Elevate: COVID-19 Lunch-n-Learn

March 25, 2020

Questions and Answers

1. **Can FQHC's bill telephone visits as well as other platforms like Life Size or Zoom?**

   Providers can bill for Virtual Communication Services (VCS) that use technology (e.g., phone, Zoom, email, text) to provide evaluation and interpretation in response to a communication/request initiated by a patient. Patient must have had a billable visit within the previous year. Services must exceed five minutes in duration for condition(s) NOT related to a visit in the past seven days and that does not result in an appointment in the next 24 hours or next available appointment. VCS must be performed by an authorized CMS/Medicare provider. Coinsurance applies. See NACHC's *Reimbursement Tips: FQHC Requirements for CMS VCS* (available on the Elevate platform) for more details.

   Under the Coronavirus Preparedness and Response Supplemental Appropriations (CARES) Act and Section 1135 waiver authority, the Centers for Medicare and Medicaid Services (CMS) broadened access to Medicare telehealth services and added provisions specific to health centers. NACHC is working to clarify guidance related to FQHC CMS/Medicare telehealth requirements and will provide additional guidance soon.

   The Health and Human Services (HHS) Office for Civil Rights (OCR) relaxed HIPAA rules for health care providers that serve patients in good faith through everyday communication technologies such as FaceTime or Skype. https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.

2. **Can telehealth (virtual visit) be used for an initiating visit for CMS/Medicare care management visits?**

   Yes, telehealth visits are a substitution for an in-person visit and can be used in place of a face-to-face visit.

3. **What about patient consent for telephone or virtual visits? Is a verbal consent sufficient?**

   For CMS/Medicare Care Management Services and Virtual Communication Services, consent may be verbal or written and must be documented in the medical record.

4. **If a patient calls and wants to speak to a provider, does the provider need to first state that it will be a billable visit?**

   Patient consent (verbal or written) is required to bill for VCS. Coinsurance applies. Providers who intend to bill for these services (see *Reimbursement Tips: VCS* for more details on requirements), must inform the patient that coinsurance applies and obtain informed consent.

5. **Does private insurance or Medicaid pay FQHC's for chronic care management (CCM)?**

   For private payors you will need to check your contracts. For Medicaid, reach out to your State Primary Care Association.

6. **Any suggestions about practical ways to track time?**
   Many EHRs, particularly the care management modules, have the capability to track time. One health center on the call noted they are using TimeDoc. As a short-term, no cost solution, care teams could explore posting a tracking tool in a shared document where staff could enter time spent on CCM services. NACHC welcomes ideas and suggestions that can be shared with health centers.

7. **Has there been any talks or implementation of reimbursement for CHWs and/or support staff for those that are part of care management or patient outreach?**

   Community health workers (CHWs) and other support staff can provide services under general supervision of the billing practitioner (provides overall direction and control but physical presence is not required in the room) subject to state law, licensure, and scope of practice definitions. Services provided by auxiliary staff count toward time thresholds to bill for services.

8. **G2012 can this be used for nurse triage line reimbursement and medication refill?**

   VCS (G2010/G2012) must be performed by an authorized CMS/Medicare provider. Nurses, health educators, or other clinical staff that provide similar services should not report this service under the provider's billing number as incident-to/direct supervision.

9. **Comment from participant: In Ohio if you are part of Comprehensive primary care under Medicaid you are not able to bill CCM**.

   As the rules and regulations for each state vary, health centers need to contact their State Medicaid offices for guidance regarding Medicaid billing.

10. **If a person has been in contact with someone that tested positive, can that person remain at work and if so what precautions?**
    See CDC's Healthcare Personnel with Potential Exposure Guidance.

11. **Is there a NACHC charge for FQHCs to participate in the ELEVATE program?**
    No. There is no fee to health centers, PCAs, HCCNs, or NCAs to participate in Elevate.