that comes up to \$5.

12:17

Since 69 Cent you multiply that by five hundred that comes out to two thousand eight hundred and \$45. You multiply that by the 80% that Medicare would pay and your remit would be 2276 dollars additional you would be paid for those businesses.

12:37

Yeah suppose if you're alright see if you're a are is above so in this example to your RHCs visit rate is \$180 and between January 27th of June 30th that RAC provided 500 Telehealth visits the rhc was only entitled to 92.3 to the Telehealth visit. And in this case CMS will recoup \$35,200 from the RAC because they paid \$180.

13:06

You subtract the \$92 that they should have which equals and so that's \$88 too much that the clinic was paid times 500 is 44,000. You multiply that by 80% and Medicare would recoup three \$35,200. So critically important as a rural Health Clinic when you get that payment for Telehealth visits you need to you you should not spend that you would put that difference aside put it in.

13:36

Accounts, but but you that money that additional money between your AIR and \$92 is going to be recouped. So, you know again don't spend it but it into some kind of an account and escrow account or something so that when CMS recoup that money you have it available to give back to Medicare.

14:01

After July 1 of 2020 CMS will have been able to undertake the system changes that are necessary in order to allow you to then be paid correctly for your Telehealth visit. So for visits that occur after July 1 or on or after July 1 of 2020 and until the end of the public health emergency rhcs will use an rhc specific G-Code G2025.

14:30

Identify services that were furnished via Telehealth, you will no longer use the 95 modifier but instead use to G2025. All right see claims with this new G-Code then will be paid at the \$92 rate and we won't have this remit recoup situation. Unfortunately CMS only updates their computer systems every so often and the next opportunity to update their system is not until June.

15:00

A lie. And so that's why we have to we could have been Theory waited until July for any money to be transmitted folks needed that money. So CMS made the decision to at least put money into your pocket get you some of the money get you the money you were owed, but unfortunately it either wouldn't be all if your rate

was below 92 or would require recoupment if it was above ninety two dollars, but rather than waiting until the system could be updated they went with this approach.

15:30

Only distance I tell how Services again are authorized for payment for RHCs during the period of the public health emergency. If it goes for some reason Beyond December 31st of 2020 that \$92 rate will be updated based on the 2021 average payment rate for these Services again weighted by volume. Hopefully in many ways.

15:56

I think we all hope that the public health emergency will be lifted for December 31st of 2020 because I think the consequence is that for our health care delivery system for a whole slew of reasons. We just may not want that to have to extend that far in terms of your RHC cost report the cost of Furnishing distant site. Telehealth services will not be used to determine your rhcs AIR but must still be reported on your cost.

16:30

You must report to cost Associated if you're in originating site and it just insight for Telehealth on your CMS cost report due to 2-1 Seven online 79 of worksheet a or the comparable line on your provider based car seat in the section titled cost other than our it service.

16:55

Because televisions will not count as rhc visits it will be necessary to remove those costs associated with the delivery of services from the cost report the combination of reduce patient volume that we're hearing already from folks do to covid-19 patients not willing to come into the office providers who may be not able to come into the office and the determination that are easy Telehealth is it's are not RAC visits Hood effect.

17:25

Ability of many our agencies to meet the minimum productivity requirement for cost reporting purposes. We are aware of this we have had conversations with CMS. They are aware of it and we're working with CMS to address the situation so that our ACS are not harmed long-term by the effects of this policy.

17:47

I can't emphasize enough. You're going to want to develop a mechanism for tracking both your Telehealth visits as well as your Telehealth costs in order to properly account for these on your cost report you if you have a consultant work with your Consultants, we will try and get information out on kind of best practices in terms of how you might want to try and account for these. I think CMS has put some information out.

18:17

With regard to how you might want to at least count visits but this is something you're going to need to do so that you don't have an adjustment or other changes that are going to affect your rhc all-inclusive rate in an adverse way moving forward.

18:36

In terms of covid-19 related testing via Telehealth. This is retroactive to March 1 of 2024 covid and I want to emphasize this is for covid related testing via Telehealth retroactive to March 1 Medicare will pay 100% of the rhc, including Telehealth for visits and services related to covid-19. Testing emphasizing the word.

19:06

Are testing for visits and services related to testing racs must waive the collection of the coinsurance from beneficiaries because Medicare is going to pay for those at a hundred percent. This would be similar to what we have now is certain preventive services.

19:24

We're all visits and services in which the coinsurance is waived the rhc must put the Cs modifier on the service line. So if it's in Telehealth, you're going to have 95 or at a unifying it as Telehealth and if it is for for testing you have the C s-- modifier which then means that they will pay you 100 percent and you will not collect a copay.

19:49

The Medicare administrative contractor will automatically reprocess the Claims again to getting on July 1 coinsurance shouldn't be collected from beneficiaries. If the coinsurance is waived. I also want to mention that even if the tell us L service is not related to covid-19 that you have the option of waiving the coinsurance for Telehealth visits and services. This is optional on your part and it is only for the Telehealth services that you do have the option.

20:23

Option of waiving the coinsurance for for other services not related to covid-19 at this point. Nathan is going to talk to you about some of the other things that are going on then I'll come back later to talk to you about some other programs so Nathan.

Nathan Baugh:

20:41

Yes, thank you Bill. And I just wanted to point out just one last thing on that modify or CTS. Obviously, you're not going to be doing a test through Telehealth physically, but any service any evaluation and Management Service that is to determine whether or not a patient needs a test. That would be something that could you could use a modifier CS4.

21:12

So the first thing that I want to go over and we talked about this a bit if you were on our webinar a week and a half ago, which is the the terminology when we talk about all these different Telehealth or telemedicine Services, the terminology is very important to get accurate.

21:33

All right, so I made this chart to hopefully better explain or so folks can visualize the differences here between These different types of services the first chart ever. The first line here is of course our virtual check-ins or sometimes referred to as a virtual care Communications. Okay. These were services that we could do since January 1 of 2019 and it is essentially there's two different CPT codes on the fee schedule GG 2010, which is the remote.

22:12

Oh devaluation of a picture sent from the patient and then there's G 2012 which is a brief communication with the patient at least five minutes. And that can be Audio Only and we'll talk a little bit more about that in the second you build for these with G 0 0 7 1 you bill on the ubo for there's no modifier necessary for the these services and the Revenue code is zero, five, two one, okay.

22:42

And the payment for these are is twenty four dollars and 76 cents. Now the digitally visits we bill for it the exact same way in the payment is the exact same way. These were expanded to rit's as of March 30th. And these are what we call the online digital evaluation and management. Okay. So this is kind of the second tier here. This is a back and forth with the patient over the course of seven days, Jen.

23:12

Really through the the patient portal answering X Y and Z question that the patient may present through the through the patient portal. And then finally I still just went over we have to tell a Health visits and these you have to think of our true Wonder one substitutes for in-person visits as Bill already explained you use your normal Hicks coding until June 30th. And then G2025 after that you still bill for these under UB-04 on this one. We use modifier 95 as Bill already.

23:42

Blind and the payment is \$92. We have to think about these things separately. So when you ask a question, if you say telephone visit, we don't know what that means. It has to be a virtual check in digitally visit or Telehealth visit, okay?

24:04

Again, virtual check-ins. This is something we could do since January 1 of 2019 involves five minutes or more of a medical discussion and that includes Audio Only just over the phone or remote evaluation of a photo for condition not related to an IT service that had been provided within the previous seven days and does not lead to an RIT visit within the next 24 hours.

24:33

And this still applies so you end up getting get on the phone with the patient and have the patient come in physically still to your heart rate see within the next 24 hours. You would not be able to build G0071 initially and and up until March 1st. These were all paid at \$13.51, but after March 1st, these are now paid out that higher rate which is \$24.76.

25:06

Again on March 30th CMS expanded that G0071 code, which is what rhcs used to build a virtual care communication Services. They expanded it to include digitally visits. All right, here's the full language from the interim final Rule and you can see that there are actually three different codes that are few schedule peers use to build different links.

25:35

Of digitally visit time. So this would be more time going back and forth with the patient over a seven day period now for us as soon as we cross that five minutes threshold, we now have G0071 billable service, right? So for us once we go past five, it really doesn't matter, but just so you guys are aware on the fee schedule side.

25:59

They get paid more or less depending on how much time they spend going back and forth with the patient through the through the patient portal. There's been a couple of flexibilities that are have been expanded during the public health emergency generally for virtual care Communications and the digital he's has its it was it was before covid-19. It was only with established patients. However, as of the public health emergency, it will also be available.

26:35

For new patients or for patients that you haven't seen within the last 12 months and this is verbatim straight from the final rule. So if you need to Source documentation, I put the link there and you can cite this if someone disagrees with you furthermore patient consent previously before covid-19 had to be obtained before you provided the service now patient consent.

27:05

Be obtained at the time of service as long as it's in but before the services are billed and it can be acquired by staff under the general supervision of the RHC or fqhc practitioner. So that's key in that your staff can wind and perhaps when they're prepping the patient to go talk to the RHC practitioner. They can obtain verbal consent before.

27:35

passing along the patient to the practitioner a couple of other clarifications in the FAQ that I think are particularly notable their CMS released a more recent FAQ about a week ago and has some really important clarifications. First one here is again, these are verbatim from the FAQ does the RAC or fqhc practitioner have to be physically in the RIT or of qtr?

28:05

Can they respond from another location such as their home and the answer is of course that RIT practitioners can Respond from any location during the time that they are scheduled to work for the rhc. So this is very similar again to the Telehealth visit that we just discussed where the doctor PA nurse practitioner can be located in their home and be providing these G 0 0 7 1 Services as well. I do want to note that this is it does say that they must be scheduled.

28:41

to work at the time that they are providing these services. So if you have your physician maybe after dinner is, you know winding down the day and wants to answer some patient questions through the patient portal sort of, you know some emails you centrally you would need to make sure that they are scheduled to work at that time or or have some sort of process where whereby that that's work.

29:12

Schedule time so that might be something that we get some further clarification on down the road, but I did want to note that the next one here is how frequently can G0071 be billed by RHCs and fqhcs and the answer here is because the codes are for minimum seven day period of time they cannot be billed more than once every seven days. This is a this was one of the ones that I gotcha.

29:41

Ripped up a detail that I got tripped up with on the G0071 previously because the virtual care or the virtual check-ins as long as it didn't lead to a visit within the next 24 hours. Theoretically you could have built those more than once every seven but this is makes it very clear that you can only bill G0071 once every seven days, okay.

30:12

Again, some of the technicalities we might get further clarification down the road, but that that is what was in the FAQ.

30:23

A couple more things that are not necessarily Telehealth related but related to the covid-19 tens emic and changes that have been made during the covid-19 pandemic. The first one here is that RIT for Home Health visits rit's can bill for visiting nursing Services furnished by registered nurse or LPN to a homebound individual under a written plan of treatment and areas with a shortage of home.

30:53

Agencies and effective March first any area that is served by an rhc is considered a home health agency shortage area and therefore you don't need a determination until to go ahead and provide these visiting nursing Services. However, you do need to check the HIPAA eligibility transaction system before you go ahead and start these Services just to ensure that the patient is not already.

31:23

Under a home health plan of care, but if the patients are not under that you are now free to go ahead and do you do not need a determination that their area that you serve is has a shortage of Home Health agencies.

31:42

Two last things and I'm going to turn it over to Bill and then we should have plenty of time for questions.

31:49

The supervision of nurse practitioners and RHCs has been relaxed slightly for the Emergency period and again, this is effective back to March 1st of 2020 and that is Verbatim. What is in the the CMS document their that I've linked at the bottom, but I'll just read it. We are modifying. We being CMS the requirement that Physicians must provide medical direction for the clinics or centers health.

32:18

Care activities and come consultation for and and medical supervision of the healthcare staff only with respect to Medical supervision of nurse practitioners and only to the extent permitted by state law The Physician either in person or through Telehealth or and other remote Communications continues to be responsible for providing medical direction for the clinic or centers Health Care activities and consultation for healthcare staff and medical supervision of the remaining Health Care staff this allows our agencies and nephew.

32:48

Agencies to use nurse practitioners to the fullest extent possible and allows Physicians to direct their time to more critical tasks. So there is a slight modification in terms of physician supervision from nurse practitioners.

33:05

furthermore the requirement that rural health clinics have a PA and NP or a certified nurse Midwife available to furnish Care at least half the time that the RHC operates is also waived they are but CMS is not waiving the fact that you have to have somebody available to furnish a furnished care at all times the the clinic or Center operates. So you do have to have a physician in PPA CNM clinical social worker or clinical psychologist available at all times. You just no longer need the nurse practitioner PA or certified nurse Midwife to be there at least half the time that the RAC operates. So this is just going to assist in sort of the soft demand that we might be experiencing in some areas and whether or not it makes sense.

34:02

To have the PA or NP there as much. So again, this is just for the public health emergency and there is the link to the source documentation.

34:27

Okay, let's come our way.

Bill Finerfrock:

34:33

I wanted to give some quick updates on the provider lost Revenue grants and some other things so many if not, most of you should have received some money from CMS either on Friday or the week before out of what is referred to as the provider provider lost Revenue grant program. This was money that was provided to any provider enrolled in either.

35:03

Are Medicaid that's submitted claims to either program in 2019 are eligible for a provider. We leave payment providers who are normally played by CMS be an EFT electronic funds transfer should have received payment automatically in your account either Friday April 10th for Friday, April 17th. Now if you did not submit Medicare claims, let's say you're an RA see that is pediatric only you would not have received a mess.

35:33

Men because it was based on your Medicare claim filings from 2019. That does not mean however, you won't be getting a payment at some point. If you did not get a payment on either of those dates. If you do EST, then you I would strongly encourage you to call the provider relief payment hotline 866-569-3522 to inquire.

36:03

What what may have happened you're going to be asked for the name of the provider as enrolled and the tax ID number that is linked to that provider either your EIN your employee identification number or your social security number depending upon the how the the practice is is organized. If you receive payments from Medicare by check not by EFT your payments are still coming. It's taking them a little too.

36:33

Little bit longer to process and get checks out. So it's possible that you submitted Medicare claims, but you submitted claims and you get paid by check rather than EFT those payments are still yet to come so be on the lookout for those if you if you get paid by check now for Rural health clinics, if you are a part of a group because we've heard from some clinics as they will we never got anything and you're part of a group.

37:00

Let's say you're a provider based RAC and You're under a critical access hospital and under a small rural hospital or you're an independent. All right, see but you're part of a group of our agency in all likelihood. The payment has gone to the parent entity and it was a lump sum payment to that parent entity encompassing all the providers who are part of that system.

37:26

So if you're part of a car, it's very likely that the Cog got the money that the money that the conga It's not only money directly for the cop but any world health clinics that are part of that cause or provider-based entity similarly. If you're a part of a group of rural health clinics, the group may have gotten the check versus you individually as a rural health clinic. So you need to check to see if internally money was deposited versus your so you may think we'll we didn't get anything, but it may have gone to the parent entity. Also more relief.

38:03

Is on the way so in the original provider relief program Congress approved a hundred million, I'm sorry a hundred billion dollars for the provider Relief Fund and the first 30 billion of that was is what was released and that was based upon a percentage of your Medicare payments from 2019. And while they provided a rather cumbersome formula in the end what it amounted to is it a buzz about 6.2 percent of your Medicare payments received.

38:33

That you would have received in 2019 the second phase so that means there's a there's 70 billion dollars yet to be released out of that fund the second phase we believe is expected to be based on non medicare payments such as Medicaid. So there are many providers who see little or no and no patients who are on Medicare pediatricians. I've already mentioned certain Specialties that for whatever reason have very little Medicare exposure.

39:03

Those if you base it, exclusively on Medicare those providers would have been disadvantaged. So the second phase we believe is going to look more at what your Medicare payments were and then have a formula that will be more reflective of providers who do not have a significant Medicare penetration. And so you can anticipate that if you're an rhc that is in that category more money should be forthcoming.

39:33

We've heard rumors that it could be this week. But you know, this is a very fluid process. We don't know but stay tuned. As soon as we hear we will let you know and you may find it in your account before we even know we'll only know when we start getting calls from people saying hey this money showed up in my account. The typically is going to be identified as HHS payment and it will show up as such in your account. So stay tuned on more.

40:03

With regard to the provider wheelies fun, but there is an additional 70 billion dollars yet to be released from this part.

40:12

The next is the paycheck protection Loan program. I know there are rural health clinics who have received money from this program. Is this a special Loan program that was established just for the covid 19 initiative. It is through the small business administration and it is to provide loans to providers that can be converted to Grants. If you're able to maintain your payroll during the two-month period covered by this program.

40:40

There was an initial 340 49 billion allocated for this fund as I'm sure many of you heard last week the all that money was obligated. And so they were not accepting any more applications. We are expecting that Congress and the White House will come to an agreement this week to put an additional 250 billion dollars into this fund.

41:05

So if you have not received any monies, I would encourage you and you didn't apply and And you think this is something that could be helpful. I would encourage you to apply again these are loans, but they can be converted to Grants. If you maintain your payroll during the two-month time period over which these the payroll Protection Program is intended to cover. So I would go we did a presentation. This was on our previous presentation. I would encourage you to go and pull that information to get more information or go to the SBA.

41:42

Website sba.gov and they have buttons there. You can click on to get more information on this program.

41:51

So in terms of some additional resources, there's the rural Health television guidance that we've been talking about if you want to get that document there is the link to that and then associated with that is an FAQ now this covers a variety of topics, but there are specific questions in their of to rural health clinics the Telehealth benefit and some of the other things that we've talked about here today. You might want to download that document and look at the questions specific to rural health clinic at this point. I'd like to open it up for questions and open up the line for Corinne and Tracy and also Nathan and myself and we'll be happy to try and respond to your questions that you can now put into the chat box.

42:42

Take as many of them as we have time.

Nathan Baugh:

42:47

Alright great. Thank you Bill. And I know there's a serious and fast and they already are some of the go ahead Sandy Steffi who asks do the RAC clinics need to utilize the condition code Dr. And I will open that up to anyone I can take well

Bill Finerfrock:

Corinne you and I had talked a little bit about that. You want to address that or Tracy?

43:13

That the use of the DR code?

Corinne Axelrod:

Yeah, I think that would be a Tracey question. Thank you..

Tracey Mackey:

43:23

Can you hear me?

Nathan Baugh:

43:35

Tracey are you if you're on speaker. You got a really bad Echo.

Tracey Mackey:

43:53

Is that better? That sounds a lot better? Oh, that's better. I had to get out of the webinar. I think there's some epic use out there and what we've said is in doubt, you can put the condition code on the claim. That's mostly for waiver cases for 1135. But unless you fall under that there's no need to use condition code GR.

Nathan Baugh:

44:18

All right. Thank you. Tracey. Next question is from Jane Carly for PPP. So this is a bill question. Did they expand it to governmental or ACS? We are a special district and we were declined due to that we have now reduced hours.

Bill Finerfrock:

44:37

Know the answer to that question is no unfortunately, they have not resolved that problem. We have had conversations with folks in Congress and elsewhere about the idea of lifting that or allowing the SBA to make loans to governmental entities. This is affecting about 17 percent of rural health clinics are municipal. I owned or government-owned.

45:03

I believe it's an even higher percentage of critical access hospitals that are Municipal Leandra government-owned. We're also looking at potentially trying to create a new Loan program a PTP version through the department of agriculture's Grant and Loan program. So Economic Development who has USDA can award loans to municipalities government and government entities. That is a proposal. I don't want people to think it's a guarantee.

45:37

It's Going to go through we don't know but folks are working trying figure out how to allow that go to Health Care Facilities that are owned by municipal or County government that you can have access to those those monies, but unfortunately, we've not been able to get that resolved yet.

Nathan Baugh:

45:57

Thank you. Bill. Next question is probably for Corinne or Tracey. Coleen Nolan asks, what about the GT modifier for critical access Hospital method to billing? Is that relevant or should critical access hospitals use modifier 95?

Tracey Mackey:

46:18

Mm-hmm. Oh, I'm sorry. This is Tracy and commented to should continue to bill with the GT modifier. There are no changes for comment that to Providers billing distance like services.

Nathan Baugh:

46:36

Okay. So even the provider even the real has connects owned by critical access hospitals.

Tracey Mackey:

46:45

If there are billing as an RHC they would use the modifier 95 as you described in your presentation, but if it's tough cause it's too soon for the distant site. They would continue to bill those services with modifier GT. GT is only used for comment.

Nathan Baugh:

47:03

Got it. Thank you. Tracy. Next question is from Ashley. Do we still use modifier CG as well as modifier 95 for Telehealth visits. I'll open that up to Corinne or Tracey.

Tracey Mackey:

47:20

This is Tracey and that is correct. You would continue to use modifier CG with modifier 95 and we are looking to update our FAQ with that information.

Nathan Baugh:

Okay, so that's that's new information right there Tracy. So I just want to really highlight that because we didn't have that in our presentation. But you are saying that you do want modifier CG on all the Telehealth visits claims.

Tracey Mackey:

47:48

Yes, any line that's being paid on an RFP claim must be built with modifier CG. So you would also put nine five on there just indicating that that service was performed via Telehealth.

Nathan Baugh:

48:04

If I might ask the question, then a lot of folks will want to know then if that as Bill mentioned, I think it gave the example of marriage and family therapists.

48:19

Would they also put modifier CG and modifier 95 and be able to bill that or because that is not traditionally a definition of RAC visit if it was done in person and we wouldn't use modifier see G. What is do you see where I'm going with that question?

48:45

Okay, or let me use a different example what a registered nurse so not in Ric practitioner performing A99 201 or nine nine two one one so level one E&M. Would they be able to bill this service as a Telehealth visit and use modifiers CG.

Corinne Axelrod:

Nathan is that if I can just add to that? I think the question is do we use the cg

49:15

modifier for services that are not paid as under the all-inclusive rate methodology. So I think that's basically the question is that right? Yeah.

Nathan Baugh:

Yeah services that if we they were performed without a Telehealth Communication System would not be considered rhc visits and we wouldn't be able to put a CG on let's say a 99201 claim.

49:41

Let's say we throw telehealth out you have a 99201 claim you're not supposed to put CG or that would get rejected because that does not rise to the level of an rhc visit and the old main on the traditional sense. So but for Telehealth.

50:00

If I'm doing an 99201 and can I put modifier 95 and modifier CG and have that be paid?

Tracey Mackey:

50:13

So let me let me clarify the CG with the modifier 95 and I should have explained this better during until the system changes are implemented in July. The CG is needed with the 95 because we will be paying those claims at the are now if it's a service that currently is not paid at the air and we need to do some testing. Unfortunately.

50:37

I don't believe you will be better to build that with the 95 today until the Things are updated in July.

Nathan Baugh:

50:46

Okay. Okay. So that's a little bit different than what we explained.

Corinne Axelrod:

Oh, so I'm sorry. So I think this is a really important question and maybe we will need to just verify it and get back to it. That's okay.

Bill Finerfrock:

Okay, it sounds like it's like there's something we need to follow up with.

Nathan Baugh:

51:11

Yeah, alright. Okay, so we're will have further clarification and of course we will get that out to everyone through all our methods of distribution as soon as we soon as we get that. All right.

51:27

I'm getting a couple of questions there all along that same line there Rebecca asks, we receive communication from fqhc PPS at CMS dot hhs.gov today that stated the originating site cannot be the patient's home. Can you clarify during covid-19 can fqhc RIT furnished just inside Telehealth services to a Medicare patient who is in their home. The patient is in their home.

51:57

Bill, you want to take take that one.

Bill Finerfrock:

52:00

I mean, I don't know what she's reading. But you know, there is no limit on where the patient is where the Telehealth visit and frankly that's assumption is that in many of these cases the patient will be in their home that whether it's for social distancing or other reasons the patient does not or cannot leave their home. So absolutely there is nothing that prevents this from doing it from the patient engaging from their home.

Corinne Axelrod:

52:29

So Bill, this is Corinne it if I could just add to that that there are requirements for the originating site for Telehealth and I am not sure if they have been waived or not under the phe but but my understanding is that typically the patient's home is not an originating site. So why don't we put that on our list to just go back and clarify?

Bill Finerfrock:

All right. Okay, that's fine.

52:56

But actually the one of the Original first Lifting for Telehealth was that it was no longer a requirement that they had to present to a distance site and it expanded to any didn't have to be world could be Urban could be Rural and that the I mean if you want to clarify, but I think it's I think that's already out in an FAQ that that CMS issued early on in this process.

Corinne Axelrod:

53:24

No, you just said distant site, but I think Nathans question was Originating site.

Bill Finerfrock:

You know used to be that originating site had to be World Health clinic or some other recognized sites as part of one of the first things Medicare did when it modified. The Telehealth benefit was they lifted the requirement that the patient had to present from an originating site and that anywhere was an eligible originating site for purposes of a Medicare Telehealth visit.

Tracey Mackey:

53:57

Friends this is Tracy and I do think that's correct. But let us go back and verify that I think you're correct. They made home an originating site and they waive the requirement for it to only be in a rule designated area. I think you are correct, but we should follow up and it may be in a fake you all ready. Yep. Okay, okay.

Nathan Baugh:

54:20

All right. Here's another question. That is a good question is when I had that this is from Nancy Costello. She asked will the recoupment in July be a one-time bill for the number of visits and you know the value or will we receive recoupment for each individual patient on the eobs? How exactly is the recoupment or the remittance going to be executed?

54:49

Do we have those details at this time?

Tracey Mackey:

54:54

This is Tracy Nathan. And I don't think we have those details at this time, and we would probably have to refer them to their Medicare administrative contractor to see how those will be processed.

Nathan Baugh:

55:06

Okay, so we don't know necessarily answer to that yet. Nancy. Next question is from Consuelo. So this can provider be reimbursed with only telephone audio appointment. We have elderly patients stating no internet access no email Etc. I'll go ahead and answer this one the audio. The only way the RHC are able to bill an audio-only service is through G0.

55:35

Zero seven one and your billing the on the fee schedule the G20 one to service, which is a virtual check in its for five minutes of communication with the patient. It can't be a follow-up for anything you've done in person in the last seven days and it cannot lead to them having a visit directly in the clinic within the next 24 hours.

56:02

But if it's initiated by the patient and the Agent calls that talks to the doctor for at least five minutes the pa the MP the RIT practitioner for at least five minutes. That is billable as a g 0 0 7 1 you get paid the twenty four dollars and 76 cents and that is how we can do audio appointments or Audio Only appointments Corrine or Tracy. Do you want to weigh in on that?

Corinne Axelrod:

56:36

That was perfect.

Nathan Baugh:

56:39

Okay.

56:40

Perfect, all right. Next question is from Kim Walters says the Washington Post reports the second phase of relief on payments will be based on total revenue per the IRS governmental RIT and hospital-based rit's attached to go to hospitals. Don't file IRS returns and will be left out of the funding. If this is correct that's news to me. But Bill do you want to take that one on?

Bill Finerfrock:

57:08

Yeah, I have not seen that in the Washington Post. You know, if you want to send the article, I'll go back and look but I haven't seen that I don't I have not seen the methodology. What we've seen is that the next focus is on providers who do not have a substantial Medicare presence because of the way the first Formula was weighted. So I'm happy to take a look at that.

57:37

But I have not seen that and that's not something I've heard.

Nathan Baugh:

Yeah, great and I just want to clarify. I know we're coming up on three will we're going to go well beyond three o'clock as long as we continue to ask questions, which we probably will and get to as many as we can probably go to maybe about 3:30 at the final and point Samantha asks.

58:00

What was the logic behind a \$92 Rai are is almost double This Not That Not only are we hurting for cash, but now we're not being paid to fall and I are well other rit's are getting paid more during this time. If they are is less than ninety two dollars seems like an odd seventh. I'll answer part of that and then I'll turn it over to occur in the reason behind the way that this is the way it is is because that is the way Congress wrote the expansion of distance sighs services for rhc.

58:37

He's into the law as a part of the cares act this they directed CMS very explicitly to create a payment methodology that is based on the averages average payment amount of the physician fee schedule. So that is the reason is Congress. That's the way that they said a lot of but some of the details I'll turn over to Corrine and Tracey.

Corrine Axelrod:

59:07

Thanks, Nathan. And you're exactly right?

59:11

This is the way that the statute was written, which didn't get us a lot of wiggle room and and it's probably the reason why it took us a little while to get the information out to all of you in terms of the rate and the billing because we really, you know, we really understand how difficult the situation is for the rhcs in terms of Providing services to your patients and so we were trying to figure out how we can make this work as favorably as possible for you so we couldn't do much with the rate. But but as Bill said earlier on on on this webinar, we did expand the Telehealth benefit in other ways.

1:00:02

So like other practitioners, who are Working under for the rhc under their state scope of practice any service that's on the physician fee schedule Telehealth list. Another thing that I'm not sure if it was mentioned or not, but there's no frequency limitations. So you can build more than one Telehealth visit a day as long as you meet the requirements to do so, so it's not like you can doing a Telehealth visit and then say, well, let's hang up and I'll call you back and then I'll bill for two.

1:00:36

To know you can't do that. But if you meet the requirements that being medically necessary and you know on a new issue has arisen or whatever you can bill for more than one visit a day. So we've tried to make it as easy as possible. But the payment rate we were pretty limited by the statutory language.

Bill Finerfrock:

1:01:08

I need to weigh in here because I think you know certainly is corrected. The it is the way that the statute was written but the statute was written that way because it is what CMS requested that is what how they said. They wanted. The benefit is what they sent to Congress to say. This is how they wanted it others requested that at that Ric simply be paid including the National Association of rural health clinics your AI.

1:01:35

Our because these visits were largely substituting for visits that would have been in-person visits. And so as the questioner goes out, you know, particularly for those who have an rhc rate that is higher than this \$92. You know, there is it it really is is going to I think going to create some issues. We're happy for the Independence that the rate is higher than the AR.

1:02:01

That's also because the AI are for Independence is artificially low if the a Aii are was where it should be it would be even higher than \$92 a visit. So yes, it is.

1:02:11

Correct that it is a way that Congress wrote the statute the Congress wrote the statute that way because is what the leadership not Karin Tracy but individuals in the leadership at CMS insisted upon when this issue first came out.

Nathan Baugh:

You can look at our website if you want some more on what What went on there we've written some letters on this matter. Next question is from Anna Bennett is FaceTime or Skype considered a Telehealth visit right now since it's technically not a secure portal easy one. Bill, you want to take that.

Bill Finerfrock:

I'm sorry. I didn't hear the can you repeat?

Nathan Baugh:

The question is FaceTime or Skype considered a Telehealth visit right now since it's technically not a secure portal.

Bill Finerfrock:

1:03:05

Yeah, the the issue so the office of civil rights who oversees security and privacy aspects where the HIPAA law said that they will not enforce the privacy and security requirements as it relates to Telehealth. So Skype would be an acceptable platform to use because it's a one-to-one communication and is not publicly facing. I believe FaceTime as well is a one-to-one.

1:03:35

Communication and is not publicly facing there are some Facebook applications or other applications that are more group communication. Those would not be acceptable. But as long as it is one to one and you take

reasonable steps to try and ensure our privacy, there will be no issue. So unless I don't understand FaceTime it would be acceptable as with Skype be acceptable for communication for the ol physics.

Nathan Baugh:

1:04:06

Yeah, Facebook live Instagram live twitch when you're streaming yourself publicly out to the whole world. Those are not ones that you can use but you can use FaceTime and Skype.

1:04:19

Next question is really good question from Rebecca Hayes who says what could what code would a rhc cement in place of nine nine four four one, which is a telephone only 5 to 10 minute visit and I For two and I'm nine nine, four four, two three the answer and I'll go ahead and take a crack at this and then Corinne if you want to follow up rhcs, there is no code that we would submit in place technically these just to give folks background. These are codes that Medicare has not never paid until March 30th.

1:05:06

And on March 30th and an interim final rule on this position c Schedule side are fee-for-service peers Medicare did value these codes and they said we will pay for telephone only and by this we mean Audio Only not a smartphone Audio Only sort of evaluation and Management Services and there's three codes that folks that can build evaluation and management.

1:05:36

holds would be able to Bill and this is all again on the fee schedule side nine nine, four four one, four, four two and four for three that has not technically been included in our G zero zero seven one valuation and sewed up the scope of G 0 0 7 1 however G20 1/2 G 2012 is essentially a five-minute conversation with the patient over the phone. It can be Audio Only and once you get to that five minutes of phone conversation, you can now build a g 0 0 7 1 so it's not technically G zero zero seven one, but essentially the code that you would replace.

1:06:35

Your telephone only visits with is G 0 0 7 1 the only I think that the difference that I can think of between these nine nine four four one that you're referencing is that those don't have the seven-day sort of period where you can only build one time. So you could technically still a nine nine four four one, perhaps two three four days in a row for the G zero zero seven one as I mentioned.

1:07:05

Mentioned one time every seven days. So unless the patient is calling you back frequently. We are able to build G 0 0 7 1 and the final thing I'll note on this is that the evaluations of these codes or pretty low? I think the nine nine four four three, I'm ballparking. This only pays about 43 as Scholars. So even if CMS did add those into the G zero zero seven one.

1:07:35

Evaluation and probably wouldn't change the payment very much. So, you know, it's something that maybe we'll look at in the future, but technically there is no replacement.

1:07:47

However, you can use G zero zero seven one four five minute plus phone audio only conversation because that doesn't qualify as these three, but it does qualify as a g 2012 so I know that was long-winded but Corrine you can or you can opt not to weigh in on this one.

Corinne Axelrod:

1:08:11

No, I think you said thank you.

Nathan Baugh:

1:08:15

Okay.

1:08:17

Alright, hopefully that answered your question. I've gotten that question quite a bit which is why I thought it was a good question. Don Captain asks in regards to the Cs modifier for the coinsurance waiver does covid-19 lab tests need to be ordered during the visit and does the covid-19 tests need to be confirmed as a positive result if they end up negative and with no covid you. Are you all still allowed to use CSS my fire see us?

Bill Finerfrock:

1:08:50

Corinne or Tracy. Did you want to weigh in or I can give you first shot at it?

Corinne Axelrod:

Why don't you start?

Bill Finerfrock:

So the the code or the standard is that it is possible or actual.

1:09:08

So if you go through and you do the evaluation and you believe that whatever information you have from the Patient suggest that that a covid related test is warranted you order that test it's performed as long as the criteria used I think are reasonable in other words.

1:09:32

You're not just every patient that you see your immediately saying, okay regardless, I'm going to order a covid test and therefore get paid a hundred percent, you know regardless of what the Result is if it comes back and says no no covid you had a reasonable belief going into that patient warranted covid testing. Then the Cs modifier would be appropriate so it does not require that the result be covid. It just simply requires that you had a reasonable belief that ordering a test for covid warranted and that E&M visit that led to that conclusion would then be eligible for the Cs modified?

Nathan Baugh:

1:10:19

and Bill if I could add in that's what I posted initially when this policy came out on the forums and I was corrected or just it was pointed out to me in the announcement, which was just a centrally a web page on cms.gov that the use the evaluation and management could be could even not lead to a test and still All the eligible for modifier CS perhaps if there's you know a lack of testing and a readily available and the symptoms are minor but patients suspect that they have covid-19. Even those in atoms are theoretically eligible for CS now.

1:11:09

I will know that you know that I don't think the intent here is to just use CSS on everything and just be like, oh, well, it's just as we suspected that they might have had covid-19. This is not a way to just get a hundred percent of your payment from for Medicare and all cases. However, it does not have to lead to a test now.

Bill Finerfrock:

But I guess what the question was, so that's what I was answering.

Nathan Baugh:

Right right. Sure. Next question from Stacy Woodhouse always still required to report CG. Sorry. We already answered that.

1:11:49

When the answers were going to have more information on CD and whether CG will be also required required with 95. So more to come on that Stacey Deborah asks, you said that paycheck protection loan would be forgiving if you maintain your payroll. Does this mean you cannot furlough some employees?

Bill Finerfrock:

1:12:13

So the requirement you you have some flexibility and you can furlough as long as you re hire. Those are bring those individuals back by the end of the end of June. There are specific requirements that you have to spend 75% of the money on your payroll.

1:12:34

You can temporarily furlough individuals again, as long as you bring them back what they're going to look at is How many employees did you have? When when the when you've got the money through the paycheck protection Loan program? And then how many employees did you have at the end of that time period and was 75% of the money spent on payroll.

1:12:58

So there are some criteria there you can get a partial, you know relief some of it is possible that if all of it is in some of it will be if none of it is if you don't Meet the payroll protection requirements at the end. Then the money would convert to a loan and I would be at a 1% interest rate. You would have a deferral on payments which I believe if I'm recalling correctly as six months, you would not make any payments on that for six months and you would have two years after that to repay that that portion of a loan that was not forgiving so you really have to look at how many people did you employ and its employees not FTE?

1:13:42

So if you have you know, three full-time and three part-time they count is six employee you have six employees at the start and at the end you have six employees, then you and 75 percent of the money that you took was sent on payroll should be fine. If you start with 6 and you are and in June you have end of June you have four then you are going to be subject to some level of repayment. And if you have not spent 75 percent on payroll.

1:14:12

All you would be subject to repayment again. I don't have the details in front of me. So but that's generally the way it will work again. I would encourage you to go to the SBA website. They have very detailed fa Q's that go into all of that that would answer those questions and probably better than I am just going over my memory.

Nathan Baugh:

1:14:35

All right, great Jill elstree asks, I'm going to shorthand this a little bit drill. Is there any consideration to increase the reimbursement for virtual check-in and digitally visits our G zero zero seven one, and she makes the case for increased reimbursement there. Well, I'll let Corinne answer.

Corinne Axelrod:

1:15:04

What you know we but we just doubled the reimbursement for go7 one. So because we added the additional codes the formula is based on what's paid under the fee schedule. So, you know, we don't just kind of make up these numbers. So unless the payment changes Under The Physician fee schedule, then it's not going to change under for G0071

1:15:33

One unless we change the codes that are included in G0071..

Nathan Baugh:

1:15:41

And and I'll just note that there is some Congressional movement to Value Audio Only Services higher or have them be considered true Telehealth visits, but that is again something that Congress would have to move on to in order to give CMS the authority to increase reimbursement significantly for those Audio Only sir.

Bill Finerfrock:

1:16:11

Assess and and we and we engage with some faith in Pompeii. We've engaged with some folks in Congress on that point. I think one of the things that we've tried to remind them of is cell service and internet service in rural areas is often very spotty, which means that you know engaging in a video communication with a patient in many rural communities can be very difficult.

1:16:38

And so that is an impediment to To having that type of Adele help visit so Nathan's right? We are engaging Congress. We are pushing the idea that telephone only particularly in areas where there is not good cell service or Internet service would be able to engage in a telephone only visit as a Telehealth visit but that will require an act of Congress CMS does not have the authority that we see right now to do that on its own but who knows maybe a lawyer away?

1:17:11

Up tomorrow and go you know what? I think we can do that. So we'll see.

Nathan Baugh:

Alright. Next question is from Brandon Weeding. He says if we waive coinsurance for non covid-19, testing RH sees as a so presumably only the ones that he's doing from for through Telehealth.

1:17:33

But if we waive the if they opt to waive the coinsurance, can we add that to our Medicare bad debt immediately?

Bill Finerfrock:

I don't know the answer that question and rather than then trying to give my own opinion. Let us do a little bit of research and get back to you on that Corinne or Tracey has that ever come up in conversations.

1:17:59

You've been a part of?

Corinne Axelrod:

Not for me.

Nathan Baugh:

1:18:09

Alright, next question is from Stacy Brown does digitally visits particular pertain to telephone only the digitally visit the nine nine four two one through three codes are largely in reference to online patient portal communication. So text and typing it out.

1:18:35

However, I do believe in one of the interim final rules. They clarified that let's say the patient initiated the conversation through the patient portal and then maybe the doctor responded and then the patient called back in and decided. Okay. I don't want to respond via email. I want to call back in then the time that the patient calls back in is considered a part of that digital.

1:19:05

Either that so they're not the telephone only Services the G 2012 service can be telephone only but the digitally visits largely are in reference to going back and forth through the patient portal at least that's where it starts and it can shift some sort of email text to audio on the phone. But largely that's designed around that the patient portal.

1:19:35

You all right. Next question.

Bill Finerfrock:

Let me hold on initiation. If a patient has a scheduled visit in the rhc and contacts the office and says hey, you know, I know it's supposed to come in on Wednesday.

1:20:05

A clock but I'm really not comfortable doing that and the practice says well, would you prefer to we could arrange it to be a Telehealth visit since you're uncomfortable coming in? Does that qualify as patient initiated in other words?

1:20:25

What what is the threshold who's in terms of who says I want to do this does the patient have to say I want to have a They Telehealth visit in order for it to be patient initiated versus what we had you scheduled for an in-person visit, but if you'd like we can convert that to a Telehealth with that still meet the patient initiated because the patient had called or there was supposed to be an in-person visit. Do you have any insight on that that you could could add or elaborate?

Corinne Axelrod:

So, this is Corinne and I'm not sure that I've seen any any CMS.

1:21:05

Information that sort of went into great detail about that. I think the concern was not to have practitioners just calling up patients and saying hey how you doing and then billing for that but let me go back and see if on the physician fee schedule side if they have elaborated a little bit more on that whole concept of patient initiated, but I don't I don't recall seeing anything that went into that level of detail.

Bill Finerfrock:

and that was the I had neither and I agree.

1:21:35

That you know what they didn't want was this Dialing for patient's kind of scenario for the provider. But you know that there's this kind of you know, what is this line of what constitutes initiated versus like I said, well we were supposed to have a visit patient doesn't come on a come in and we offer them and Telehealth is that still meet the patient initiate it requirements?

Nathan Baugh:

1:22:02

Okay. Well Bill. Can you clarify Telehealth visits do do not need to be patient initiated what our act

Bill Finerfrock:

yeah, that's true the the Telehealth but if you wanted to do it I should have you're right I should have said if you wanted to call the patient and stead of a Telehealth is Telehealth doesn't have to be patient initiated but the the virtual check in and said well, you know virtually.

1:22:31

Checking on the digitally visit. How about if I call you then? Does that meet the standard?

Nathan Baugh:

Right? All right, good. Okay. So next question is a good one. I as well. I've seen this one before it's not necessary color, but it's very relevant right now. And it's from Jesse Siegel is he says can patients be seen in the parking lot as a billable RIT service outside the four walls of the rhc clinic.

Bill Finerfrock:

1:23:00

Oh, I don't know. I don't know if this was it was posted on the Forum and actually current and I were talking about this before the call began crane. You want to kind of tell me what your what Your what your comment was?

Corinne Axelrod:

Yeah. So the location is any issues related to location are overseen by our survey and certification folks who

1:23:29

Unfortunately not on this call today, but I did check with them if they have responded to this question before and so because I think that they've gotten it but so far there's been no public response to it. I would just say that it's if it's okay with them in terms of the space is certified RIT space. There's no issues from the payment side as long as the Serbian certification side of the house.

1:23:59

Says that it's okay. I just would remind people that bill for a visit. It has to be medically necessary with a rhc practitioners. So it's not like somebody can just stick their head in the car and say oh, yeah, you know blah blah blah that it does have to be like a real visit whether it can be in the parking lot or not.

1:24:24

We're going to try to find that out for sure, but and let you As soon as possible and I don't know if anybody if Tracy you have anything to add or Bill or Nathan, but I guess we don't have an exact answer for you right now. But those are some of the considerations and hopefully we'll get that back and answer back to Bill and Nathan very soon.

Nathan Baugh:

1:24:49

Great. Next question is a good one as well. I think it's from Lindsey Thompson. She wants to know can we hold our Telehealth visit claims until July 1st to avoid the whole recruitment process.

Tracey Mackey:

That is an excellent question. Yes, you have a year for timely filing. So as long as those claims are filed before which is a year of the date of service. You certainly can.

1:25:19

Those until July 1 until the system changes are updated.

Nathan Baugh:

1:25:24

All right. Great. Thanks Tracey got about well, they'll do you want to go past 3:30 or um,

Bill Finerfrock:

I think the be respectful of certainly Karin and Tracy we can we can let them go if okay. I can sound a little bit longer if I can I just say Sir some folks. Who were was it for purposes of the certified rural Health Clinic professional. This webinar does count towards meeting your educational.

1:25:54

Requirements however, because of the way that we handled registration for this call, there is no need for a code. So if you are already see rhcp, you'll be because of the registration you will be credited with participating in this call for purposes of meeting your requirements there. There's nothing additional you need to do.

1:26:17

So great Tracy and all right Karin if you know, thank you for being on you're certainly welcome to stay on if you'd like, but we want to be respectful of your time for being here. We want to thank you for being here to answer questions and really, you know, I think amplifies some of the things and Enlighten us on some of the things that are going here. We appreciate all that you're you do. I also want to take the opportunity.

1:26:46

I know some of You have been at rural Health Clinic conferences know that this past year. We recognize Korean because T is going to be retiring and my understanding is that that date is sooner rather than later and so on behalf of the rural health clinics Community again. I want to thank you Karin for everything that you've done for rit's over the years. You've been a great Advocate at one level and you've been a real friend of rural health clinics you've been available. You've made yourself.

1:27:17

If accessible and we want to thank you for everything you've done and wish you well as you and your husband go off and enjoy some well-deserved and well-earned time together as you embark on the next phase of your life.

Corinne Axelrod:

Well, that's really nice Bill. Thank you so much.

1:27:35

And it really has been I have felt very fortunate to be able to work with our agencies over all these years and the timing of my retirement is a little weird because who knew that we were going Of this pandemic, but you know, once the paperwork is in there, it goes that Ship Sails and so 10 more days. I retire the end of this month, but I really want to thank you for letting me be a part of what you do and working with me and with you and it's really been great. Hopefully, we'll all get through this covid stuff with our health and sanity not entirely sure about that second part the sanity part.

1:28:18

But thank you everybody and and thank you for having us on this call today as well

Bill Finerfrock:

And Tracy thank you for what you do and I didn't mean to I wasn't trying to overlook you because my understanding is you're going to work with our ABCs for another 40 years. So we've got plenty of time to thank you for all the things you'll do with rural health clinics. I'm sure

Tracey Mackey:

no thank you to you and Nathan for putting this together. It's a pleasure to be here and we will miss Korean so I do not feel overlooked.

1:28:47

Q thank you.

Bill Finerfrock:

Alright. Well, we'll stay on Nathan. I'll stay on and take a few more questions if folks want and try and help people out here

Nathan Baugh:

great. Thank you. Thank you for being as well. I want to get in my thanks in there as well as thanks to current and Tracy for everything. Alright diving back into the questions.

1:29:12

The next one is a bit of a tricky one Ruth and Grimes asks how do we handle crossover claims with our local Medicaid? I'm presuming she's talking about crossover Telehealth claims. Bill Do you have any insight initially on this?

Bill Finerfrock:

No, I've not seen anything on crossover claims the a good question.

1:29:44

Oh, yeah, and it's going to be Complicated by What Medicare is paying versus what they're going to do if you have when they adjust the clean, so it is a good question because we're going to look into to see how that'll be handled.

Nathan Baugh:

1:29:57

Yeah, so no answer, but we will look into it. Sorry Ruth. Next question is from Chelsea rust who asked can't Medicare be built for LCSW Telehealth Services since they'll see has W is RIT practitioner in yes. Absolutely. They can they can be billed through Telehealth. There's a bulge it I think we'll ever know.

Bill Finerfrock:

1:30:27

Be clear. So LCSW, as long as their Masters trained, right? They have to have a master's degree. In order to be Medicare recognized. Typically. There are in some states. What would be a licensed clinical social worker who may not have a master's degree. They may have a bachelor's degree.

1:30:45

For example under the Telehealth benefit any health care practitioner who is acting within the scope of practice of their state law is eligible to engage on a Telehealth visit as for Rural health clinic. So a bachelor's craned LCSW would be eligible to provide a service and the rhc could build for it as a Telehealth visit and get paid for it, even though they would not normally be recognized as an LCSW because they did not have that Masters degree.

Nathan Baugh:

But Bill I have to push back a little bit. I think that's the main thing that we just discovered. We really do need.

1:31:27

clarification on because if it's if it's not if you couldn't bill for it as an rhc visit in person Then it's but you were not clear. If you're eligible. You put CG on the Telehealth claim and modifier and go ahead

Bill Finerfrock:

The problem with the example you gave was a 99211 or 9 1 whatever the level one. Yeah, okay that is never recognized as an RHC visit because it does not rise to the level of being.

1:32:09

A Service, it is medically necessary and otherwise recognized in the example we're talking about here is it is a service. We still have to be a service that is recognized. So let's say it's a mental health code it is a service that would have been recognized and paid for has an rhc visit if provided by a psychologist PhD or Masters trained LCSW, but is now being provided by a faster strain LCSW if they need that code.

1:32:39

Reading requirement that you know level 2 level 3 whatever that may be then it is billable even though it's provided by the an individual who would not otherwise have been recognized. So the issue isn't the professional who's performing it. It's meeting the level that is required to be considered a medically necessary visit. That's what is not clear. It needs to be clarified.

Nathan Baugh:

1:33:06

Okay, but it still would you put a CG on that claim or not?

Bill Finerfrock:

1:33:10

I think that's Well, if I if it is if it is a service that would have otherwise been paid as a rural Health Clinic visit, but for the fact that it was performed by an individual who did not meet the recognized professional credential for that service. Then I would put the CG modifier on it and it would be paid.

1:33:33

I don't believe there's anything that would be in an RN scope of practice as a licensed RN that would rise to the level of a billable visit in a rural health clinic setting

Nathan Baugh:

okay, I think maybe I'm misunderstanding. So I apologize there but we will certainly need to get more information as when did you see G what did not you see G so we apologize for not having explicit Clarity on that.

1:34:07

Heidi asks, how do we bill for the RN or LPN providing services to homebound individuals they'll do you want to take that I believe there's a Revenue code right before the the home.

Bill Finerfrock:

Yeah, I believe there is a Revenue code for that. However, I don't know the answer that question, you know, we historically providing Home Health Services is not something that I've encountered.

1:34:37

Lot in the years that I've worked with. Rhcs, so I don't know how much it has occurred in the past and I don't know a lot about billing. I think the important thing here is the there is greater flexibility in terms of what constitutes a home health shortage area in the past.

1:34:55

There's been a lot of confusion over what constitutes a home health shortage area in that I think is why a lot of times billing for that has not rarely occurred the fact that they have Difficult Lee expanded what would constitute a home health shortage areas, essentially mirror the rhc service area opens that up, but I simply don't know enough about how to bill. That's one of the things we're going to have to look into and get back to folks.

Nathan Baugh:

1:35:23

Yeah, okay. Sorry Tracy still on sorry.

1:35:33

Okay. All right. We build you want to do hard stock? 345?

Bill Finerfrock:

Yes, that's fine.

Nathan Baugh:

Okay. All right, we're going to do we're going to go to 345. These questions were all sent in at 244 exactly. We haven't even got to the 245 questions. So obviously we're not getting through all of them.

1:35:56

So as always Contact information on the screen. No, it's well are no go. Do you have our emails on the first screen? You want to throw that up? All right step out on the grass.

1:36:17

Can you more than one time per seven days if you are addressing a diagnosis now, that's a good question Stephanie I had I had expressed that you could do that and I've put in the previous webinar and the QA that came out since then was very explicit that you've already built one time every 7 Days even if it's a different diagnosis that might be one of those ones that I think we need more explicit clarification on until we get something that says, okay different diagnoses you can go ahead.

1:36:58

Do it again within seven days till we get that wouldn't do it, but it's one of those that we might be able to get clarified that yes, if it's a different diagnosis, you can build you zero zero seven one in the within the 7-Day period. So again, that's a that's a tricky one.

1:37:22

A couple of people have less. I'm not going to read their questions. Again. This is another question about the GT modifier.

1:37:33

Who are the clients Julie Wiegand asked will the claims have CG modifier also, so 3cg 95 again. We need more clarification exactly on all the ccgs and went and when do you use those? When not to use those? All me saying is when do we expect that? The Medicaid provider relief payment will come Bill you want to tackle that.

Bill Finerfrock:

1:38:02

Yeah, I mean we've heard rumors that it could come out this week. We you know official word is soon we keep checking in but hopefully soon I know that it's something that's very important. There's a lot of providers who are really in need of those Grant dollars in order to help keep their doors open. We're encouraging CMS to release that as soon as possible but short of saying rumors are this week.

1:38:31

I just don't know anything else. And again, those are rumors. Hopefully whoever cited The Washington Post. Yeah, send that to us so we can take a look at it. I don't recall seeing that in an online story and I get a subscription at home. I don't recall seeing it this morning before I left but it's possible. There was something that I missed send that to us.

Nathan Baugh:

1:38:55

Great brand asked a good question. Brian Harrison. Are we able to have nursing home visits and the answer is definitely yes, you you would bill for those like you would belie normal nursing home visit which I believe is a different different Revenue code. Am I correct on that bill?

Bill Finerfrock:

1:39:18

Yes, it's a different Revenue code I don't know what else? I'm a head. But there's a Revenue code for the right.

Nathan Baugh:

1:39:24

Right, right.

1:39:25

It's it brings up questions in my mind about when you convert over to G20 25 after July 1 how that's going to work with our nursing home visits that are furnished via Telehealth because I think I believe that the Revenue code, you know, might be the way to indicate that the service was the, you know, build or what Provided to a patient in a nursing home. But Bill are they are there CPT codes specifically for nursing home visits or is it just the Revenue code?

Bill Finerfrock:

No, I believe there are nursing home visit codes. But but at the same time, I'm not CPT codes. But yeah, I'm not sure why it necessarily matters. In other words if they're going to pay the same amount regardless, and there is no good.

1:40:24

Action or limit on site of service and

Nathan Baugh:

isn't it to certify that the patient?

1:40:33

isn't it to certify that the patient, you know needs to remain in the nursing home isn't there some

Bill Finerfrock:

well, there are medically necessary service is different than certification for the need to be there or meeting the monthly requirements for ensuring you know that the patient continues to be Are you have to have a you know eat, I believe it's every 30 days you're supposed to go in and really see the patient and then you have interest in the interim medically necessary visits that can occur

Nathan Baugh:

right and dollars and certainly the certification.

1:41:16

I know as you know can be done through Telehealth for the for the covid period as well as those ad hoc medically necessary visits that are outside of that certification process, so Again, you know, I'm not sure if G2025 is going to be allow you to do that certification, but maybe something that will get again clarified. I'm scrolling past a bunch of repeat questions.

1:41:51

Debbie asks on the advanced payments can they pay those back before with holds begin? So, you know basically before July 1 start paying back their the money that they've their overpayment. I don't think that the Medicare will be that sophisticated. But it maybe they do Bill any thoughts on that.

Bill Finerfrock:

1:42:18

Are we talking about wait we gotta Youyou brought in an issue that was not part of the question that if I heard the question correctly the patient is asking about advance and can you repeat the question?

Nathan Baugh:

Okay sure that I should have clarified. We have the advanced accelerated payment program which is if she's talking about that. It's different. I assumed it was the overpayments for the Telehealth visits.

Bill Finerfrock:

1:42:53

I am not I have not seen anything with how you would be able to pay that back prior to the recruitment process beginning a hundred twenty days after because these are handled through the max. I would encourage you to reach out to your Mac.

1:43:21

And express to them that you may be interested in paying back and accelerated payment prior to them commencing the recruitment that is would occur automatically a hundred twenty days and inquire of them. Can you do it and if so, how do you do it?

1:43:39

I would my mind believe that you could but I've not seen anything to say how you would do that or indicate whether you can I think your max should be able to help you with that.

Nathan Baugh:

1:43:54

All right. Okay, so we'll go to our last question which is from again. This was received at 2:45. So obviously we're not getting through bulk of questions. So feel free to contact us after and we'll try to do our best to put information out. But Amanda asks, can you talk about the coinsurance being waived again? Do we just waive at the time of visit or not? Even build the patient?

1:44:22

What about the deductible?

1:44:25

Bill you want to take that.

Bill Finerfrock:

Well, there are two different issues. One is the voluntary waving versus the mandatory wait. So if it is covid related care, then the the coinsurance and the deductible are waived or covid related care.

1:44:49

And that is where you use the Cs modifier to indicate to your contractor that this was covid covid related either you suspected or it was actual covid related care for non covid related care. The decision to waive is voluntary and that would presumably occur at the time at which the services provided you as it were.

1:45:19

Clinic would make that determination as to whether or not you want to waive the coinsurance for that care if you waive the deductible and that just means you're not going to get paid if you're waiving the coinsurance for that visit, then you're not going to collect it for that visit.

1:45:40

I think there are some specific faQ's that we can try and provide to you to go into more detail, right but The so you just make a distinction between the mandatory where Medicare is going to pay you 100 percent versus the voluntary where you're only going to get paid the 80% of whatever you're aIR or your your Telehealth rate would happen to be for non covid related care.

Nathan Baugh:

All right. Okay guys, well, we appreciate it.

1:46:13

So we did not get to most questions, but we're going to go ahead and end this I'd like to Thank everyone on stage call the office of rural Health policy for the rural Health Clinic technical assistant series again, please encourage others who may be interested to register for the only technical assistance series to do so we welcome you to email us with your thoughts and suggestions for future topics at this is building though. BF@narhc.org.

1:46:46

Again, that's a b as in Bill Finerfrock Or f as incentive Rock BF at Nara c.org and be sure to put our RHC TA topic in the email subject line. We're going to be scheduling the next RHC technical assistance call sometime in the next month or two and notice were sent out by email to all those go ahead

Bill Finerfrock:

Or sooner depending upon need.

1:47:13

I mean if information comes and we think there's a need we will go ahead and schedule when When we built feel there's enough information to share or report.

Nathan Baugh:

Okay. Alright with that. We're going to thank everyone for their participation that concludes today's call.