Indiana Medicaid and Medicare Telehealth Reimbursement for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

Indiana Medicaid Reimbursement for FQHCs and RHCs

Subject to the following criteria, reimbursement is available to FQHCs and RHCs when they are serving as either the hub site or the spoke site for telemedicine services:

- When serving as the hub site (the location of the physician or provider rendering services), the service provided at the FQHC or RHC must meet both the requirements of a valid encounter and an approved telemedicine service as defined in the IHCP's telemedicine policy.
- When serving as the spoke site (the location where the patient is physically located), an FQHC or RHC may be reimbursed if it is medically necessary for a medical professional to be with the member, and the service provided includes all components of a valid encounter code.

Pursuant to the Code of Federal Regulations (42 CFR 405.2463), an encounter is defined by the Centers for Medicare & Medicaid Services (CMS) as a face-to-face visit (either in person or via telemedicine) between an IHCP member and a qualifying practitioner at an FQHC, RHC, or other qualifying, nonhospital setting.

All FQHC and RHC facilities are required to submit fee-for-service claims for valid medical encounters to the IHCP on the professional claim (CMS-1500 claim form, Portal professional claim, or 837P transaction) using HCPCS encounter code T1015.

All components of the service must be provided and documented, and the documentation must demonstrate medical necessity. All documentation is subject to post-payment review.

Separate reimbursement for merely serving as the spoke site is not available to FQHCs and RHCs. Neither the originating site facility fee, as billed by HCPCS code Q3014, nor the facility-specific PPS rate is available, because the requirement of a valid encounter is not met. Pursuant to the Code of Federal Regulations 42 CFR 405.2463, an encounter is defined by the Centers for Medicare & Medicaid Services (CMS) as a face-to-face meeting between an eligible provider and a Medicaid member during which a medically necessary service is performed. Consistent with federal regulations, for an FQHC or RHC to receive reimbursement for services, including those for telemedicine, the criteria of a valid encounter must be met.

FQHC and RHC providers are reminded that their facility-specific PPS rate, which is calculated based on an FQHC's or RHC's operating costs, is an all-inclusive enhanced rate that covers any ancillary services that are not billable as valid encounters. FQHC and RHC providers may request an increase in their facility-specific PPS rate when the scope of services changes.

FQHCs and RHCs may submit telemedicine claims to a member's MCE and receive reconciliation review through Myers & Stauffer, which, in coordination with the Family and Social Services Administration (FSSA), determines billable and non-billable services.

Source:
https://www.in.gov/medicaid/files/federally%20qualified%20health%20centers%20and%20rural%20health%20clinics.pdf

Medicare Telemedicine Reimbursement FQHCs and RHCs:

FQHCs and RHCs may serve as an originating site for telehealth services, which is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. FQHCs and RHCs that serve as an originating site for telehealth services are paid an originating site facility fee.

Although FQHC services are not subject to the Medicare deductible, the deductible must be applied when a FQHC bills for the telehealth originating site facility fee, since this is not considered a FQHC service.

RHCs and FQHCs are not authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner at the time the telehealth service is furnished, and may not bill or include the cost of a visit on the cost report. This includes telehealth services that are furnished by a RHC or FQHC practitioner who is employed by or under contract with the RHC or FQHC, or a non-RHC or FQHC practitioner furnishing services through a direct or indirect contract. For more information on Medicare telehealth services, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, and Pub. 100-04, Medicare Claims Processing Manual, chapter 12.

Sources:

https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10843.pdf

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

CARES Act Telemedicine Reimbursement FQHCs and RHCs:

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was signed into law. Section 3704 of the CARES Act authorizes RHCs and FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. RHCs and FQHCs with this capability can immediately provide and be paid for telehealth services to patients covered by Medicare for the duration of the COVID-19 PHE.

Distant site telehealth services can be furnished by any health care practitioner working for the RHC or the FQHC within their scope of practice. Practitioners can furnish distant site telehealth services from any location, including their home, during the time that they are working for the RHC or FQHC, and can furnish any telehealth service that is approved as a distant site telehealth service under the Physician Fee Schedule (PFS). A list of these services can be found here: *https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes*. Payment to RHCs and FQHCs for distant site telehealth services is set at $92.

For additional information on payment, billing, and claims processing, see *https://www.cms.gov/files/document/se20016.pdf (PDF)*

Source: *https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center*

IHCP Issues Telemedicine Billing Guidance for Providers During COVID-19 Outbreak

March 19, 2020
http://provider.indianamedicaid.com/ihcp/Bulletins/BT202022.pdf

Effective March 1, 2020, and through the duration of the Governor's Declaration of Public Health Emergency for Coronavirus Disease 2019 Outbreak, Indiana Health Coverage Programs (IHCP)-enrolled providers may use the following billing guidance for providing services through telemedicine. This policy applies to both in-state and out-of-state providers and all IHCP-covered services, with some exceptions for services that require physical interaction. This policy includes both Traditional Medicaid (fee-for-service) as well as all managed care benefit programs. All services rendered must be within the provider's applicable licensure and scope of practice.

Additional Indiana Health Coverage Programs Bulletins from IHCP:

July 9, 2020
IHCP COVID-19 Response: IHCP provides update on telemedicine policy
http://provider.indianamedicaid.com/ihcp/Bulletins/BT202086.pdf
June 11, 2020
IHCP COVID-19 Response: COVID-19 policy FAQs as of June 11, 2020
http://provider.indianamedicaid.com/ihcp/Bulletins/BT202071.pdf
April 21, 2020
IHCP COVID-19 Response: Telemedicine FAQs as of April 21
http://provider.indianamedicaid.com/ihcp/Bulletins/BT202049.pdf
April 8, 2020
IHCP COVID-19 Response: IHCP revises home health prior authorization and telemedicine policies
http://provider.indianamedicaid.com/ihcp/Bulletins/BT202040.pdf
April 2, 2020
IHCP COVID-19 Response: IHCP responds to telemedicine FAQs as of April 1, 2020
http://provider.indianamedicaid.com/ihcp/Bulletins/BT202034.pdf

Frequently Asked Questions (FAQs):

1) **Since, the Indiana Medicaid reimbursement and Medicare reimbursement for telemedicine services contradict each other; do federal or state laws take precedence if they conflict?**

   Federal law provides states with flexibility to design their own coverage/reimbursement options for telehealth in their Medicaid programs, under the condition that these options "must satisfy federal requirements of efficiency, economy and quality of care." The states submit their plans for telehealth coverage/reimbursement to the federal government for review and approval through the state plan amendment process. More information on this process is available through the *Medicaid.gov page on telehealth*

2) **Does the guideline in Chapter 13 manual at CMS website only pertain to Medicaid and Medicare or it also included private payers?**

   The information in the *Chapter 13 Benefit Manual* applies only to Medicare. Medicaid and private insurers may have telehealth coverage/reimbursement policies that differ from Medicare, with significant authority over Medicaid and private insurers residing at the state-level.

3) **What documentation is required for telemedicine visits?**

   Patient consent for receiving a service through telemedicine and the location of the patient should both be documented. Patient consent may be received verbally or by electronic signature, and should be documented as such. Uploading the visit documents with the claim is not required.

4) **Do technologies need to be HIPAA compliant?**

Health Insurance Portability and Accountability Act (HIPAA) federal guidance has been waived during this public health emergency. For additional information, see the *FAQs on Telehealth and HIPAA during the COVID-19 nationwide public health emergency* at hhs.gov. We ask that providers take steps to protect confidential information to the best of their abilities.

5) **What type of technology can be used for telemedicine?**

Any technology that allows for real-time interactive communication between the patient and provider is acceptable. This can be done either in a video format or in audio-only communication. Services provided via email and text message formats are not reimbursable.

6) **What is the specific guidance for federally qualified health centers (FQHCs) and rural health clinics (RHCs) when billing telemedicine?**

When acting as the distant site:

- If billing FFS, bill the T1015 code with the appropriate place of service (POS) code (11, 12, 31, 32, 50, or 72). T1015 is not needed when billing claims to managed care entities.
- Bill procedure codes for the services rendered.
  - If the procedure code is on the existing Telemedicine Services Codes (accessible from the *Codes Sets* page at in.gov/Medicaid/providers), bill POS 02 and modifier 95 on the claim details.
  - If the procedure code is not on the existing Telemedicine Services Codes, bill the most appropriate place of service for where the member is located. It is strongly encouraged to also bill the GT modifier on the claim details.

It is still required that at least one service provided must meet the definition of a valid encounter. If the claim has no valid encounter procedure codes on the claim, it will deny.

When acting as the originating site, follow the instructions in the *Telemedicine and Telehealth Services* provider reference module. No changes have been made to this guidance when acting as the originating site.

Sources:

https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center

http://provider.indianamedicaid.com/ihcp/Bulletins/BT202034.pdf