

Apple Health (Medicaid) behavioral health policy and billing during the COVID-19 pandemic (FAQ)

Effective 7/1/2021

In this time of the COVID-19 pandemic, HCA is aware that usual and customary ways of providing and billing/reporting Apple Health (Medicaid) services may not be feasible. It is also understood that different providers will have different capabilities. Therefore, in the interest of public health, HCA is trying to be as flexible as possible and is creating new policies that will allow providers to provide medically necessary services and bill or report the encounter with the most appropriate code you determine applicable using the guidance below.

This FAQ reinforces HCA’s current policies regarding telemedicine as defined in WAC 182-531-1730 and covers new telehealth policies that will only be in effect during this health care crisis. We will update this FAQ as necessary to respond to new information as it develops. This FAQ is not applicable to involuntary treatment act (ITA) evaluations by designated crisis responders (DCRs).

The FAQ below was developed after new information was released Friday, March 20, by the Centers for Medicare & Medicaid Services (CMS) in an all-state call about the use of telehealth in Medicaid. Note: Medicaid is not subject to the same policies as Medicare.

FAQ Table of Contents

General questions	2
PART I:	2
<i>Questions specifically for a BH provider who is reporting a “higher acuity” encounter using Service Encounter Reporting Instructions (SERI)</i>	
PART II:	4
<i>Questions specifically for a BH provider who is providing and billing for BH services under the Fee for Service program as described in the “Mental Health Guide, Part II: High Acuity Services”</i>	
PART III:	5
<i>Questions specifically for a BH provider who is providing and billing for “lower-acuity” BH services under the FFS “Mental Health Guide, Part I: Services for clients enrolled in an integrated managed care plan or BHSO”; or as covered by the physical health care benefit administered by a Medicaid managed care organization.</i>	
PART IV:	6
<i>BH questions applicable to all services rendered under PART I - III above</i>	
PART V:	8
<i>New services covered during this crisis to support providing care to clients.</i>	
PART VI:	10
<i>Information specific to federally qualified health centers (FQHCs), rural health clinics (RHCs), and Tribal Facilities (Direct IHS Clinics, Tribal Clinics and Tribal FQHCs)</i>	

Frequently Asked Questions

General questions

Q: Is there any more information regarding telemedicine and telehealth that I can review?

A: Yes, You will find more information in the [Apple Health \(Medicaid\) telemedicine and telehealth brief for COVID-19](#) and [Apple Health \(Medicaid\) telehealth policy recorded webinar](#).

Q: What are the requirements for providing services via telemedicine/telehealth to a Washington State Apple Health (Medicaid) client residing in Washington?

A: You must be licensed in Washington State to bill for telemedicine or telehealth services. Out-of-state practitioners can apply to be emergency volunteer health practitioners and register to practice in Washington state, or apply for Washington State licensure that may result in a temporary practice permit. Service(s) must be rendered consistent with the scope of professional licensure or certification. Please see [Washington State Department of Health website](#) for further information and details related to each option. This rule does not pertain to providers in a Direct IHS Clinic, Tribal Clinic or Tribal FQHC as those providers may be licensed in any state per Federal law.

If the Washington Apple Health (Medicaid) client is receiving services outside of Washington State by a Washington State provider, the provider must follow the applicable laws of the state in which the client is located.

Q: If I have a primary care provider in my Behavioral Health (BH) clinic, can they collect the specimen for COVID-19 testing?

A: Yes, if you have medical provider rendering physical health services in a bidirectional clinical model that provider can collect the specimen. If the office visit was conducted and being billed as an office-based evaluation and management (E&M), payment is included in the E&M.

PART I: Questions specifically for a BH provider who is reporting a “higher acuity” encounter using Service Encounter Reporting Instructions (SERI)

Q: What modes of technology can I use to provide outpatient BH services to my patients?

A: Under the circumstances, Medicaid is covering a variety of technology modalities in lieu of in person visits to support evaluation, assessment and treatment of clients. These modalities include: telemedicine for HIPAA compliant, interactive, real-time audio and video telecommunications, which is already covered; and other forms of telehealth, such as online digital exchange through a patient portal; and telephone calls. Texting and email may also be used, but only for virtual check-ins using the HCPCS code G2012. (See Part V for how to bill for texting or email) These technologies can be used for all modalities described in SERI, except those described below or Involuntary Treatment Act (ITA) evaluations.

Q: How do I bill for outpatient BH services if I am using telemedicine to conduct the visit?

A: Consistent with the Instructions on page 127 of [SERI](#), report the service modality code (CPT or HCPC code) from SERI as you would if the encounter was in-person. During this crisis, you can provide any modality in SERI using telemedicine (HIPAA-compliant real-time video chat), even if SERI does not include the GT modifier in the modality narrative, except as described below. Always document the modality used for delivery of the care in the health care record.

- If your Electronic Health Record (EHR) allows you to report the encounter as described in SERI, using the GT modifier and the 02 place of service (POS) code, do so.

- If your EHR doesn't allow you to use both the GT modifier and POS 02 code, and you cannot get your EHR modified timely to support billing in this way, you may report the service modality code (CPT or HCPC code) from SERI using:
 - just the GT modifier, or the POS 02; or
 - neither, if one or the other is not an option.

Q: How will I be paid for a service rendered using telemedicine?

A: HCA policy is to pay for these services equivalent to the payment for the CPT or HCPC code billed if the service was conducted in-person. HCA-contracted MCOs should also follow this policy.*

Q: How do I bill if I am using audio-only/telephone to conduct the outpatient BH encounter?

A: HCA is aware that there are instances when telemedicine, as described above, is not feasible and providers need to use other methods to provide care.¹ In this case, Apple Health is temporarily allowing BH services using audio only/ telephone to conduct a visit when doing so in-person or with telemedicine (HIPAA-compliant real-time video chat) is not an option. Report the service modality code (CPT or HCPC code) from SERI as you would if the encounter was in-person. During this crisis, you can provide any modality in SERI using a telephone, except as described below. Always document the modality used for delivery in the health care record.

- If your Electronic Health Record (EHR) allows you to report the encounter as described in SERI, using the CR modifier and the POS indicator that best describes where the client is, e.g. 12 is home; 31 is skilled nursing facility, 13 is assisted living facility, do so.
- If your EHR doesn't allow you to use both the CR modifier and the POS code (examples 12, 31 13), and you cannot get your EHR modified timely to support billing in this way, you may report the service modality code (CPT or HCPC code) from SERI using:
 - just the CR modifier, or the client's POS e.g. 12, 31, etc.; or
 - neither, if one or the other is not an option.

Q: How will I be paid for a service rendered using another type of telehealth technology?

A: HCA policy is to pay for these services equivalent to the payment for the CPT or HCPC code billed as if the service was conducted in-person.

Q. What if I start an appointment with a client via telemedicine (audio-visual HIPAA compliant modality) and there is a technical issue that isn't able to be resolved and I complete the appointment via audio-only/telephone?

If the majority of the appointment was provided via telemedicine then bill according to telemedicine instructions found in the [SERI encounter guide](#).

Q: Are there any outpatient BH services in SERI that can't or shouldn't be delivered using one of these technologies?

A: Yes, some outpatient modalities in SERI may not be appropriate for using one of these technologies, for example Day Support or Mental Health Clubhouse services. The delivery of these services as described in SERI does not lend itself to a telemedicine/telehealth delivery model. The milieu in which these services are

¹ The provider is quarantined at home, the clinic is closed, the client lives remotely and doesn't have access to the internet or the internet does not support HIPPA compliance, or the circumstances require the provider to utilize a different technology modality to provide behavior health services.

rendered are essential to the modality as described in SERI. In these situations, provide care, but provide the service using a different modality; maybe use Group Therapy or Individual Treatment Therapy to meet the client's needs. Report the appropriate code under one of these modalities and follow the instructions above applicable to the technology used. Document in the health care record the service and how service(s) are rendered.

Q: What about reporting residential BH services delivered using one of these technologies?

A: Residential services cannot be reported as a service delivered through telemedicine or telehealth. However, the professional services rendered can be provided to the admitted person using one of these technologies. In this case, you should just report the encounter as described in SERI, as the professional services are included in the per diem code and not reported separately. Document how the services were rendered in the health care record.

PART II: Questions specifically for a BH provider who is providing and billing for BH services under the Fee for Service program as described in the “Mental Health Guide, Part II: High Acuity Services”

Q: What technology modalities can I use to provide outpatient BH services to persons covered under this program?

A: Under the circumstances, Medicaid is covering a variety of technology modalities in lieu of in person visits to support evaluation, assessment and treatment of clients. These modalities include: telemedicine for HIPAA compliant, interactive, real-time audio and video telecommunications, which is already covered; and other forms of telehealth, such as on-line digital exchange through a patient portal; and telephone calls. Texting and email may also be used, but only for virtual check-ins using the HCPCS code G2012. (See Part V for how to bill for texting or email for Virtual Check-In)

Q: How do I bill for outpatient BH services if I am using telemedicine to conduct the visit?

A: Report the service modality/procedure code (CPT or HCPC code) from the [Mental Health Guide](#), Part II: High Acuity Services that best represents the service rendered. Please see HCA's [telemedicine/telehealth brief](#) for how to prepare claims using the correct POS and modifiers. Always document the modality used for the delivery of care in the health care record.

- If your EHR doesn't allow you to prepare the claim as instructed at this link, then just add the POS 02, if that is an option.
- If complying with this guidance is not an option and you cannot get your EHR modified timely to support billing in this way, report the service modality code (CPT or HCPC code) from the Mental Health Guide, Part II: High Acuity Services only and be sure to document the mode of delivery in the health record.
- Remember to also follow any specific billing instructions in this section of the Mental Health Guide, including billing with the TG modifier, as directed.

Q. What if I start an appointment with a client via telemedicine (audio-visual HIPAA compliant modality) and there is a technical issue that isn't able to be resolved and I complete the appointment via audio-only/telephone?

If the majority of the appointment was provided via telemedicine then bill according to telemedicine billing instructions found in the FFS Mental Health Guide, Part II: High Acuity Services .

Q: How will I be paid for services rendered using telemedicine?

A: HCA policy is to pay for these services equivalent to the payment for the CPT/HCPC code billed if the service was conducted in-person.

Q: How do I bill if I am using audio only / the telephone to conduct the outpatient BH encounter?

A: HCA is aware that there are instances when telemedicine is not feasible and providers need to use other methods to provide care.¹ In this case, Apple Health is temporarily allowing BH services using a telephone to conduct a visit. Report the service modality code (CPT or HCPC code) from the Mental Health Guide, Part II: High Acuity Services as you would if the encounter was in-person. During this crisis, you can provide any modality in the Mental Health Guide, Part II: High Acuity Services using the telephone, except as described below. Always document the modality used for delivery of the service in the health care record.

- If your Electronic Health Record (EHR) allows you to report the CR modifier and the place of service indicator that best describes where the client is, e.g. POS 12-home; 31-skilled nursing facility, or 13-assisted living facility, do so.
- If your EHR doesn't allow you to use this modifier and POS codes, and you cannot get your EHR modified timely to support billing in this way, report the service modality code (CPT or HCPC code) from the Mental Health Guide, Part II: High Acuity Services only.
- Remember to also follow any specific billing instructions in this section of the billing guide, including billing with the TG modifier, as directed.

Q: How will I be paid for a service rendered using telemedicine or audio-only telehealth?

A: HCA policy is to pay for these services equivalent to the payment for the CPT/HCPC code billed if it were conducted in-person

Q: Are there any outpatient BH services in the Mental Health Guide, Part II: High Acuity Services that can't or shouldn't be reported using one of these technologies?

A: Yes, some current outpatient modalities in the Mental Health Guide, Part II: High Acuity Services may not be appropriate for using one of these technologies, for example Day Support services. The delivery of these services doesn't lend itself to a telemedicine/telehealth delivery model. The milieu in which these services are rendered are essential to the modality. In these situations, provide care, but provide the service using a different modality; maybe use Group Therapy or Individual Treatment Therapy to meet the client's needs. Report the appropriate code under one of these modalities and follow the instructions above applicable to the technology used. Document in the health care record how services are rendered. Remember to also follow any specific billing instructions in this section of the billing guide, including billing with the TG modifier, as directed.

Q: What about reporting residential BH services delivered using one of these technologies?

A: Residential services cannot be reported as a services delivered through telemedicine or telehealth. However, the professional services rendered can be provided to the admitted person using one of these technologies. In this case, you should just report the encounter as in the Mental Health Guide, Part II: High Acuity Services, as the professional services are included in the per diem code and not reported separately. Document how the services are rendered in the health care record. Remember to also follow any specific billing instructions in this section of the billing guide, including billing with modifier TG, as directed.

PART III: Questions specifically for a BH provider who is providing and billing for "lower-acuity" BH services under the fee-for-service Mental Health Guide, Part I: Services for clients enrolled in an integrated managed care plan or BHSO; or as covered by the physical health care benefit administered by a Medicaid managed care organization.

Q: What technology modalities can I use to provide outpatient BH services to persons covered under this program?

A: Under the circumstances, Medicaid is covering a variety of technology modalities in lieu of in person visits to support evaluation, assessment and treatment of clients. These modalities include: telemedicine for HIPAA compliant, interactive, real-time audio and video telecommunications, which is already covered; and other forms of telehealth, such as on-line digital exchange through a patient portal; and telephone calls.

Texting or email may also be used, only for virtual check-ins using the HCPCS code G2012. (See Part V for how to bill for texting or email for Virtual Check-In).

Q: How do I bill for outpatient services if I am using telemedicine to conduct the visit?

A: Report the service modality/procedure code (CPT or HCPC code) from the Mental Health Guide, Part I: Services for clients enrolled in an integrated managed care plan or BHSO that best represents the service rendered. Please see HCA's [telemedicine/telehealth brief](#) for how to prepare claims using the correct POS and modifiers. Always document the service(s) rendered and the modality used for the delivery of care in the health care record. HCA-contracted MCOs also pay for telemedicine.*

Q: How will I be paid for a service rendered using telemedicine?

A: HCA policy is to pay for these services equivalent to the payment for the CPT/HCPC code billed if it were conducted in-person. HCA-contracted MCOs should also follow this policy*

Q: How do I bill if I am using audio only / the telephone to conduct the outpatient BH encounter

A: HCA is aware that there are instances when telemedicine is not feasible and providers need to use other methods to provide care.¹ In this case, Apple Health is temporarily allowing BH services using a telephone to conduct an office visit. Report the service modality code (CPT or HCPC code) from the Mental Health Guide Part I: Services for clients enrolled in an integrated managed care plan or BHSO, as you would if the encounter was in person. During this crisis, you can provide any modality in the Mental Health Guide, Part I: Services for clients enrolled in an integrated managed care plan or BHSO using audio only telehealth, except as described below. Always document the modality used for delivery in the health care record.

- If your Electronic Health Record (EHR) allows you to report the CR modifier and the POS indicator that best describes where the client is, e.g. 12- home; 31-skilled nursing facility, 13- assisted living facility, do so.
- If your EHR doesn't allow you to use this modifier and POS codes, and you cannot get your EHR modified timely to support billing in this way, report the service modality code (CPT or HCPC code) from the Mental Health Guide, Part I: Services for clients enrolled in an integrated managed care plan or BHSO, only.

HCA-contracted MCOs are also following this policy.*

Q: How will I be paid for a service rendered using audio-only telehealth?

A: HCA's policy is to pay for these services equivalent to the payment for the CPT/HCPC code billed if it were conducted in-person.

PART IV: Questions applicable to all services rendered under PART I - III above

Q: What if I am to receive the non-facility rate for the in-person service?

A: Bill the procedure/modality code (CPT/HCPC code) that denotes the service rendered (including E/M codes) with POS 02 (telemedicine). In addition, add modifier 95. The MCO will follow this policy as well.*

Q: Can an Outpatient Hospital facility bill for the originating site facility fee associated with telemedicine (as defined above and billed with the POS 02) when the client is at home?

A: Yes, when the Outpatient Hospital staff is providing administrative and clinical support to a client who is at home and receiving services via telemedicine from a provider associated with that facility. To receive payment for the originating site facility fee when using telemedicine, providers must bill only HCPCS code Q3014 with modifier CR. Do not bill HCPCS code G0463 for the same date of service. [See the COVID- 19 fee schedule](#). HCA's contracted MCOs will follow this policy as well.*

Q: Are you following Medicare's guidance and allowing the provider to select the E&M code level based just on the MDM, OR on either the MDM or time, with time defined as all of the time associated with

the E/M on the day of the encounter? Is Medicaid removing any requirements regarding documentation of history and/or physical exam in the medical record?

A: Yes, Apple Health (Medicaid) is allowing the provider to code the E&M based on this CMS guidance. Yes, Medicaid is removing requirements regarding documentation of the history and/or physical exam in the medical record when providing services via telemedicine or telehealth. HCA's contracted MCO's will also follow this policy*.

Q: How do I comply with the face-to-face requirements for BH services as required in the Department of Health's Chapter 246 WACs?

A: During the COVID 19 crisis, this requirement is waived by the Department of Health for all BH services for which this was required. This includes PACT team and WISE services. See <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/BHAWaiver.pdf> for details. HCA-contracted MCOs will also follow this policy.*

Q: How do I provide SUD services using these telemedicine/telehealth technologies and be compliant with 42 CFR part 2?

A: SAMHSA provided guidance on this issue. See [COVID-19 Public Health Emergency Response and 42 CFR Part 2 Guidance](#). Since there are providers asserting this publication is not clear about the release of information without written consent and meeting the specifications for a HIPAA compliant release of information per this CFR, HCA is seeking additional clarification from SAMHSA. HCA encourages providers to use email and scan, the mail, or electronic signature functionality to obtain written consent for the release of records.

Q: Do I need to take any measures to inform the client about video interface technologies that may not be HIPAA compliant, such as Skype or Facetime?

A: Yes, clients must be informed when using a non-HIPAA compliant video interface technology. Using the mail to obtain written consent is an option, or use of an electronic signature. As the next option, consent to participate using these technologies can also be verbal, but the information provided and the verbal consent must be documented and dated. Once in-person visits are resumed, the client must sign a consent form that is communicating in writing that the client provided consent to use a platform that could not protect their personal health information. Webinars to provide assistance in using telehealth/telemedicine to provide behavior health services are available on [HCA's COVID-19 information page](#).

Please note that allowances for video interface platforms that are not HIPAA-compliant (e.g. Facetime, Skype) expire on July 1st, 2021.

Q: If I am making the call from my house to the client that is at home, what POS do I use?

A: Place of Service (POS) *is where the client receives the behavior health service*. For example, if the client is at home or any place the client deems home, use POS 12. HCA-contracted MCOs will also follow this policy.*

Q: SERI (and the MH State Plan) state services provided by individuals without a Master's Degree must be provided under the supervision of a Mental Health Professional (MHP), how do we comply with this when services are provided through telemedicine/telehealth and practitioners are working remotely?

A: To provide these Medicaid services, providers must submit a plan to HCA describing how they will implement and operationalize clinical supervision of all staff with less than a Master's Degree in a behavioral health field. This plan must be sufficiently detailed to address when and how staff will receive clinical supervision. Submit the plan to the HCA/DBHR COVID mailbox: HCADBHRBHCVID19@hca.wa.gov with the Subject line: "Supervision Plan". HCA/DBHR staff will review the plans and may require follow-up details, if needed. Providers will be notified when their plans have been approved. When plans are approved, the approval will be retroactive to the date of submission.

Q: Can behavioral health providers continue to provide Medicaid Peer Services to individuals experiencing mental illness or substance use disorders?

A: Yes. Peer services will still need to be ordered on the treatment plan. All Peer Services must be provided under the supervision of an appropriately credentialed senior practitioner. For Peers working with individuals with substance use disorders, supervision must be provided by a licensed Substance Use Disorder Professional (SUDP). For Peers working with individuals with a mental illness supervision must be provided by a Master’s Level clinician who meets the MHP definition in the state Medicaid plan. Provider agencies must submit a clinical supervision plan to HCA describing how they will implement and operationalize clinical supervision of all staff with less than a Master’s Degree in a behavioral health field. This plan must be sufficiently detailed to address when and how staff will receive clinical supervision. Submit the plan to the HCA/DBHR COVID mailbox: HCADBHRBHCVID19@hca.wa.gov with the Subject line: “Supervision Plan”. HCA/DBHR staff will review the plans and may require follow-up details, if needed. Providers will be notified when their plans have been approved. When plans are approved, the approval will be retroactive to the date of submission.

Q: How do I provide professional services in the hospital setting?

A: FFS AND MCOs will pay for telemedicine/telehealth for professional services in the inpatient settings. Bill the services using the appropriate inpatient hospital CPT E&M or consult code(s).

If conducted using telemedicine, please see HCA’s [brief on telehealth services](#)

Please also see the [COVID-19 clinical policy for billing FAQ](#) for guidance in this setting.

Q: How do I bill for telemedicine to provide professional services within the same inpatient facility?

A: During this time, HCA wants Apple Health providers to be able to use telemedicine services to provide patient care even if it is within the same facility. When providing telemedicine services within the facility, do not submit a claim for the originating site. HCA-contracted MCOs will also follow this policy.*

Q: What if I am providing telemedicine or telehealth services outside of Monday - Friday 8-5 office hours?

A: The following codes are available as add-on codes for services provided via telemedicine/telehealth Monday-Friday between 5pm to 8 am; on weekends or holidays. Effective 4/24/2020.

CPT® Code	Short Description	Modifier
99050	Medical services after hrs	CR
99051	MED SERV EVE/WKEND/HOLIDAY	CR

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[See COVID-19 fee schedule for Fee for Service rates.](#) *HCA’s contracted managed care organizations (MCOs) will follow this policy.

PART V: New services covered during this pandemic to support providing care to clients.

Q: What other codes are available for reporting BH services delivered through these new covered technologies?

A: Below is a matrix of codes that can also be used in the rare situation that using an CPT/HCPC BH visit or procedure code(s) as described in PART I-III above isn't applicable to the care scenario.

For CPT® codes 99441-99443, to support access to care, Medicaid allows these telephone codes to:

- be used by any physician or other qualified provider, as defined by the policies under each benefit described in PART I-III above, to conduct a telephone call with the client; not just those who can report an E&M, as described in the official code definition.
- be provider-initiated telephone calls.

The following codes are available. Please see the [COVID-19 fee schedule for rates](#).

CPT® Code	Short Description
99441	PHONE E/M PHYS/QHP 5-10 MIN
99442	PHONE E/M PHYS/QHP 11-20 MIN
99443	PHONE E/M PHYS/QHP 21-30 MIN
99421	OL DIG E/M SVC 5-10 MIN
99422	OL DIG E/M SVC 11-20 MIN
99423	OL DIG E/M SVC 21+ MIN

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Q: How do I bill these modalities?

A: Bill the CPT code provided using the CR modifier (catastrophe/disaster) modifier at the line level.

Q: What do I need to know to use the online digital E&M code?

A: The online digital E&M service via a patient portal must be HIPPA compliant per coding rules.

Q: What if I am trying to serve a new client, the codes listed above are for established patients?

A: Apple Health is allowing use of CPT® codes 99441-99443, and 99421-99423 for new or established patients during this pandemic.

Q: What will I be paid for providing services using these modalities in the chart above?

A: If billing for a FFS covered client, bill with the CR modifier. You will be paid the corresponding E&M encounter rate.

[See COVID-19 Fee schedule](#)

HCA-contracted MCOs will also follo this policy. However depending on your contract and if it is paid at a capitated rate, or another non-fee for service methodology, their payment policy may not be the same.

Q: Medicare has given guidance to use HCPCS code G2012, is Apple Health covering that code?

A: Yes. This HCPCS code is covered and must be billed with modifier CR. Apple Health (Medicaid) considers texting and email a virtual check-in. If billing for texting to complete a telehealth visit with a client, bill HCPCS code G2012for payment of this service.

To support access to care, Medicaid allows this procedure code to be used by any physician or other qualified provider, as defined by the policies under each benefit described in PART I-III, to conduct a brief communication or participate in a texting exchange with the client. It is not just those who can report an E&M, as described in the official code definition. HCA-contracted MCOs will also follow this policy*.

HCPCS Code	Description
G2012	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

Q: What if I need to consult with another provider over the phone regarding treatment of my patient?

A: CPT® code 99446 is already a covered code and must be billed with modifier CR. [See Physician-related/professional services fee schedule](#). HCA-contracted MCOs will also follow this policy.*

PART VI: Information specific to federally qualified health centers (FQHCs), rural health clinics (RHCs), and Tribal Facilities (Direct IHS Clinics, Tribal Clinics and Tribal FQHCs)

Q: What behavior health services described above are encounter eligible for federally qualified health centers (FQHCs), rural health clinics (RHCs), and Tribal Facilities (Direct IHS Clinics, Tribal Clinics and Tribal FQHCs)

A: Any CPT/HCPC code as if it were conducted in-person and CPT® codes 99441-43, 99421-23, or HCPCS code G2012 should be billed with modifier CR.

Fee For Service (FFS) Claims:

As with all FFS encounter eligible claims, the above listed CPT codes should be billed directly to ProviderOne with HCPCS code T1015.

Managed Care Claims:

Encounter billers (FQHCs, RHCs, and Tribes) should bill HCA-contracted MCOs using these codes for Apple Health managed care clients. For all FQHCs and those RHCs who reconcile directly with HCA, these claims will be included in the annual reconciliation.

For those RHCs who receive the full encounter rate, MCOs will ensure these clinics receive their full encounter rate for the above listed services. As with all encounter eligible services, RHCs are required to bill HCPCS code T1015 in addition the above listed CPT codes in order to get the full encounter rate through MCOs.

For Tribal Facilities (Direct IHS Clinics, Tribal Clinics, and Tribal FQHCs) – the MCO payment of the encounter rate is scheduled to begin on 04/01/2020 (AI/AN clients) and 07/01/2020 (non-AI/AN clients). Until MCO payment of the encounter rate begins – the balance of the encounter rate may be billed to ProviderOne for encounterable services.

Q: Are FQHC's or RHC's eligible to be an originating site?

A: Yes, both FQHCs and RHCs are approved originating sites. Apple Health (Medicaid) pays an originating site facility fee only for services provided via telemedicine. HCA-contracted MCOs are also adopting these policies.*