Center for Connected Health Policy

Billing for Telehealth Encounters

AN INTRODUCTORY GUIDE ON MEDICARE FEE-FOR-SERVICE

March 2022

INTRODUCTION

The COVID-19 Public Health Emergency (PHE) was declared on January 31, 2020 and extensions of the PHE every 90 days[1] have continued, leaving the temporary telehealth policy, coding and billing guidelines issued by the Center for Medicare and Medicaid Services (CMS) to continue to guide clinical safety, services and reimbursement. This situation continues as this billing guide is being written. As such, certain permanent telehealth policies that have been put into place due to legislation like the Consolidated Appropriations Act (passed in December 2020) or administrative policy changes made by CMS for 2022, are not in effect as long as the PHE is still active. With the PHE continuing at this time, CMS has also been slower to put out guidance on these newer policies which has continued to leave certain aspects of how they are to be interpreted unclear. Additionally, the recently passed 2022 federal budget bill contained language that would extend some of the temporary telehealth policy waivers in Medicare 151 days after the end of the PHE. This guide will attempt to provide as much clarity as possible, but as CMS has not issued more explicit guidance on some of these new changes as of March 1, 2022, available information is limited.

As it did last year, the Center for Connected Health Policy (CCHP) is providing this informational billing guide to assist those who have questions regarding telehealth billing. The guide is primarily about Medicare fee-for-service billing as policies vary from state-to-state for Medicaid and commercial payers. The purpose of the guide is to clarify:

- telehealth billing and reimbursement
- current legislation dictating billing requirements
- requirements applicable during calendar year 2022 (in a non-PHE environment)
- the requirements relevant only during the periods of PHE extensions

TOPICS COVERED IN THIS DOCUMENT

With that in mind, this guide is meant not only for those who are new to Medicare telehealth billing, but for intermediate and veteran telehealth providers and staff who may find this guide useful: to validate, challenge and perhaps inspire taking on services that seem initially too confusing to tackle. The guide's secondary purpose is to separate what CMS terms "telehealth"[2] and what tele-modalities are "Communication Technology Based Services (CTBS)" or virtual care. Knowing the difference can assist you in making choices for short- and long-term practice planning as policies differ.

The guide will outline the permanent Medicare policy and call-out boxes will highlight temporary expansions in place during the PHE (See Color Guide for Boxes). As each state's Medicaid telehealth reimbursement policies vary, Cal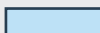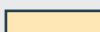ifornia is being used for the Medicaid example, and these tips should assist in researching your own state's Medicaid policies. Please note, at the time this guide is being written, proposals have been made that could impact California's Medicaid policies although the temporary telehealth COVID waivers in the program will remain in effect until December 31, 2022. As with all policies listed in this guide, changes can be made at any time. Therefore, it is suggested that you check the CCHP website for any updated information such as your own state Medicaid telehealth policies, www.cchpca.org.

The focus of this guide is on Medicare "Fee for Service" (FFS)[3]. The guide will not delve into specifics about commercial plans, although it is important to know that some follow CMS' policies. Managed care plans, private payers and employer-based plans may also follow CMS' rules but be sure to check with the plan. Payment is not guaranteed for every visit, whether due to frequency limitations, diagnosis code or extent of coverage afforded by the plan. (For more detailed information on California government and commercial billing, please visit the California Telehealth Resource Center's website at www.caltrc.org.) Finally, please know that this CCHP resource is only provided as a guide and should not be considered legal advice nor a guarantee of reimbursement.

Color Guide for Boxes

- ■ Medicare PHE/Federal
- ■ Medicare Permanent
- ■ Medicaid/California
- ■ General billing tips
- ■ Reminders

Part 1: Understanding the Terminology

It is useful to understand some of the terms that are used in telehealth reimbursement as they will impact the potential for receiving payment. Note that definitions can vary from jurisdiction-to-jurisdiction. Medicare may have a specific definition for one term, but your state Medicaid program may have another and you may have to modify your claims, whether billed via the CMS 1500 (professional fee claim form), or the UB-04 (facility fee claim form) based on the payer.

2) Center for Medicare and Medicaid Services, MLN Booklet: Telehealth Services, June 2021. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf.
3) HealthCare.Gov, "Fee for Service," https://www.healthcare.gov/glossary/fee-for-service/.

BILLING FOR TELEHEALTH ENCOUNTERS
An Introductory Guide on Medicare Fee-for-Service

CCHP

ORIGINATING SITE

The originating site is where the patient is located when the telehealth encounter takes place. In Medicare, it is limited both geographically and by the specific site a patient is located in at the time of the telehealth interaction (home, doctor's office, school, etc.). Under the usual Medicare policy, the beneficiary must be located in:

- A county outside a Metropolitan Statistical Area (MSA);

- A Rural Health Professional Shortage Area (HPSA) in a rural census tract; or

- From an entity that participates in a federal telemedicine demonstration project approved by the Secretary of HHS as of Dec. 31, 2000; and

- Be in a specific eligible site (Figure 1)

The Health Resources and Services Administration (HRSA) decides HPSAs, and the Census Bureau decides MSAs. To see an originating site's potential payment eligibility, go to HRSA's Medicare Telehealth Payment Eligibility Analyzer.[4] There is a growing list of exceptions to the rural requirement for the treatment of behavioral health, end stage renal disease, acute stroke and substance use disorder (SUD). Due to the passing of the Consolidated Appropriations Act of 2021, Rural Emergency Hospitals were also added as eligible originating sites, but that policy change will not happen until 2023. Additionally, there was an expansion for the provision of mental health services to the home and without the geographic limitation which is noted in Figure 1.

BILLING TIP!

Note that an originating site may bill Medicare a facility fee using code Q3014. If the originating site is the home, no facility fee may be billed

Figure 1
Medicare Originating Sites
(Some are allowable only for certain conditions)

- Physician and practitioner offices
- Hospitals
- Critical Access Hospitals (CAHs)
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNFs)
- Community Mental Health Centers (CMHCs)
- Renal Dialysis Facilities*
- Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis*
- Mobile Stroke Units*
- Home of Patient receiving treatment for SUD/Opioid Abuse and co-occurring mental health disorders*
- Home of patient for mental health services and geographic requirements would not apply if certain conditions are met including an initial 6 months in-person visit with the telehealth provider prior to provision of services via telehealth.

* Geographic limit may not apply to these facilities in specific circumstances.
NOTE: Geographic limitations on originating site removed for treatment & diagnosis of acute stroke.

PHE EXCEPTION: MEDICARE

During the PHE, the patient's home can serve as an originating site, in addition to the sites originally specified without the patient being treated for one of the stated conditions. Because the patient's home can serve an originating site, a clinic or facility can bill Q3014. (Covid-19 FAQs. Covid-19 FAQs, located here: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (updated 2/28/22)

4) Telehealth Payment Eligibility Analyzer, https://data.hrsa.gov/tools/medicare/telehealth.

Medicaid Example: California

"Originating site" means the place where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates. For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the patient or by the health care provider is not limited (California Welfare and Institutions Code [CA W&I Code], Section 14132.72[e]). Source: California Department of Health Care Services, Medi-Cal Provider Manual: https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf.

DISTANT SITE

Medicare does not define "distant site" locations; however, providers cannot be physically located out of the United States when providing the telehealth services. A recent court decision, *RICU LLC v. United States Department of Health and Human Services* noted that in a review of the case, the Acting Director of CMS' Chronic Care Policy Group wrote that Medicare cannot reimburse any telehealth services by medical providers outside of the United States because of the Medicare Act's ban on foreign payments.[5] Therefore, while there might not be a specific list of eligible distant sites like there is for originating site, there are limitations on where the provider may be, geographically.

TRY IT!

Click on CCHP's site, here, to find your state. Compare your state's policy definitions to Medicare's: What is the same? What is different?

Medicaid Example: California

"Medi-Cal defines the "distant site" as "... a site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location." This allows the practitioner to be in a location suitable to telehealth encounters, but not necessarily in a clinic or facility themselves.

Source: California Department of Health Care Services, Medi-Cal Provider Manual: Telehealth https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf.

5) RICU LLC v. United States Department of Health and Human Services.

PHE EXCEPTION: MEDICARE

Provider-Based and Facility Clinics

A provider may be at home and provide services. However, there is a difference in the originating site payment depending on whether the provider is home or "on site."
- Because the originating site requirement is waived during the PHE, the program may bill for the originating site fee with the patient at home. The "Hospital Without Walls" allows:
  - Provider and Patient at home: bill Q3014
  - For facility-based (i.e., those who "split bill"): Provider on site and patient at home: bill G0463 (facility fee associated with evaluation and management services)
    - not considered 'telehealth' as the facility wall has extended to the patients' homes, as long as provider is on site
- Expansion of Hospitals Without Walls for Inpatient Services
  - During this COVID-19 surge, CMS also has expanded payment to extend to a patient's home while still admitted as inpatient
  - The provider may see the patient via telehealth, but this would be billed as if the patient were at the facility (no modifier)
  - RN visits to the patients' homes are part of the program

https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge

ELIGIBLE PROVIDERS

CMS limits the type of provider who can provide a service. Those providers include:

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs) and clinical social workers (CSWs)[6]
- Registered dietitians or nutrition professionals

Providers must also be aware of licensure laws. While Medicare relaxed their requirements on licensure during the PHE, it noted that providers would still need to abide by state laws. States control the licensure requirements.

PHE EXCEPTION: MEDICARE

As of Dec 1, 2020, "The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services." https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

FQHCs and RHCs were added to the eligible list of who may serve as distant site providers. However, FQHCs and RHCs will not be paid their typical prospective payment system (PPS) or "all inclusive rate" (AIR). While these entities may provide services via telehealth under Medicare, they will be paid a set rate calculated by CMS each eligible service delivered via telehealth, all of which are billed using HCPCs code G2025. This amount is based on a formula created by CMS. https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

6) CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or get paid for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.

Medicaid Example: California

Medi-Cal does not limit the type of provider who may provide services via telehealth. However, FQHCs and RHCs do face certain limitations.

Flexibilities during the PHE regarding cross-state licensing can be viewed on the Federation of State Medical Board's site: https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf and on the CCHPCA site located here: https://www.cchpca.org/topic/cross-state-licensing-covid-19/

WHAT ABOUT AT AN RHC OR FQHC?

Section 1834(m) (4) (C) (ii) of the Act authorizes RHCs and FQHCs to serve as telehealth "originating sites" (where the patient is located) for qualified telehealth services in Medicare. FQHCs/RHCs may bill the Q3014 facility fee, however, Section 1834(m) (1) of the Act, which describes distant site telehealth services (where the practitioner is located), does not include RHCs and FQHCs.

Under the new policies in place for 2022, CMS redefined what a **mental health visit** is for FQHC/RHCs to include the use of live video and audio-only to deliver the service. Since this was a redefinition of "mental health visit," FQHC/RHCs are not viewed as providing a telehealth service if live video or audio-only is used, they are simply providing a mental health visit as defined for their entity. Therefore, they are not considered telehealth providers when providing these services.

CODES

CODES TO DESCRIBE SERVICES PROVIDED

A brief overview of Common Procedural Terminology (CPT) codes will help novices to understand how CMS, Medicaid, other payers, coders and billers discuss coverage. Note that CPTs can go on the CMS 1500 or the UB-04. A CPT code is defined by the American Medical Association (AMA) as follows[7]:

[A] uniform language for coding medical services and procedures … All CPT codes are five-digits and can be either numeric or alphanumeric, depending on the category.

Category I: These codes have descriptors that correspond to a procedure or service. Codes range from 00100–99499 and are generally ordered into sub-categories based on procedure/service type and anatomy.

Category II: These alphanumeric tracking codes are supplemental codes used for performance measurement. Using them is optional and not required for correct coding.

Category III: These are temporary alphanumeric codes for new and developing technology, procedures and services. They were created for data collection, assessment and in some instances, payment of new services and procedures that currently don't meet the criteria for a Category I code.

CMS groups CPT codes for different programs and this is how CMS categorizes eligible services that may be provided via telehealth. CMS maintains a Telehealth CPT Code list[8] which grew from 103 CPT codes at the start of 2020 to 271 codes for calendar year 2022. Note that 99 services are temporary and will be removed at the end of the PHE, and 63 codes will remain on the list through December 31, 2023, per the below (Category 3). An added feature of the list includes which services can also be provided "audio only" during the PHE: there are 87 of those.

7) American Medical Association, "CPT overview and code approval," https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval.

8) Center for Medicare and Medicaid Services, "List of Telehealth Services," https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes (Accessed January 30, 2022- Updated January 5, 2022).

Process to Request Services for Telehealth CPT List

To request a service be added to the approved telehealth CPT list, CMS assigns the requests into three "categories."[9]

Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services.

Category 2: Services that are not similar to the current list of telehealth services. Review of these requests will include an assessment of whether the service is accurately described by the corresponding code when delivered via telehealth and whether the use of a telecommunications system to deliver the service produces demonstrated clinical benefit to the patient.

Category 3: A temporary holding place for some codes approved for reimbursement during the pandemic. These codes will remain available for reimbursement if provided via telehealth until December 31, 2023, no matter when the PHE ends.

As noted above, due to the PHE, other codes have been made temporarily available for telehealth but will no longer be eligible once the PHE is declared over. See Figure 2 for an example.

Figure 2

Review the codes on the list:

Code	Short Descriptor	Status
		LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2022 - updated January 5, 2
99215	Office/outpatient visit est	
99217	Observation care discharge	Available up Through December 31, 2023
99218	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic

- 99215 - After the PHE is over and the patient is in an HRSA-eligible geographic location at an eligible originating site will be reimbursable.

- 99217- Available through December 31, 2023 (as observation discharge, when the PHE is over, in-person care will again be required). It will not be reimbursed the following calendar year unless evidence collected confirms eligibility. If so, it will be moved over to permanent list. Patient will need to be in an HRSA-eligible geographic location at an eligible originating site.

- 99218 – Will no longer be available once the PHE is over.

MODIFIERS

Like CPT codes, a brief overview of modifiers will help to clarify questions regarding their usage for telehealth services. Billing examples showing how they are used are located at the end of the guide.

According to Noridian, the Jurisdiction E Medicare Administrative Carrier (MAC), modifiers[10] are:

- *two-digit numbers, two-character modifiers, or alpha-numeric indicators. Modifiers provide additional information to payers to make sure your provider gets paid correctly for services rendered.*

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9) Center for Medicare and Medicaid Services, "CMS Criteria for Submitted Requests," https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Criteria.

- *more than one modifier may be used with a single procedure code; however, they are not applicable for every category of the CPT codes. Some modifiers can only be used with a particular category and some are not compatible with others.*

For Medicare telehealth claims, the CPT modifiers listed below are used for particular situations:

- G0 (zero): Used to identify telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

- GQ (not used unless you are in Alaska or Hawaii): asynchronous telehealth service.

- GT: Critical Access Hospital distant site providers billing under CAH Optional Method II. This goes on an institutional claim and pays 80% of the Professional Fee Service rate.

- GY: Notice of Liability Not Issued, Not Required Under Payer Policy. 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.

PHE EXCEPTION: MEDICARE

During the PHE, the CPT codes representing telehealth services require a modifier 95 (telehealth) to be placed on the CMS 1500 in order to differentiate between telehealth and on-site services. This is because the regular Place of Service (POS) code is indicated to ensure a higher rate of reimbursement to partially offset reimbursement losses incurred when patients cannot come into an office or hospital outpatient department clinic.

Audio-Only Specific Modifiers

- FQ: audio only. Some states are requiring the use of the FQ modifier already, such as the Washington State Health Authority[11]. Once the PHE is over, CMS will also require it if mental and behavioral health services are provided via audio-only.

- UD: audio only. This is the modifier required by Arizona Medicaid.

- 93: audio only. This is the modifier introduced by the AMA and would be adopted by Medi-Cal, according to its recently published Department of Health Care Services Post-COVID-19 Public Health Emergency Telehealth Policy Recommendations.[12]

Managed care and private plan policies vary on what modifier they require in order to bill for telehealth (GT or 95). Always check with the plan to see what is required for your billing.

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11) Apple Health (Medicaid) Provider Alert, Bulletin 12/17/21, https://content.govdelivery.com/accounts/WAHCA/bulletins/3017104.

12) DHCS Telehealth Policy Proposal for the post-Public Health Emergency period, https://www.dhcs.ca.gov/services/medi-cal/Documents/DHCS-Telehealth-Policy-Paper-2-3-22.pdf.

Medicaid Example: California

For Medi-Cal, the modifiers for telehealth are as follows:

Synchronous, Interactive Audio and Telecommunication Systems: Modifier 95
Modifier 95 must be used for Medi-Cal covered benefits or services delivered via synchronous, interactive audio/visual telecommunications systems. Only the portion(s) of the telehealth service rendered at the distant site are billed with modifier 95. The use of modifier 95 does not alter reimbursement for the CPT or HCPCS code.

Asynchronous Store-and-Forward Telecommunication Systems: Modifier GQ
Modifier GQ must be used for Medi-Cal covered benefits or services including, but not limited to, teleophthalmology, teledermatology, teledentistry and teleradiology, delivered via asynchronous store-and-forward telecommunications systems, including e-consult (CPT 99451). Only the service(s) rendered from the distant site must be billed with modifier GQ.

The use of modifier GQ does not alter reimbursement for the CPT or HCPCS code billed. Source: California Department of Health Care Services, Medi-Cal Provider Manual: Telehealth https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf

PLACE OF SERVICE CODES

CMS publishes a Place of Service (POS) code list[13] that tells CMS via the CMS-1500 where the provider and patient are located during a health encounter. The treatment location affects reimbursement, the CPT code categories and sometimes the modifiers to use with the CPT codes. What follows are codes specific to telehealth services.

Synchronous Services POS Code
For Medicare synchronous telehealth services, a POS 02 (telehealth) is required for use on the billing form CMS 1500. However, NEW in 2022, is also POS 10 (home telehealth). The updated and new code definitions are:

- **02 - Telehealth Provided Other than in Patient's Home.** The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology. (Effective January 1, 2017) (Description change effective January 1, 2022, and applicable for Medicare April 1, 2022.)

- **10 - Telehealth Provided in Patient's Home.** The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology. (This code is effective January 1, 2022, and available to Medicare April 1, 2022.)

13) Center for Medicare and Medicaid Services, Place of Service Code Set, https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

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Additionally, due to the new policies around mental health that CMS has implemented for 2022, audio-only can be used to deliver mental health services when the patient is in the home, if certain conditions are met. POS 10 will be reported and FQ is the audio-only modifier used.

In addition, the physician clinic location must go onto the CMS 1500 as well. The address lets the MACs know what conversion factor to use based on the geographic factor payment rate to calculate accurate reimbursement. Noridian stated that when a provider assigns their enrollment rights to a group or facility, then the group address is what is indicated on the CMS 1500, with the practitioner's address known to CMS (if working a large portion of time at home), but billed through the group entity.[14]

GQ is a modifier used to signify the service took place via asynchronous technology. Your state Medicaid program may require the use of this modifier if the service is provided via store-and-forward.

BILLING TIP!

If a provider or a facility staff member provides a telehealth visit to a Medicare beneficiary that did not meet the statutory guidelines (ineligible originating site, for example), put a GY modifier on the CPT (on either the CMS 1500 or UB-04) to indicate that you provided an excluded service.

Medicaid Example: California

Medi-Cal's address requirement for telehealth claims: "The distant site for purposes of telehealth can be different from the administrative location." An interpretation of this statement, based on the above discussion, would indicate that under POS 02, the address for Box 32 means the practitioner's "usual" place of business.

PHE EXCEPTION: MEDICARE

CMS is paying providers the fee they would have received had their patients physically come into a non-facility/provider based or facility-based clinic. Note that prior to the PHE, non-facility clinics received only the facility-based reimbursement for its distant site provider services (the originating site collecting the facility fee in billing Q3014 and receives $27).

During the PHE, non-facility clinics indicate POS 11 (using a modifier 95 on the CPT billed) and receive 100% reimbursement.

To offset the loss of a facility fee which is not paid for telehealth encounters (as the patient is not coming on site), during the PHE, CMS instructs facility-based clinics to use POS 19 or 22 (with a modifier 95 on the CPT billed). Depending on where their provider is located at the time of the telehealth encounter, the facility can:

- receive the facility-based professional fee, plus either an originating site fee (Q3014) if the provider is off campus (typically, home) or
- if on site, the facility evaluation and management fee (G0463-PN)

THE REST OF THE POS CODES

Can you describe your place of work in two numbers? If so, you must be a coder/biller. If not or if you are asked to bill for a different type of facility, a succinct listing of practice types is provided by CMS on its website. There are descriptions that describe the practice and what code to put on the bill. The following describes a few of the settings that people regularly ask about in terms of billing.

BILLING TIP!

When an MD located in a provider-based clinic bills CMS for a telehealth encounter with an established patient at an eligible originating site, the codes used could be, for instance, 99214, POS 02 (telehealth). Because the patient is not at the clinic, the non-facility - or provider owned clinic - is reimbursed at the *facility provider rate*, which is less than a provider-based, in-clinic visit.

- **Independent Clinic (POS 49):** A clinic that is not part of a hospital and is for outpatient treatment. The employees in this type of practice will be able to act under general or direct supervision of the treating practitioner who is managing patient care. This means incident-to billing can occur, which has an impact on the remote patient monitoring (RPM) codes. This also affects whether or not certain Chronic Care Management (CCM)[15] services can be billed. This can be an originating site for Medicare services if eligible under HRSA guidelines, as well as a distant site. Note that Remote Physiological Monitoring and CCM do not fall under geographic restrictions, as they are not "telehealth."

- **Off Campus Outpatient Hospital Clinic (POS 19):** This type of clinic employs staff who do not have a direct employment relationship with the ordering physicians. Thus, any activities performed under the direct or general supervision of the physician are bundled with the facility services on the UB-04 and cannot be reported on the CMS 1500 or billed under the physician's NPI.[16]

  A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016.)[17]

  POS 19 can be an originating site for Medicare services if eligible under geographic requirements, as well as serve as a distant site location for a provider.

- **Inpatient service (POS 21):** This can be an originating site for Medicare services if eligible under requirements, as well as a distant site. Refer to the List of Telehealth Services for Healthcare Common Procedure Coding System (HCPCS) codes applicable to Medicare-only billing. The usual inpatient codes apply to Medi-Cal and other payers for reimbursement.

15) Center for Medicare and Medicaid Services, Health Care Professional Resources, https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/ccm/hcpresources.html.

16) Center for Medicare and Medicaid Services, Medicare Learning Network, MLN Matters: SE0441, Sept 2, 2004. https://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/JA0441.pdf.

17) Center for Medicare and Medicaid Services, Pub 100-04 Medicare Claims Processing, August 6, 2015. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3315CP.pdf.

- **Emergency Room – Hospital (POS 23):** This is a great place to use the modifier applicable to stroke intervention – G0 (zero) – for remote neurologists, as geographic restrictions do not apply for Medicare beneficiaries. Other services are billable with the geographic limitation caveat and there are specific HCPCS codes applicable to the ER setting. You can find these codes on the Medicare Telehealth List that can be downloaded with the Physician Fee Schedule related materials.

- **On-Campus, Facility-Based Hospital Clinic (POS 22):** A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization can serve as an originating site, as well as a distant site. As with the other identified sites, services will be billed out using POS 02.

- **Federally Qualified Health Center (FQHC)[18] (POS 50):** Authorized to serve as an originating site for telehealth services if the FQHC is located in a qualifying area. An originating site is the location of an eligible Medicare patient at the time the service being furnished via a telecommunications system occurs. FQHCs that serve as an originating site for telehealth services are paid an originating site facility fee.

> **NEW POS! RURAL EMERGENCY HOSPITAL – COMING IN 2023**
>
> The Section 125 of the Act 2021 establishes Medicare payment for "rural emergency hospitals" as a new provider designation. Must currently be a CAH.
>
> https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf

- **Rural Health Clinic (POS 72):** A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician. May serve as an originating site in Medicare.

Permanent Medicare policy does not allow FQHCs and RHCs to serve as a distant site for telehealth. Medicaid policies vary from state-to-state and an exception was made temporarily for the PHE. The cost of a visit may not be billed or included on the cost report.

> **PHE EXCEPTION: MEDICARE**
>
> Per the Interim Final Rule Comment (IFC) IFC issued on March 30, 2020, in addition to services expanded to be reimbursed under G0071, CMS included digital evaluation and management services under CPT Codes 99421-99423. The IFC clarified: (1) the face-to-face requirement for an FQHC or RHC was waived; (2) the requirement that a patient have prior treatment within the last year was waived so that everyone who needed care could get it; and (3) any requirement to obtain consent prior to these services was waived, and consent can be obtained at the time of service, including by staff under the general supervision of the RHC/FQHC practitioner. These expansions will continue through the end of the PHE.

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18) Center for Medicare and Medicaid Services, Medicare Learning Network, Federally Qualified Health Center, January 2021, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf.

HRSA published a publication "Starting a Rural Health Clinic- A How-To Manual."[19] It states "There are two types of RHCs: provider-based and independent. Provider-based clinics are those clinics owned and operated as an "integral part" of a hospital, nursing home or home health agency. Independent RHCs are those facilities owned by an entity other than a "provider" or a clinic owned by a provider that fails to meet the "integral part" criteria." While considering incident-to, one may think that a provider-based clinic would allow for this billing; however, according to the manual it does not. All facility services are considered bundled.

Indian Health Services (IHS): multiple places of service fall under the jurisdiction of Indian Health. They are:

- Funding: Federally funded.
- Location: Both on and off of surrounding reservations.
- Customer: Federally recognized Tribal Members from surrounding areas.

The POS codes for such entities are:

- Tribal 638 Agreement Free-standing Facility (POS 07).
- Tribal 638 Agreement Provider-based Facility (POS 08).
    - o Funding: The Tribe self-administers the funding and Health Services.
    - o Location: Tribal Reservations (Federal Trust Land).
    - o Customer: Tribal Members only.

The IHS maintains a Telehealth Behavioral Health Center of Excellence (TBHCE)[20] and acts as a "hub" to health sites all over the country. The TBHCE contracts its services to the sites and the sites then can bill Medicare and Medicaid for those services. Other specialty services include Rheumatology, Endocrinology, Psychiatry, Infectious Disease and the aforementioned Behavioral Health. All services are based at the clinics.

REVENUE CODES

Facilities utilize revenue codes to indicate the type of service provided by the facility. It describes a category of service and is entered on the UB-04. The codes are 4-digit codes "that are descriptions and dollar amounts charged for hospital services provided to a patient. The revenue code tells an insurance company whether the procedure was performed in the emergency room, operating room or another department."[21]

Revenue Code 780 is used for telemedicine institutional claims billed both to Medicare and Medicaid[22]. Examples will be provided below when this is appropriate to submit on a UB-04.

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19) US Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, "Starting a Rural Health Clinic – A How To Manual." https://static1.squarespace.com/static/53c5f79de4b0f4932a3942a8/t/53d43b20e4b000707bc7e83f/1406417710401/RHC+How-To+Manual.

20) Indian Health Services, Telebehavioral Health Center of Excellence, https://www.ihs.gov/telebehavioral/.

21) https://valuehealthcareservices.com/education/understanding-hospital-revenue-codes/.

22) Noridian Healthcare Solutions, Revenue Codes. https://med.noridianmedicare.com/web/jea/topics/claim-submission/revenue-codes.

Part 2: Medical Services

Now that we have covered Terminology and the Codes you **may be** wondering if you can bill yet. **Almost!** Next we have to look at what constitutes a 'telehealth service' and the most common service is covered first.

EVALUATION AND MANAGEMENT CPT CODES

This category of CPT codes, primarily outpatient "office visit," are used for telehealth, as opposed to having a separate code solely describing a telehealth E/M service. The updated guidelines were announced in 2019 for implementation in 2021. The 2021 Outpatient E/M Guidelines allow providers to bill CMS and private payers based on time or medical decision making (MDM). The CPT codes affected are: 99202-99215 only. 99201 was deleted.

Time Component: total non-face-to-face (F2F) and F2F time per patient, per 24-hour day
Time Documentation should include:

- Reason for visit

- Medically appropriate physical exam

- Assessment and plan

- The precise total number of minutes spent on patient care

    o Note the time parameters that the total time falls into

    o A description of how that time was accrued

MDM Component per the AMA:

- The number and complexity of problems addressed in the encounter

- The amount or complexity of data to be reviewed and analyzed. This reduces cut-and-paste note bloat by not requiring physicians to enter "voluminous," repetitive test data that is irrelevant or ancillary to the purpose of the visit.

- Risk of complications or morbidity of patient management. This can now include social determinants of health and reasons behind decisions not to admit a patient or intervene in some way.[23]

Note that CMS has a different code for prolonged care based on the maximum time reached past 99205 or 99215) – G2212. The Commercial payers will need to be consulted, although it is anticipated they will follow AMA CPT which is 99417, and the time is accrued from the *minimum* time of the level 5 time-durations.

23) Robeznieks, Andis, American Medical Association, "How 2021 E/M coding changes will reshape the physician note." (November 6, 2020). https://www.ama-assn.org/practice-management/cpt/how-2021-em-coding-changes-will-reshape-physician-note.

G2212:

Prolonged office or other outpatient evaluation and management service(s) **beyond the maximum required time** of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPG codes 99205, 99215 for office or other outpatient evaluation and management services) (do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes).

99417:

Prolonged office or other outpatient evaluation and management service(s) **beyond the minimum required time of the primary** procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services.)

OTHER E/M SERVICES

As discussed above in the CPT section, CMS' list of approved telehealth codes can be found on its site. Categories of services include behavioral health, inpatient E/M, emergency department and others.

COMMUNICATION TECHNOLOGY BASED SERVICES (CTBS) - NON-TELEHEALTH TECHNOLOGY SERVICES

CTBS are represented by CPTs that describe technology-based services but are not labeled "telehealth" by CMS. Because of this, providers may bill and get reimbursed for them even if they do not meet the requirements that telehealth health services must under the Medicare program. Therefore, services that take place when the patient is at home or if they live in a city could be reimbursable.

REMEMBER:

Professional Fee and Facility Fee Differences

Can your practice bill incident-to services? Do you employ the RNs and other clinical staff? Do you work at an off-campus (physician based) facility outpatient clinic? Part B outpatient services for Professional fees are submitted on the CMS 1500 and the Part A or Facility Fee portion is submitted on the UB-04.

The CTBS CPT codes do not require a modifier and the POS should reflect the location of where the provider normally practices medicine or provides patient care during the provision of the service. There is also no originating site facility fee for CTBS since they aren't considered telehealth services.

Remote Evaluation and Virtual Check-In

These CTBS codes were introduced in 2019 in order to reimburse providers for a review of an image or for a brief conversation with their patients. Following that introduction, CMS noted in the 2020 final rule that the CTBS should be patient-initiated (e.g., the patient calls in and the provider calls them back).[24]

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24) Federal Register, Vol 85, No 248. https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf, December 28, 2020.

The definitions are:

- **G2010 -** Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store-and-forward), including interpretation with follow-up with the patient within 24 business hours, 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.

- **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.

- **G2252 -** 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: 11–20 minutes of medical discussion.

For providers who cannot bill independently (utilizing appropriate incident-to guidelines), the following check-in codes may be billed. The service definitions are almost the same but are to be done by non-QHPs: G2250 and G2251.

FQHC'S AND RHC'S may provide virtual check-in services BUT MUST USE G0071 if the service is provided.

Source: Center for Medicare and Medicaid Services, "Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Question, December 2018. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf

PHE EXCEPTION: MEDICARE

Providers can get reimbursed for these services for use with new patients (in addition to established patients), but should otherwise follow the rest of the code description.

CARE MANAGEMENT (CM) CODES
This category of CPT codes relates to services that do not involve direct or face-to-face (F2F) patient discussion or care but are important in caring for simple or complex medical conditions.

REMOTE PHYSIOLOGICAL OR PATIENT MONITORING (RPM)

RPM is a subset of CM codes for patients who "require chronic, post-discharge or senior care. By connecting high-risk patients with remote monitoring, it can notify healthcare organizations of potential health issues or keep track of patient data between visits."[25]

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25) Tech Target, Mobile: Healthcare IT, remote patient monitoring (RPM). April 2019. https://searchhealthit.techtarget.com/definition/remote-patient-monitoring-RPM.

RPM may be done under general supervision and billed by staff under an NPI-holding practitioner. You must follow the incident-to rules for different types of practices. Note that the uploading and transmission of data must be automated and cannot be billed if the data is entered manually.

BILLING TIP!

Collect 16 days of data before you bill either 99453 or 99454.

- **99453:** Staff service: initial set up of device; bill after 16 days of monitoring.
- **99454:** Staff or facility service: covers initial device payment; bill after 16 days of receipt of and monitoring readings, bill every 30 days.
- **99457:** QHP service; 20 minutes of Non F2F and F2F time spent in analysis and via synchronous communication with patient the findings or care plan.
- **99458:** Add-on code; full additional 20 minutes for services described in 99457.

Medicaid Example: California

Medi-Cal FFS started to reimburse for RPM in July 2021. The provider bulletin updates are located here. In addition to the bulletin, the Evaluation and Management Provider Manual was updated in December 2021 to include Remote Physiological Monitoring.

PHE EXCEPTION: MEDICARE

During the PHE, all four codes potentially may be billed after two days of data collection if the patient has a confirmed or suspected case of COVID-19.

Your next question may be "what device qualifies for remote monitoring?" According to the FDA:
- The device "must be a medical device as defined by the FDA"; and
- The service must be ordered by a physician or other qualified health care professional.

BILLING TIP!

What if my patient owns their own device?

Bill 99457 and 99458 only as there will be no practice expenses incurred.

The FDA outlines its medical device guidelines, here, depending on the context of how and what you are monitoring. Here are a few examples, as outlined in a recent article[26]:
- Glucose meters for patients with diabetes.
- Heart rate or blood pressure monitors.
- Continuous surveillance monitors that can locate patients with conditions like dementia and alert healthcare professionals of an event like a fall.
- Remote infertility treatment and monitoring.
- At-home tests that can keep substance abuse patients accountable for and on track with their goals.
- Caloric intake or diet logging programs.

26) TechTarget SearchHealthIT: https://www.caregivingmetrowest.org/Caregiver-Toolkit/Blog-Caregiving-Chronicles/caregiving-in-the-21st-century-how-21st-century-technology-is-streamlining-life-for-the-20th-century-generations.

Recent clarification to include omitted verbiage and update intent concerning RPM by CMS was published in the Federal Register in January 2021[27]:

> *We also note that when a more specific code is available to describe a service, CPT indicates that the more specific code should be billed. We believe that there are additional, more specific codes available for billing that allow remote monitoring (for example, CPT code 95250 for continuous glucose monitoring and CPT codes 99473 and 99474 for self-measured blood pressure monitoring). In summary, we are clarifying that CPT codes 99453 and 99454 should be reported only once during a 30-day period; that even when multiple medical devices are provided to a patient, the services associated with all the medical devices can be billed by only one practitioner, only once per patient, per 30-day period, and only when at least 16 days of data have been collected; and that the services must be reasonable and necessary.*

REMINDER

FDA DEVICE DEFINITION

"Medical devices range from simple tongue depressors and bedpans to complex programmable pacemakers with micro-chip technology and laser surgical devices. In addition, medical devices include in vitro diagnostic products, such as general purpose lab equipment, reagents, and test kits, which may include monoclonal antibody technology. Certain electronic radiation emitting products with medical application and claims meet the definition of medical device. Examples include diagnostic ultrasound products, x-ray machines, and medical lasers." For more information, see the FDA link at: https://www.fda.gov/medical-devices.

Finally, note that for 99457 and 99458 one interactive communication event must take place. As defined by CMS, *"interactive communication" is a conversation that occurs in real-time and includes synchronous, two-way interactions that can be enhanced with video or other kinds of data as described by HCPCS code G2012.* **We further clarified that the 20-minutes of time required to bill for the services of CPT codes 99457 and 99458 can include time for furnishing care management services as well as for the required interactive communication."**

MEDICARE:
Do not bill RPM at the following:
- FQHCs
- RHCs
- Home Health Agencies

(However, all can claim as an expense)

MEDICINE SERVICES AND PROCEDURES
Medicine Services and Procedure CPT codes are located in the back of the AMA CPT book. They are a series of codes that can be done by nonphysicians, as well as physicians, and the codes below can be done non-face-to-face.

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27) Federal Register, Final rule and interim final rule; Correction. https://www.federalregister.gov/d/2021-00805/p-39.

REMOTE THERAPEUTIC MONITORING (RTM)

These services were introduced by the AMA and CMS as reimbursable services in 2022. The CPT codes were based on the RPM codes' framework. However, unlike RPM, RTM does not monitor physiological vital signs but the progression of therapies performed by the patient based on a plan. In the 2022 Federal Register reporting the Medicare Physician Fee Schedule[28], CMS clarified that in addition to MDs and APPs, physical therapists and occupational therapists can be considered a service provider as the codes are currently specific to respiratory and musculoskeletal therapies.

98975	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment
98976	Device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days
98977	Device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes
98981	Each additional 20 minutes (List separately in addition to code for primary procedure)

Similar to the 99453, 98975 represents the education and set up of the device with the patient. The next two code are specific to the body areas monitored and finally, 98980 and 98981 are similar to 99457 and 99458.

Per CMS, these services must be performed by the billing providers or under direct supervision if the services are performed by a physical therapy assistant (PTA) or occupational therapy assistant (OTA). In addition, because these are "sometimes therapy codes" meaning that MDs and NPPs can bill these codes, the PT and OT must put the appropriate modifier on these codes, similar to the eVisit codes.

There are two modifiers required when assistants are involved (and reimbursement is reduced by 15%):

- PTA = CQ modifier
- OTA = CO modifier

With fulfilling the requirements of these codes, privacy concerns should not be ignored. Remember that virtual care technology may outpace privacy protection policies.[29] For instance, fitness trackers:

- If used privately, not covered by HIPAA
- If health plan or provider provides it, it becomes covered by HIPAA

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28) Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements, published 11/19/21, https://www.federalregister.gov/documents/2021/11/19/2021-23972/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part.

29) Standards for Privacy of Individually Identifiable Health Information, https://www.hhs.gov/sites/default/files/privacysummary.pdf.

Note that the next RTM code to come out in 2023[30] will address behavioral health. There are current HCPCs category III codes that were created (0X47T and 0X81T) but it was decided upon to create a numbered code for later release.

CPT® Editorial Summary of Panel Actions
September-October 2021

Tab #	Name	Code #	Request-Description	Effective Date
43	Cognitive Behavioral Therapy Monitoring	●989X6 D0X47T D0X81T	**Accepted addition** of code 989X6 to report remote therapeutic monitoring device supply to monitor cognitive behavioral therapy; **revision** of the Remote Therapeutic Monitoring Services guidelines and the Remote Therapeutic Monitoring Treatment Management Services guidelines to clarify reporting of cognitive behavioral therapy; and **deletion** of codes 0X47T, 0X81T	January 2023

ECONSULT OR INTERPROFESSIONAL CONSULTATION CODES

Unlike RPM, this set of CM codes are provider-to-provider based, as opposed to provider-to-patient. The ultimate hope is that Primary Care Providers (PCPs) will be educated in how to treat patients for commonly occurring, yet specialized disease, such as diabetes, after several consults are done. For instance, when the consults are completed, the PCP will not need to ask the endocrinologist questions as frequently. The patient also must consent each time a provider-to-provider service is contemplated, to try and prevent a billing surprise for patients, since they won't have seen a specialist. The idea is also to cut down on specialist referrals to maintain access for patients with more acute conditions.

- **99451:** Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time.

- **99452:** Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes.

- **99446-99449:** "Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a **verbal and** written report to the patient's treating/requesting physician or other qualified health care professional (5 minutes through and over 31 minutes)." [Bolding added for emphasis.]

30) CPT® Editorial Summary of Panel Actions September-October 2021, https://www.ama-assn.org/system/files/september-october-2021-summary-of-panel-actions.pdf.

Medicaid Example: California

Medi-Cal reimburses for CPT 99451, only, for all eConsult instances. It also requires a GQ modifier.

Medi-Cal also states in its policy: Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time. In accordance with the AMA requirements, CPT code 99451 is not separately reportable or reimbursable if any of the following are true:

- The distant site provider (consultant) saw the patient within the last 14 days.
- The e-consult results in a transfer of care or other face-to-face service with the distant site provider (consultant) within the next 14 days or next available appointment date of the consultant.
- The distant site provider did not spend at least five minutes of medical consultative time, and it did not result in a written report.

Source: California Department of Health Care Services, Medi-Cal Provider Manual: Telehealth: https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf.

These E/M codes were finalized for CY 2020 and were immediately useful during the PHE. The following excerpt from the Federal Register describes the use and payment for non-National Provider Identifier (NPI)[31] practitioner reimbursement (clinical staff can be pharmacists, medical assistants, technicians, nurses, therapists, according to Noridian):[32]

> *"99421-99423 are for practitioners who can independently bill E/M services while CPT codes 98970-98972 are for practitioners who cannot independently bill E/M services." Medicaid programs may adopt these codes, but you will need to check with your State's Medicaid program to determine the status."*[33]

Finally, during the PHE, licensed clinical social workers (LCSWs), clinical psychologists, PTs, OTs and SLPs were granted use of non-physician, billing practitioner CTBS "eVisit" codes.

The e-Visit CPT codes for these billing providers who cannot perform an E/M service are as follows:

- **98970** (Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes).

- **98971** (Qualified nonphysician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes).

- **98972** (Qualified nonphysician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes).

BILLING TIP!

In 2021, CMS granted *permanent* use of 98970-98972 and reimbursement of LCSWs, clinical psychologists, PTs, OTs and SLP services. It will consider other, proposed practitioners throughout this year.
https://www.cms.gov/files/document/mm12126.pdf .

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31) Look up NPI or National Provider Identifier at https://npiregistry.cms.hhs.gov/.

32) https://med.noridianmedicare.com/web/jeb/specialties/em/chronic-care-management-ccm#pelegibility.

33) Federal Register, Final Physician Fee Schedule CY 2020, page 799, https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf.

BILLING TIP!

"When billed by a private practice [or facility] PT, OT, or SLP, the codes would need to include the corresponding GO, GP, or GN therapy modifier to signify that the CTBS are furnished as therapy services furnished under an OT, PT, or SLP plan of care." (**84532 Federal Register**/Vol. 85, No. 248/Monday, December 28, 2020/Rules and Regulations: https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf.)

OTHER POTENTIAL BILLING OPPORTUNITIES IN CM

There are other ways to benefit from the use of telehealth components in bundled management of care scenarios: chronic care management[34] (CCM) and transitional care management[35] (TCM). These two programs can be billed during the same period, as they fill two distinctly different needs. This changed with the PFS 2020 Final Rule. Unlike the services set out above, FQHCs[36] and RHCs[37] can benefit from these programs. Note that as of January 1, 2019, "CCM services can be billed [by FQHC and RHC] by adding the general care management G code, G0511."[38] In addition, codes for "Principal Care Management (PCM)" were released for calendar year 2020. G2064 and G2065 are intended to address the care of single diagnosis chronic care situations, post-hospitalization or episode of onset, for short periods of time (i.e., three months).[39]

For CCM and Complex CCM, a patient has two or more chronic conditions monitored by a practitioner and staff. Depending on the type of clinic, these codes may be billed if the requirements are met: a plan is established, put into use, changed if needed and monitored. Note that CCM and Complex CCM may be under "general supervision," but remember to follow the incident-to rules.

- **99490:** 20 minutes or more per month of directed staff time for two or more chronic conditions expected to last during a 12-month period or until death. This also assumes 15 minutes of the billing practitioner's time per month.

- **99491:** 30 minutes or more of a billing provider's time, per month.

- **99487:** "Complex" CCM, which is 60 minutes of clinical staff time as directed by a billing practitioner with the above-required elements of 99490.

- **99489:** this is an add-on code, meaning you cannot bill it without 99487. It is for 30 minutes of time in addition to the 60 minutes of recorded time billed for a 99487.

ELIGIBILITY

Could be based on number of illnesses, number of meds or repeat admits or trips to the ED – check your CPT book preamble for more scenarios.

34) Center for Medicare and Medicaid Services, Details for title 2019-07. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909188.html.

35) Ibid.

36) Noridian Health Care Solutions, Federally Qualified Health Centers (FQHC) Billing Guide. https://med.noridianmedicare.com/web/jea/provider-types/fqhc/fqhc-billing-guide.

37) Noridian Health Care Solutions, RHC Billing Guide, https://med.noridianmedicare.com/web/jea/provider-types/rhc/rhc-billing-guide.

38) Center for Medicare and Medicaid Services, "Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), Frequently Asked Questions, December 2019." https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf.

39) Final Rule to CY 2020 Physician Fee Schedule. https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf.

Because of the 24/7 access to care requirement of CCM, a provider can use various modalities to stay in touch such as "telephone, secure messaging, secure Internet or other asynchronous non face-to-face consultation methods (for example, email or secure electronic patient portal)."

The intent of TCM is to manage post-inpatient-admission patients after they are discharged to ensure continuity of care within a 30-day period (the first day is date of discharge + 29 days). It can be performed by the discharging service or the PCP who is accepting care of the patient back into their community. There are two types of urgency:

- **Moderate/99495:** contact patient within 2 days after discharge, modality (telephone, electronic) or direct contact. A follow-up visit must occur face-to-face within 14 calendar days of discharge.

- **High/99496:** contact patient within 2 days after discharge, modality (telephone, electronic) or direct contact. A follow-up visit must occur face-to-face within 7 calendar days of discharge.

The in-person or face-to-face encounter may be conducted via telehealth [note: if this is a CMS patient, the telehealth geographic limitations are in effect]. However, this can stand in for the "face-to-face" or in-person encounter, which is a great benefit to the beneficiary. TCM codes can be billed during the same time period as CCM codes.

> ### BILLING TIP!
>
> - Are you the surgeon or provider who performed a procedure on the TCM patient? Then you cannot bill within the global period of the procedure.
>
> - Are you the primary care physician or hospitalist who discharged the TCM patient? Then you can bill within a global period, within the 30 days of discharge

Part 3: Other Considerations

You are almost ready to bill your telehealth encounters – but just a few more things to keep in mind!!

CO-PAYS & CONSENT

Medicare requires cost-sharing for all services so consent must be obtained but can be done by staff and at a non-specific time (not necessary at time service performed). Since the provider work is done either via audio or not necessarily face-to-face with the patient, it's a good idea for either you or your staff to educate patients about the services, so they are not surprised about receiving a bill for their plan's deductible amount or co-pay.

WHAT ABOUT COST SHARING OR A CO-PAY DURING THE PHE?
Medicare is allowing providers to reduce or eliminate cost-sharing for telehealth visits during the PHE, see the March 17, 2020 news bulletin here. However, many commercial insurers are now reinstating co-pays.

BILLING TIP!

The type of practice you work in - or where your practitioners provide services - dictates what can be billed, how the service is billed and whether or not incident-to billing can be utilized.

Non-Telehealth Specific Factors

There are other policies to consider that could impact your telehealth billing as well as opportunities that may not be readily apparent because services are not called "telehealth" but utilize the technology. The following are a few things to keep in mind.

Patient demographics

Patient demographics are going to affect your billing workflows and choices. If located in a pediatric clinic, the focus will be on private payer policies and Medicaid. Think about where your patients are located and if your providers want to contract with FQHCs to better serve sites that lack specialty care.

Payer Mix and Billing Rules

What are the companies paying your invoices? How much of a percentage is Medicare or Medicaid?

- **Medicare Fee-for-Service:** Its rules are found in the Telehealth Guidelines previously referenced.

- **Medicare Advantage:** As of January 20, 2020, Advantage plans were allowed to offer more extensive telehealth coverage as part of "base coverage" as they do for other excluded services, such as eyeglasses after cataract surgery. Telehealth policies will vary from plan to plan.

- **Commercial:** Be aware of the contracts in place for your place of work. Be cognizant that the state parity law may provide coverage security as well as advising that if a similarly covered "in-person" service at a clinic or hospital is conducted via telehealth that it should be paid in kind.

Medicaid Example: California

California enacted legislation that requires payment parity for services covered by private insurers. CA Health & Safety Code Sec. 1374.14 & Insurance Code 10123.855.

Medicaid Example: California

- Medi-Cal: DHCS finalized its policy in July 2019 and is aligned with the state regulatory language in terms of originating site, coverage and reimbursement.
- CCS-GHPP: CCS/GHPP was first in offering coverage for physical and occupational therapies, as well as other coverage for its patients.
- Covered California: this group of payers available through the California Marketplace Exchange must offer basic coverages as mandated by the Affordable Care Act. In Calendar Year 2020, it is up to the insurance payers in the Exchange to determine whether telehealth will be covered as a "base."

Preparation for Billing and Where To Find Reimbursement Figures

Each summer, CMS releases the proposed Physician Fee Schedule (PFS) for the following calendar year. The proposed fee schedule, as well as the finalized fee schedule, is published on the same web page, entitled "PFS Federal Regulation Notices."[40] The proposed rule is indicated by a number ending in "P"; final in "F" and correction notes as "CN." The finalized schedules are released in November.

The downloads contain Excel spreadsheets with different numbers, but the two Zip files needed are the first one "Final Rule Addenda" and further down the long list: "Final Rule List of Telehealth Services."

- **Step 1:** Download "Addendum B – Relative Value Units and Related Information Used in CY 20XX Final Rule". This list will provide details on whether or not the non-telehealth codes are "A" active or not.
- **Step 2:** Then Download "CMS-XXXX-F List of Medicare Telehealth Services." The second spreadsheet lists all the current, active telehealth services. Save the spreadsheets in a convenient place on your computer.
- **Step 3:** Next, go to your state's Medicaid website or if you are coding multi-state encounters, you can easily find each state's policies on the CCHP's 50 state review webpage.[41] If there are specific CPT codes covered in those states, add them to your Telehealth spreadsheet and start to keep track of what you are billing, who is paying and who is denying and for what reasons the denials are applied.

Conclusion

Now you are ready to fill in those billing forms. As you can see from the information provided, changes to telehealth billing can happen quickly, especially in these challenging times. We can't predict the future, but this guide should help you weather any changes, such as the outcome of any Congressional activity in passing legislation to allow the home as an originating site and coverage in MSA's – or what will go back to pre-COVID-19 status.

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41) Center for Connected Health Policy, 50 State Current State Laws and Medicaid Policies, https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies.

EXAMPLES

PATIENT 1: The practitioner documented a synchronous telehealth visit, with an established, follow-up patient, aged 65, total time spent non-F2F and F2F of 25 minutes, with a diagnosis of XX.
Insurance: Medicare

CODE IT:[42]
- Pro Fee: 99213 (2021 E/M Outpatient Guidelines time duration = 20-29 minutes)
- Then- check the CMS Telehealth Services List.

    - CPT codes are listed in the first column, headed "Code."

    - 99213 is on the list

    - No Modifier needed, because POS is 02 (Medicare feels the 95 modifier is redundant)

LIST OF MEDICARE TELEHEALTH SERVICES for PHE for the COVID-19 pandemic effective March 1 2020-updated January 14 2021				
Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirements?	Medicare Pa; Limitatio
99211	Office/outpatient visit est			
99212	Office/outpatient visit est			
99213	Office/outpatient visit est			

24. A DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	DIA PO
From MM	DO	YY	To MM	DO	YY				
01	29	21	01	29	21	02		99213	

- Check the patient's originating site clinic address on the HRSA site: Yes! The originating site qualifies for reimbursement.

✔ Yes

Yes, the geocoded address is eligible for Medicare telehealth payment.

- Put the address of the distant site provider (your provider) in Box 32:

[Form image: FEDERAL TAX I.D. NUMBER, SSN EIN, 26. PATIENT'S ACCOUNT NO. PATIENT ACCOUNT NUMBER, 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO, SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.), 32. SERVICE FACILITY LOCATION INFORMATION NAME AND ADDRESS OF SERVICE FACILITY, SIGNATURE OF PROVIDER]

42) You may refer to the List of Medicare Telehealth Services or the AMA's CPT book Appendix P for the list of covered telehealth codes

PATIENT 1 (cont): The practitioner documented a synchronous telehealth visit, with an established, follow-up patient, aged 65, total time spent non-F2F and F2F of 25 minutes, with a diagnosis of XX.
Insurance: Medicare

CODE IT (cont):
- Facility Fee: For in-clinic encounters, the G0463 is billed for all outpatient evaluation and management visits. BUT
  - For telehealth, CMS does not pay for distant site facility charges.
  - The originating site facility can bill Q3014 (originating site facility fee) and that can be submitted on the CMS 1500 or UB-04.

Finally, what if the Medicare beneficiary's originating site address had NOT meet HRSA's guidelines?
  - Then you bill the same, except with a GY modifier

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIA PO
From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER	
01	29	21	01	29	21	02		99213	GY	

The GY tells the Medicare Administrative Carrier (MAC) that the service was statutorily excluded and to not pay the practitioner.

PHE Exception: Medicare

During COVID-19, patients and providers are encouraged to remain home.
- Pro Fee: 99213-95; POS 22
- Distant Site Facility: Q3014 (Same place where Pro Fee took place)
- If the provider is on the facility site, then G0463 may be billed with a PN modifier.

PHE Medicaid Example: Medi-Cal

- Pro Fee: 99213-95, POS 11 (get paid 100%)
- Pro Fee: 99213-95, POS 22
- Facility: Nothing

PATIENT 2: Synchronous telehealth visit, follow-up patient, aged 25, documented 99213 (25 minutes total time), analysis and interpretation of Continuous Glucose Monitoring (CGM) data (95251), diagnosis XX.
Insurance: Medi-Cal I Originating Site: Home I Distant Site: Hospital Outpatient Department

CODE IT:
Since this is Medi-Cal, its policy states that any medically necessary service that is feasible via telehealth is reimbursed, so there is no need to check any CPT Code list.

PATIENT 2 (cont):

CODE IT:

The CGM is separately reimbursable, so the E/M code (99213) requires a modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).[43] In addition, Medi-Cal requires a 95 modifier for the E/M encounter, so your CMS 1500 would look like this:

24. A. DATE(S) OF SERVICE From MM DO YY	To MM DO YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	D. DAYS OR UNITS
01 29 21	01 29 21	02		99213	95 25			
01 29 21	01 29 21	22		95251				
01 29 21	01 29 21	02		T1014				15

95251 is not a telehealth service and does not require modifier 95. However, the analysis and interpretation took place in the office, so POS 22 goes onto the same claim but as a separate line item.

Finally, bill the allowed transmission fee code T1014 x the # of minutes for the F2F portion of the encounter (15 minutes). No modifier.

PHE Medicaid Example: Medi-Cal

- 99213-95, 25; POS 22
- 95251, POS 22
- T1014 x 15, POS 22

PATIENT 3:
65-year-old patient meets with staff of an independent clinic to be fitted for/educated about a remote monitoring device with Bluetooth capabilities to keep track of her blood pressure. The physician interprets the transmitted data for 15 minutes and has a synchronous conversation with the patient about her blood pressure for another 25 minutes. *Insurance: Medicare*

CODE IT:

The codes for remote monitoring were outlined, above. As a private practice, POS 11 is used. This is not telehealth, according to Medicare, so POS 02 is not applicable in this situation.

24. A. DATE(S) OF SERVICE From MM DO YY	To MM DO YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVI (Explain Unusual Circu CPT/HCPCS
01 29 21	02 28 21	11		99453
01 29 21	02 28 21	11		99454
01 29 21	02 28 21	11		99457
01 29 21	02 28 21	11		99458

43) Medi-Cal Modifiers: Approved List, Updated August 2020: https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/modifapp.pdf.

PATIENT 4: 45-year-old patient meets with staff of an FQHC clinic to be fitted for/educated about a remote monitoring device on the 15th of the month and undergoes monitoring that lasts through the 16th of the next month (30 days). The physician interprets the data and communicates to the patient about changing her regimen. *Insurance: Medi-Cal.*

CODE IT:

There is nothing to be billed with regard to RPM. The place of treatment is at an FQHC; however, the visit with the patient can be billed.

PATIENT 5: 74-year-old man has consented to an eConsult, as he agrees his Primary Care Provider (PCP) should consult with an endocrinologist. The PCP prepares the clinically relevant question to the endocrinologist. The endocrinologist responds back to the PCP and PCP contacts patient to engage in care plan per the specialist's recommendations. *Insurance: Medicare*

CODE IT:

PCP Coder: The PCP documented the question, received the information back, and communicated the findings and care plan back to the patient. The PCP documented 35 minutes of time.

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPL. (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER
01 29 21	01 29 21	22		99452	

Specialist Consultant Coder: the specialist, located at a tertiary care center in a facility-based clinic, documented the response and indicated at least 5 minutes of time was spent in the consideration of the reported findings and in responding to the question

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPL. (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER
01 28 21	01 28 21	22		99451	

PATIENT 6: 35-year-old man has consented to eConsult. Primary care physician (PCP) prepares question to a specialist. Specialist responds back to the PCP and PCP contacts patient to engage in care plan per the specialist's recommendations. *Insurance: Medi-Cal*

CODE IT:

PCP Coder: The coder has nothing to do. Medi-Cal only reimburses for the specialist's activities. However, a follow-up visit might be done if there is follow-up activity advised by the specialist that the PCP can act on.

Specialist Consultant Coder: Same scenario as for Patient 5, above, but with a GQ modifier on the 99451.

PATIENT 7: 65-year-old woman discusses results of genetic testing regarding cancer diagnosis with a Genetic Counselor at a facility-based cancer center. *Insurance: Medicare*

CODE IT:

Medicare does not cover genetic counseling services, as the provider type is not included on its list of eligible telehealth providers. Submit the service on the UB-04 with the GY modifier.

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47
780	Telehealth - General	96040-GY	01/29/21	1	

PATIENT 8: 36-year-old woman discusses results of genetic testing during pregnancy with a Genetic Counselor for one hour at a facility. *Insurance: Medi-Cal*

CODE IT:

Medi-Cal reimburses for genetic counselors (as does GHPP/CCS). Submit with the 96040-equivalent code – S0265, the HCPCS code billed in 30-minute increments for genetic counseling.

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47
780	Telehealth - General	S0265-95	01/29/21	2	

RESOURCES

For more information about your state, please contact your Regional Telehealth Resource Center (RTRC).

California Telehealth Resource Center *(California)* www.caltrc.org 1-877-590-8144	**South Central Telehealth Resource Center** *(Arkansas, Mississippi, Tennessee)* www.learntelehealth.org 1-855-664-3450
Great Plains Telehealth Resource & Assistance Center *(Iowa, Minnesota, Nebraska, North Dakota, South Dakota, Wisconsin)* www.gptrac.org 1-888-239-7092	**Southeast Telehealth Resource Center** *(Alabama, Florida, Georgia, South Carolina, Puerto Rico, Virgin Islands)* www.setrc.us 1-888-738-7210
Heartland Telehealth Resource Center *(Kansas, Missouri, Oklahoma)* www.heartlandtrc.org 1-877-653-4872	**Southwest Telehealth Resource Center** *(Arizona, Colorado, Nevada, New Mexico, Utah)* www.southwesttrc.org 1-877-535-6166
Mid-Atlantic Telehealth Resource Center *(Delaware, Kentucky, Maryland, New Jersey, North Carolina, Pennsylvania, Virginia, West Virginia, District of Columbia)* www.matrc.org 434-906-4960	**TexLa Telehealth Resource Center** *(Louisiana & Texas)* www.texlatrc.org 1-877-391-0487
Northeast Telehealth Resource Center *(Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont)* www.netrc.org 1-800-379-2021	**Upper Midwest Telehealth Resource Center** *(Illinois, Indiana, Michigan, Ohio)* www.umtrc.org 1-855-283-3734, ext. 238
Northwest Regional Telehealth Resource Center *(Alaska, Idaho, Montana, Oregon, Utah, Washington, Wyoming)* www.nrtrc.org 1-833-747-0643	**Center for Connected Health Policy** **(National Policy TRC)** www.cchpca.org 1-877-707-7172
Pacific Basin Telehealth Resource Center *(Hawaii & US Affiliated Pacific Islands)* www.pbtrc.org 1-808-956-2897	**Telehealth Technology Assessment Center** **(National Technology TRC)** www.telehealthtechnology.org 1-907-726-4703