MEDICARE FEE-FOR-SERVICE

BACK TO DOOR 2

Telehealth Services for FQHCs and RHCs

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) have unique billing and payment processes for telehealth services under Medicare. The Centers for Medicare and Medicaid Services (CMS) have established specific guidelines that these entities must follow to ensure compliance and proper reimbursement when providing telehealth services.

Consent for Telehealth Services

Before billing for telehealth services, FQHCs and RHCs must obtain patient consent, which can be either verbal or written. This consent should inform the patient of any cost-sharing responsibilities, such as potential deductible and coinsurance amounts. Consent can be obtained at the time the service is provided and must be documented in the patient's medical record. This ensures that the patient is fully informed and agrees to receive telehealth services under Medicare guidelines.

Sources: Critical Access Hospital Telehealth Guide, CMS Telehealth Services Fact Sheet

Supervision Requirements

For telehealth services, general supervision by the billing practitioner is typically required. This means that auxiliary personnel, who may be employees, independent contractors, or leased employees, can obtain patient consent and perform other necessary tasks under the general supervision of the practitioner. The supervising practitioner must be available through real-time audio and video communication to provide immediate assistance if needed, but does not need to be physically present.

Source: CMS Telehealth Services Fact Sheet

The California Telehealth Resource Center (CTRC) and all resources and activities produced or supported by the CTRC are made possible by grant number U1UTH42520-01-01 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS. This information or content and conclusions are those of the CTRC and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

Co-Pay

For telehealth services billed under Medicare Part B, patients are responsible for a 20% co-payment after meeting the deductible. This applies to FQHCs and RHCs as well, and the co-payment for telehealth services is consistent with in-person visits. It's important to note that while most FQHC services aren't subject to a deductible, the facility fee for the originating site is not considered an FQHC service and, therefore, the deductible must be applied.

Sources: Telehealth Insurance Coverage (medicare.gov), Federal Telehealth Laws (Center for Connected Health Policy)

Originating Site

FQHCs and RHCs are authorized to act as originating sites for telehealth services provided to Medicare beneficiaries. These facilities can receive reimbursement for the originating site fee using HCPCS code Q3014. Through December 31, 2024, geographic and location restrictions have been lifted, allowing patients to receive telehealth services from any location without the need for the originating site to be in a specific rural or underserved area.

Sources: Critical Access Hospital Telehealth Guide, CMS Telehealth List of Services, CMS MLN006397 FQHC

Distant Site

FQHCs and RHCs are also authorized to act as distant site providers for telehealth services through December 31, 2024. This allows them to bill Medicare for telehealth services provided remotely. Practitioners working for these facilities can deliver telehealth services from any distant site location, including their own homes, as long as they are performing their duties for the FQHC or RHC. Additionally, mental health visits can be provided using either audio-video or audio-only technology, with the same billing and payment structure as in-person visits.

Sources: CMS Telehealth Services Fact Sheet, CMS Mental Health Visits via Telecommunications

The California Telehealth Resource Center (CTRC) and all resources and activities produced or supported by the CTRC are made possible by grant number U1UTH42520-01-01 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS. This information or content and conclusions are those of the CTRC and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

Coverage, Coding, and Reimbursement

FQHCs and RHCs can bill Medicare for any service that has been approved for telehealth delivery through December 31, 2024. This includes services provided to patients in their homes and virtual communication services, such as online digital evaluations and management tasks initiated by patients through secure patient portals. While virtual communication services are covered, they are reimbursed at a different rate since they are not classified as telehealth services by CMS.

Source: Telehealth Billing for Safety Net Providers

Modifiers

When billing for telehealth services, FQHCs and RHCs must use the appropriate modifiers:

- Modifier 95: For audio-video telehealth visits.
- Modifier FQ or 93: For audio-only telehealth visits.

These modifiers should be included on claims to indicate the type of telecommunication technology used during the visit. For example, a mental health visit might be billed with Revenue Code 0900, HCPCS Code 90834 (or another qualifying code), and the appropriate modifier (95, FQ, or 93) along with CG.

Source: CMS Mental Health Visits via Telecommunications

In-Person Mental Health Visit Requirements

For patients receiving mental health services via telecommunications at home, an in-person visit is required within six months before the initial telehealth visit and at least every 12 months thereafter. However, this in-person requirement has been delayed until January 1, 2025, allowing FQHCs and RHCs to continue providing these services without the in-person visit for the time being.

Source: CMS Mental Health Visits via Telecommunications

The California Telehealth Resource Center (CTRC) and all resources and activities produced or supported by the CTRC are made possible by grant number U1UTH42520-01-01 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS. This information or content and conclusions are those of the CTRC and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

Digital Health Modifiers

For Medicare Fee for Service and other programs' digital health claims, which includes FQHCs and RHCs, the chart below shows the modifiers that should be used in the following situations:

Table 1: Medicare FQHC/RHC Digital Health Modifiers

Modifier	Definition
G0 (zero)	Used to identify telehealth services furnished for purposes of diagnosis, evaluation or treatment of symptoms of an acute stroke.
GQ	Asynchronous Telehealth service.
GT	Critical Access Hospital Distant Site providers billing under CAH Optional Method II. Must be on an institutional claim.
GY	Used to report that an Advanced Beneficiary Notice (ABN) was not issued because item or service is statutorily excluded or does not meet definition of any Medicare benefit. (Note: only to be used when the patient is not at an eligible originating site.)
FR	Supervising practitioner present through two-way audio and video communication.
FQ	Telehealth service furnished using real-time audio only communication.*
UD	Telehealth service furnished using real-time audio only communication. (Arizona Medicaid only).
93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system.*
95	Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system.

*While FQ and 93 may appear to be the same, CMS clarified in the 2023 Medicare Physician Fee Schedule (MPFS)16, that 93 is to be used for mental health claims: Additionally, effective on and after January 1, 2023, CPT modifier "93" can be appended to claim lines, as appropriate, for services furnished using audio-only communications technology in accordance with our regulation at § 410.78(a) (3).

All providers, including RHCs, FQHCs, and OTPs must append Medicare modifier "FQ" (Medicare telehealth service was furnished using audio-only communication technology) for allowable audio-only services furnished in those settings. However, consistent with our proposal for audio-only services furnished under

The California Telehealth Resource Center (CTRC) and all resources and activities produced or supported by the CTRC are made possible by grant number U1UTH42520-01-01 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS. This information or content and conclusions are those of the CTRC and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

the PFS, we are also finalizing to require all providers including RHCs, FQHCs, and OTPs to use modifier "93" when billing for eligible mental health services furnished via audio-only telecommunications technology. Providers have the option to use the "FQ" or the 93" modifiers or both where appropriate and true, since they are identical in meaning.

Table 2. Medicare FQHCs/RHCs Coverage Requirements, Codes, and Payment Amounts

Focus Area	CPT/ HCPCS Codes	Modifiers	Coverage Requirements	Reimbursement Amount
FQHCs and RHCs can provide and bill for telehealth services furnished to patients in their homes or other locations within the United States.	G2025	95 (audio-video) 93 Audio-only	Payment for a telehealth distant site service furnished by a rural health clinic (rhc) or federally qualified health center (fqhc) only. Includes audio-video or audio-only. (Unable to bill if services start from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.) G2025 - HCPCS Code for Dis site tele svcs rhc/fqhc	$95.27 Billing Medicare as a safety-net provider | Telehealth.HHS.gov
Mental Health	G0470	95 (audio-video) FQ or 93 (audio-only)	FQHC only	

The California Telehealth Resource Center (CTRC) and all resources and activities produced or supported by the CTRC are made possible by grant number U1UTH42520-01-01 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS. This information or content and conclusions are those of the CTRC and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

Focus Area	CPT/ HCPCS Codes	Modifiers	Coverage Requirements	Reimbursement Amount
Mental Health	90834 (or other qualifying mental health visit payment code)	95 (audio-video) FQ or 93 (audio-only)	**Psychotherapy** for RHC or FQHC. Federally qualified health center (FQHC) visit, mental health, established patient; a medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit Regulations Open Doors for Telehealth Services in FQHCs - AAPC Knowledge Center	

The California Telehealth Resource Center (CTRC) and all resources and activities produced or supported by the CTRC are made possible by grant number U1UTH42520-01-01 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS. This information or content and conclusions are those of the CTRC and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.