Coding for COVID: How to Bill for Telehealth During COVID-19

May 12, 2020
Welcome and Introduction to the Webinar

Mei Wa Kwong, JD
Executive Director
Center for Connected Health Policy
About the California Telehealth Policy Coalition

In 2011 when AB 415, the Telehealth Advancement Act, was winding its way through the legislative process, an ad hoc group of statewide organizations supporting the bill formed. Including such groups as the California Primary Care Association, the California Hospital Association and the California Rural Health Association, these groups met in meetings convened by CCHP in order to be apprised of any developments around AB 415 and share information with each other.

With the successful passage of AB 415, the group continued to meet and eventually formed into the California Telehealth Policy Coalition. From a handful of organizations, the membership has grown to include over eighty-five entities that include consumer groups, medical systems, payers, providers, technology representatives and others. CCHP continues to act as the convener of the Coalition and hosts monthly conference calls with continued support from the California Health Care Foundation in this work.

Please visit our website for more information or if you are interested in joining.
New Coalition fact sheets on telehealth

Fact sheets are available on our [website].

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Answer frequently asked questions on how to bill for telehealth during the COVID-19 state of emergency.

- Help stakeholders identify which services and fees can be billed, through what modalities, and by which providers.
- Distinguish billing rules for different payer types (Medicare, Medi-Cal and commercial)
Agenda

• Introduction to the webinar and the Telehealth Policy Coalition
• Introduction to our guest speakers
• Structured FAQ on telehealth billing during COVID-19
• Facilitated Q&A

Please submit any questions you have during today’s webinar into the Q&A, not the chat.
Today’s webinar speakers

Bao Xiong
Assistant Director of Health Center Operations
California Primary Care Association

Carol Yarbrough
Business Operations Manager, Telehealth
UCSF
Many thanks to the sponsors of today’s webinar
OVERVIEW OF TELEHEALTH AND TELEPHONE BILLING:
FQHCs AND RHCs
Telehealth Services During COVID-19 Public Health Emergency

Medicare Synchronous Telehealth Services
- FQHCs and RHCs can serve as telehealth originating site providers and bill for the originating site fee.
- FQHCs and RHCs can serve as telehealth distant site providers and bill for covered telehealth services to receive FFS reimbursement.

Medi-Cal Synchronous & Asynchronous Telehealth Services
- FQHCs and RHCs can serve as originating or distant site providers and bill PPS or AIR rate for synchronous and asynchronous telehealth services.

Medi-Cal Telephone Services
- FQHCs and RHCs can provide and bill their PPS or AIR rate for telephone visits that meet documentation criteria.
- FQHCs and RHCs can provide and bill FFS for telephone visits that DO NOT meet documentation criteria.
# Medicare Telehealth During COVID-19 Public Health Emergency

| Modality | Generally requires audio and visual communication  
| Effective March 1, 2020, CMS is waiving the video requirement for certain counseling and education services and for telephone evaluation and management services. |
|---|---|
| Eligible provider | Physicians  
Nurse practitioners  
Physician assistants  
Nurse-midwives  
Clinical nurse specialists  
Certified registered nurse anesthetists  
Clinical psychologists  
Clinical social workers  
Registered dietitians or nutrition professional |
| Eligible service | Current eligible telehealth services – the list of eligible codes is available at  
[https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes](https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes)  
Telehealth services expanded to include audio-only telephone evaluation and management services (CPT codes 99441, 99442, and 99443) |
| Eligible Patient | New and established patients |
| Patient’s location | The patient can be located anywhere including the patient’s home. |
| Reimbursement Rate | FFS rate of $92.03 |
# Medicare Telehealth During COVID-19 Public Health Emergency

## Synchronous Telehealth – Distant Site Provider (FQHCs and RHCs)

<table>
<thead>
<tr>
<th>Billing guidance</th>
<th>Rural Health Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Claims will be paid at the AIR rate and automatically reprocessed beginning on July 1, 2020, at the $92.03 rate</td>
</tr>
<tr>
<td></td>
<td>July 1, 2020 – End of COVID-19 PHE: Use HCPCS G2025</td>
</tr>
<tr>
<td></td>
<td>• Claims will be paid at the $92.03 rate</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Federally Qualified Health Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 27, 2020 – Jun 30, 2020: For telehealth distant site services that are also FQHC qualifying visits, FQHCs must report three HCPCS/CPT codes:</td>
</tr>
<tr>
<td>- FQHC Prospective Payment System (PPS) <strong>specific payment code</strong> (GO466, G0467, G0468, G0469, or G0470);</td>
</tr>
<tr>
<td>- HCPCS/CPT code that describes the services furnished via telehealth with modifier 95;</td>
</tr>
<tr>
<td>- G2025 with modifier 95.</td>
</tr>
<tr>
<td>Claims will be paid at the PPS rate and automatically reprocessed beginning on July 1, 2020, at the $92.03 rate.</td>
</tr>
</tbody>
</table>

When furnishing services via telehealth that are not FQHC qualifying visits, FQHCs should hold these claims until July 1, 2020, and then bill them with HCPCS code G2025.

July 1, 2020 – End of COVID-19 PHE: Use HCPCS code **G2025** |
| • Claims will be paid at the FFS rate of $92.03 |


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During COVID-19, FQHCs and RHCs are authorized to serve as originating site providers without regard to geographic location.

Bill the telehealth originating site facility fee on a RHC or FQHC claim under revenue code 0780 and HCPCS code Q3014.
### Medicare Telehealth Billing Examples

#### RHC Billing for Telehealth Distant Site Services

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS Code</th>
<th>Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>G2025</td>
<td>CG (required) 95 (optional)</td>
</tr>
</tbody>
</table>

#### FQHC Billing for Telehealth Distant Site Services

**Example of FQHC Claims for Telehealth Services January 27, 2020 through June 30, 2020**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS Code</th>
<th>Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>G0467 (or other appropriate FQHC Specific Payment Code)</td>
<td>N/A</td>
</tr>
<tr>
<td>052X</td>
<td>99214 (or other FQHC PPS Qualifying Payment Code)</td>
<td>95</td>
</tr>
<tr>
<td>052X</td>
<td>G2025</td>
<td>95</td>
</tr>
</tbody>
</table>

**FQHC Claims for Telehealth Services starting July 1, 2020**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS Code</th>
<th>Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>G2025</td>
<td>95 (optional)</td>
</tr>
</tbody>
</table>

© California Telehealth Policy Coalition
<table>
<thead>
<tr>
<th>Service</th>
<th>Synchronous Telehealth</th>
<th>Asynchronous Telehealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modality</td>
<td>• Real-time live interaction</td>
<td>• Store and forward technology</td>
</tr>
<tr>
<td>Eligible provider</td>
<td>• FQHC/RHC billable providers.</td>
<td>• FQHC/RHC billable providers.</td>
</tr>
<tr>
<td>Eligible service</td>
<td>• FQHC or RHC covered services.</td>
<td>• Teledentistry</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Teledermatology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Teleophthalmology</td>
</tr>
<tr>
<td>Eligible patient</td>
<td>• Established patient restriction remove – can be “new” or “established”</td>
<td>• Established patient restriction remove – can be “new” or “established”</td>
</tr>
<tr>
<td>Patient’s location</td>
<td>• No restriction on patient’s location – can be anywhere including the patient’s home.</td>
<td>• No face-to-face requirement – patient can be anywhere including the patient’s home.</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>• Reimburse at PPS or AIR rate</td>
<td>• Reimburse at PPS or AIR rate</td>
</tr>
</tbody>
</table>
| Documentation | • Maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT or HCPCS codes.  
• Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service. | • Similar documentation requirements to synchronous telehealth services  
• Ensure that the documentation, typically images, sent via store and forward be specific to the patient’s condition and adequate for furnishing or confirming a diagnosis or treatment plan. |
| Patient consent | • Must inform patient about use of telehealth and obtain verbal or written patient consent  
• Consent must be documented in patient’s medical file | • In addition to patient consent requirements under synchronous, asynchronous telehealth providers must:  
- Notify patients their rights to receive interactive communication with the distant specialist physician, optometrist or dentist.  
- Receive an interactive communication upon request during the visit or within 30 days. |

**Medi-Cal Provider Manual: FQHC/RHC Section:** [http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/rural_o01o03.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/rural_o01o03.doc)

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### Medi-Cal Telehealth During COVID-19 Public Health Emergency

<table>
<thead>
<tr>
<th>Service</th>
<th>Synchronous Telehealth</th>
<th>Asynchronous Telehealth</th>
</tr>
</thead>
</table>
| Billing guidance         | • FQHCs and RHCs bill using the same process as other billable visits where the patient is in-person, using the appropriate all-inclusive billing code sets and related claims submission requirements. For example:  
  - Medical visit (FFS): 0521/T1015  
  - Wrap claim: 0521/T1015SE  
  - Mental health: 0900/T1015 AH  
  - Dental (FFS): 03  
  
  • FQHC, RHC, and Tribal 638 Clinics do not bill with POS 02 or Modifier 95. | • Same as synchronous telehealth billing |

During COVID-19, DHCS is waiving the established patient requirement to allow new and established patients to receive telehealth services anywhere, including their home.

**Scenario 9**  
**FQHC/RHC to HHMS Patient Home**
- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is an established patient, and either *homebound, homeless, or a migratory or seasonal worker*.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient’s home.

**Outcome**
- FQHC/RHC is the Distant Site (or Provider Site) and can bill PPS for a face-to-face visit.

**Telehealth Reimbursement Guide:**  
During COVID-19, DHCS is waiving the established patient requirement to allow new and established patients to receive telehealth services anywhere, including their home.
Medi-Cal Telehealth Billing Examples

Example 1: RHC Telehealth Visit with Patient Enrolled in Medi-Cal FFS

<table>
<thead>
<tr>
<th>42 Rev.CD</th>
<th>43 Description</th>
<th>44 HCPCS/RATE/ HIPPS Code</th>
<th>45 Serv.Date</th>
<th>46 Serv. Units</th>
<th>47 Total Charges</th>
<th>48 Non-covered charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Medical Visit</td>
<td>T1015</td>
<td>XXXXX</td>
<td>01</td>
<td>10000</td>
<td>&lt;- payable line</td>
</tr>
<tr>
<td>0521</td>
<td>99213</td>
<td>XXXXX</td>
<td>01</td>
<td>000</td>
<td></td>
<td>&lt;- informational</td>
</tr>
</tbody>
</table>

Example 2: RHC Telehealth Visit with Patient Enrolled in Medi-Cal Managed Care

<table>
<thead>
<tr>
<th>42 Rev.CD</th>
<th>43 Description</th>
<th>44 HCPCS/RATE/ HIPPS Code</th>
<th>45 Serv.Date</th>
<th>46 Serv. Units</th>
<th>47 Total Charges</th>
<th>48 Non-covered charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Managed Care Differential Rate</td>
<td>T1015 SE</td>
<td>XXXXX</td>
<td>01</td>
<td>10000</td>
<td>&lt;- payable line</td>
</tr>
<tr>
<td>0521</td>
<td>99213</td>
<td>XXXXX</td>
<td>01</td>
<td>000</td>
<td></td>
<td>&lt;- informational</td>
</tr>
</tbody>
</table>

Disclaimer: billing examples are for demonstration purposes only.
Telephone visits are PPS eligible if provided and billed consistently with an in-person visit.

- FQHCs/RHCs must follow the documentation criteria below in order to bill at the PPS rate:
  - Document circumstances involved that prevent the visit from being conducted face-to-face. For example:
    - The patient is quarantined at home,
    - Local or state guidelines direct that the patient remain at home, or
    - The patient lives remotely and does not have access to the internet or the internet does not support HIPAA compliance.
  - Document the telephone visit to take place of a face-to-face visit in the patient record.
  - Document the service is medically necessary and clinically appropriate to be delivered via telephonic communication.
  - Meet all other procedure and technical components similar to an in-person visit, including providing a patient history, complete description of provided services, assessment/examination notes, diagnosis, treatments, etc.
  - Ensure sufficient documentation in the medical records that satisfies the requirements of the specific CPT or HCPCS.

Telephone visits that do not meet the documentation criteria are reimbursed at the FFS rate of $13.69.

<table>
<thead>
<tr>
<th>Satisfies Documentation Criteria (Reimbursed at PPS/AIR Rate)</th>
<th>Does Not Satisfy Documentation Criteria (Reimbursed at FFS Rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal FFS patients</td>
<td>Medi-Cal Managed Care Patients</td>
</tr>
<tr>
<td>▪ Use the applicable revenue code corresponding to type of service and HCPCS code T1015 in the “payable” claim line, and</td>
<td>▪ Use HCPCS code G0071 on the “payable” claim line and do not include a corresponding CPT code.</td>
</tr>
<tr>
<td>▪ Use the appropriate and regular CPT ((i.e., 99201-99203 for “new” patients, and 99212-99214 for “established patients) code that corresponds with the level of service provided on the “informational” line</td>
<td>▪ Mechanism in place allowing claims to process separate from PPS</td>
</tr>
</tbody>
</table>

MEDI-CAL BILLING QUESTIONS
How do I bill for telephone visits in Medi-Cal FFS and Managed Care if I’m not an FQHC, RHC or Tribal 638 Clinic?

**Answer**

**Medi-Cal Fee For Service and Managed Care providers can bill for telephone encounters during the PHE.**

Requirements:
- Use modifier 95 and POS 02 (do not use either 95 or 02 if you are an FQHC/RHC/Tribal Clinic if you are billing at your PPS/AIR rate)
- Service must satisfy all the procedural and technical components of the Medi-Cal covered service or benefit being provided except for the face-to-face component
- Managed Care Plans must pay the same rate for a telephone E/M visit as they would for a face-to-face visit

Additionally, DHCS is allowing for providers to bill for “virtual check-ins” using codes G2010 and G2012. Most of these changes also apply to other DHCS programs. ([DHCS Guidance](#), April 30, 2020)

**Use Cases**

**Example 1:** A physician has a phone visit following surgery with a Medi-Cal Managed Care beneficiary during shelter in place (SIP). The visit meets all the E/M code’s requirements except for the in-person component, and the provider sends the claim to the Managed Care Plan.

**Outcome:** The Managed Care Plan must pay the provider, and at the same rate as the contracted rate for the equivalent in-person service. The usual codes are 99201-99215, as well as the consult codes, 99241-99245.
How do I bill for telephone visits if I’m an FQHC, RHC or Tribal 638 Clinic?

Answer

FQHCs, RHCs and Tribal 638 Clinics can bill their PPS or AIR rates to Medi-Cal for telephone visits that satisfy the following criteria.

- Documented circumstances prevent FTF visit (i.e., shelter in place)
- Provider intends for phone visit to take place of FTF, and documents this
- Covered service is clinically appropriate
- Service meets the E/M code descriptor, other than the in-person requirements

PPS eligible telephone visits should be billed using the same process as an in-person visit.

If the encounter does not meet the above criteria, the clinic should bill at the FFS rate using HCPCS code G0071. In either situation, these clinics should bill for the service as though it were provided in-person. They do not need to attach a telehealth modifier. (DHCS Guidance, April 30, 2020)

Use Cases

Example 1: A provider employed by an FQHC conducts a telephone E/M visit with a patient. The visit is clinically appropriate, cannot be conducted in person because of shelter in place, meets the E/M descriptor, and is documented in the EHR.

Outcome: The provider can bill at the PPS/AIR rate. The billing codes can be found [here](#).

(Note that in instances where Medi-Cal is the secondary payer to Medicare, DHCS has yet to provide guidance on whether to bill G2025 on the Medi-Cal claim.)
What is the difference between a telephone E/M visit and a virtual check-in?

Answer

The key difference is in the service provided. A virtual check-in (G2010 and G2012) is either a brief, remote evaluation of patient submitted video/images or a brief communication (5-10 minutes) with a patient.

Virtual check-ins are often used to determine if an office visit is needed and are usually patient-initiated. A telephone E/M service, on the other hand, would include diagnosis and/or management, which a virtual check-in would not.

Use Cases

Example 1: A patient is not sure if she needs to schedule a visit to discuss a medication concern, so she sends her provider a message with an update on her symptoms through her patient portal.

Outcome: The provider responds via message to the patient, and can bill for a virtual check-in, G2012 (no modifier, POS 02).

Example 2: A patient thinks her symptoms are an urgent concern and schedules a telephone visit with her provider, which is conducted several days later.

Outcome: The provider can bill for an E/M telephone visit.
Can I bill for an encounter if the patient is located at home? What about the provider?

Answer

Both the patient and the provider can be located at home for billing purposes. DHCS clarified in the August revision of the telehealth provider manual that the home is an acceptable originating site for the patient’s location.

Normally, FQHCs, RHCs and Tribal 638 Clinics cannot bill for telehealth services where the patient is at home, except for HHMS. However, as mentioned, these limitations have been eased during the emergency.

DHCS has also clarified that providers can provide telehealth services that they provided for their home, including for FQHC/RHC/Tribal 638 services billed at the PPS or AIR rate. (DHCS Guidance, April 30, 2020; Telehealth Provider Manual, 2020)

Use Cases

Example 1: A provider, located at home, conducts a visit with a patient, also located at home, via telephone.

Outcome: Provider can bill for the visit, including at their PPS or AIR rate if the provider is employed by a FQHC/RHC/Tribal 638 Clinic. DHCS is temporarily waiving the “four walls” restriction for FQHC, RHC and Tribal Clinics during the COVID-19 PHE.
How do I bill for originating site and transmission fees?

**Answer**

It depends. Providers can only bill for an originating site fee if the patient is located at a facility, and transmission fees are not always billable.

For live video in FFS and Managed Care, providers can bill the originating site fee (Q3014) once per day for the same patient and provider. The transmission fee (T1014) can be billed up to 90 units (90 minutes) per day for the same patient and provider.

For asynchronous store-and-forward or e-consult in FFS and Managed Care, providers can bill the originating site fee but not the transmission fee.

DHCS does not reimburse for either the originating site fee or the transmission fee for any telephonic services, and for FQHCs, RHCs and Tribal 638 Clinics, for any telehealth services. ([DHCS Guidance](https://dhcs.ca.gov), April 30, 2020)

**Use Cases**

Example 1: A contracted physician provides live video services from a facility-based clinic to a patient located at their home.

Outcome: The facility-based clinic can bill a transmission fee but not an originating site fee.

Example 2: A contracted physician provides live video services from the physician’s home to a patient located at their home. The physician is associated with a facility-based clinic.

Outcome: The facility-based clinic can bill for the transmission fee but not an originating site fee.
Can the transmission code be billed by the hospital and be treated like an in-person, hospital visit for purposes of calculating directed payments under the Hospital Quality Assurance Fee Program?

**Answer**

The program falls under Medicaid and thus any fees deemed payable under Medi-Cal should be submitted. T1014 (x units/minutes for each telehealth encounter) should be submitted.

DHCS policy states, “The funding calculations are processed through the hospital fee model. The hospital fee model calculates the fees and payments for each participating hospital by utilizing each hospital’s daily data to determine the Medicaid utilization rate, federal upper payment limit, and various other data elements.”

( DHCS, HQAF Program Overview )

**Use Cases**

**Example 1:** A contracted physician at a facility-based clinic uses live video to a physician at home for 25 minutes.

**Outcome:** The facility-based clinic can bill a transmission fee of 25 units and should report these units under the Hospital Quality Assurance Fee Program.
How do you bill for telehealth services provided by ancillary staff, residents, or interns? Where can they provide services?

**Answer**

Bill for these visits as you would for in-person/clinic visits. Telehealth is another modality of care delivery and should follow the same rules for in-person visits. Qualified health care providers with NPI number must be on the invoice/CMS 1500. GHPP/CCS has other providers listed as eligible providers for its programs. *(Telehealth Provider Manual, 2020)*

As for residents or interns, they may continue to provide services as set out in the hospital policies and under the guidance of attendings, per usual. The only carve-out during the PHE is that a resident may ‘moonlight’ at their own training facility in order to provide emergency coverage. Otherwise, a resident must seek employment outside their training facility program to obtain additional employment. *(CMS Interim Final Rule, 2020)*

**Use Cases**

*Example 1:* A resident provides dermatology services via telehealth during the PHE.

*Outcome:* The hospital should bill for the resident’s dermatology on the CMS 1500 as it would for other physicians.
How do I get paid for a Well Child visit? Is there still a supplemental payment? Do I need to conduct an in-person follow up visit?

Answer

DHCS is allowing for providers to conduct well child visits over telehealth, including telephone. DHCS has acknowledged that some components cannot be conducted over telehealth (i.e., immunizations).

If a subsequent in-person visit is required to complete the well child visit, the provider should only submit one encounter to DHCS or the Managed Care Plan.

For FQHCs, RHCs and Tribal 638 Clinics, the clinic can receive its PPS or AIR rate if the services are rendered by a billable provider, meet all the requirements of the corresponding CPT/HCPCS codes that would correspond to the visit being done in-person, and satisfy all requirements outlined in Section III of the DHCS April 24 guidance. If not, bill FFS using G0071. (DHCS Guidance, April 24, 2020; Value Based Payment Program Specifications, May 2019)

Use Cases

Example 1: A pediatrician at a private practice conducts a well child visit over telehealth. The patient requires an immunization, provided at a subsequent in-person visit.

Outcome: The provider can bill for one encounter, even though two visits occurred.

Example 2: A pediatrician at an FQHC conducts a well child visit over telehealth during shelter in place. During the visit, the pediatrician meets all the in-person requirements during the telehealth visit.

Outcome: The provider can bill for the encounter at the PPS rate using the same billing process as an in-person visit.
MEDICARE BILLING QUESTIONS
How can I get paid from Medicare for a telephone visit?

**Answer**

During the PHE, providers can bill Medicare for certain encounters provided via telephone. Medicare has published a list of CPT and HCPS codes that can be billed where the encounter is provided using audio only.

Like Medi-Cal, the same distinctions between E/M telephone services and virtual check-ins apply.

*(CMS List of Telehealth Services, April 30, 2020)*

**Use Cases**

**Example 1:** A psychiatrist provides group psychotherapy (90853) to patients through the phone because patients cannot use interactive video.

*Outcome:* The psychiatrist can bill for the service during the PHE.

**Example 2:** A patient initiates a virtual check-in with her PCP, who then conducts a five-minute online digital evaluation of her symptoms.

*Outcome:* The PCP can bill for this service. However, since the visit started as a telephone visit and resulted in an online visit, 99421-3 would be used instead of 99441-3. The PCP cannot bill for a G2010/G2012 because a virtual check-in cannot result in a subsequent E/M visit within 24 hours or soonest available.
What does a digital E/M look like?
Consent obtained and term and conditions simply set forth.

Thank you for your [EMR] message to [Practice/Provider]. We are now offering eVisits where your practitioner can evaluate your question (including photos you uploaded) and make recommendations. These eVisits will be billed to your health plan and may result in your receiving a bill for your copay or any amount applied to your deductible. Please reply and confirm that you would like us to proceed with your eVisit.

Thank you. I would like to proceed with scheduling an eVisit.
What does a digital E/M look like?
Consent obtained and term and conditions simply set forth.

Thank you. I’ll follow your instructions.

That looks painful. I’ve ordered you a new RX and after a couple days check back in with me if the medication is not helping.

I spent a total of 25 minutes reviewing the patient’s prior medical records and eVisit submission, prescribed medication, replied to the patient and documented the encounter. I did not schedule the patient for a face-to-face visit within the next 7 days.
What is required to document a telephone E/M?

99441 - Telephone evaluation and management service by a physician or other qualified health care professional **who may report evaluation and management services** provided to a[n] [new or] established patient, parent, or guardian 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

99442 - …; 11-20 minutes of medical discussion

99443 - …; 21-30 minutes of medical discussion
I heard that providers don’t need to document anything other than time or MDM during the PHE. Is that true?

- Yes – the 2021 E/M Guidelines are in use under the PHE; however, the times indicated by current CPT are in use, not the time spans indicated to the right.
  - MDM or Time
  - Slight modifications to Table of Risk to assess MDM

What providers can bill Medicare for telehealth?

**Answer**

CMS has temporarily expanded the set of providers that can bill for telehealth services. Traditionally, only physicians and certain “qualified health care professionals” can bill telehealth services. During the PHE, an expanded set can, including occupational therapists, physical therapists, and speech therapists.

Additionally, FQHCs and RHCs can serve as distant sites during the PHE. Providers working for FQHCs and RHCs can furnish services from any location, including their home, for any approved telehealth service included in the PFS.

- From January 27 to June 30, 2020, FQHCs/RHCs should report the revenue code, HCPCS code G2025, and the CG modifier.
- From July 1, 2020 onward, RHCs should report the revenue code, HCPCS code G2025 and the modifier 95.


**Use Cases**

**Example 1:** An occupational therapist employed by a non-FQHC/RHC ambulatory facility provides an OT evaluation of high complexity for 60 minutes (97167) via live video.

**Outcome:** The OT can bill for this service during the PHE by attaching modifier 95 to the claim.

**Example 2:** A physician employed by an FQHC conducts a routine office visit with an established patient (99201) on May 12, 2020.

**Outcome:** The FQHC can bill for telehealth services with dates of services from 1/27/20 through 6/30/20 by reporting 3 CPT/HCPCS codes:
- FQHC PPS payment code (G0466-70)
- HCPCS/CPT code that describes the services, with modifier 95
- G2025 with modifier 95

As of 7/1/20, FQHCs/RHCs should bill telehealth claims with HCPCS code G2025, not modifier CG.
How do I bill for “incident to” services provided via telehealth?

Answer

*CMS changed this rule earlier this year for “incident to” services.* “Incident to” services are certain services provided by non-physicians “incident to” a physician service. As of January 1, 2020, therapists only require a minimum level of general supervision to be able to submit encounters for “incident to” services.

As mentioned, during the PHE, non-physicians (including occupational therapists, physical therapists and speech therapists) can now bill for the same telehealth services as physicians and other qualified healthcare practitioners. Supervising physicians can amend their care plans with these non-physicians to include telehealth.

(CMS Manual System, January 15, 2020)

Use Cases

*Example 1:* An occupational therapist and her employer physician amend a patient’s care plan to allow for her to conduct her visits with patients through live video telehealth or telephone. The OT then conducts a visit with therapeutic activities over live video (97530).

*Outcome:* The OT can bill for this service during the PHE.

Note: “Incident to” means there is a contractual relationship between the QHP and the non-QHP. Therefore, these therapists at a facility-based clinic must bill on a UB-04.
How can palliative care physicians bill for advance care planning conversations performed via telehealth or telephone?

**Answer**

Palliative care providers can bill for advance care planning conversations provided through telehealth and telephone. Normally, CMS requires these encounters (CPT 99497-8) to be provided in person for reimbursement.

However, during the PHE, CMS is allowing for providers to bill for these encounters using audio-only interactions and live video telehealth ([MLN Matters, August 2019](https://www.cms.gov/newsroom/market-access-and-telehealth-services) ; [CMS List of Telehealth Services, April 30, 2020](https://www.cms.gov/telehealth-services)).

**Use Cases**

*Example 1:* A nurse practitioner conducts an advanced care planning visit with a patient to discuss an advance directive (99497) using a live video platform.

*Outcome:* The nurse practitioner can bill for this service during the PHE.
COMMERCIAL PAYER BILLING QUESTIONS
How do I bill commercial health plans for telehealth? What services are covered?

**Answer**

DMHC has told its licensed, commercial health plans that they must reimburse contracted providers for services that have an in-person equivalent. This includes live video, telephone and asynchronous store-and-forward where there is an in-person equivalent. Live video and telephone should be billed using modifier 95, and store-and-forward using GQ.

CDI has not published a mandate to regulated PPO insurers but has reminded insurers that they must continue to provide medically necessary services. You should check with the insurer to understand their telehealth coverage and billing policies during COVID-19. ([DMHC APL 20-013](https://www.dmhc.ca.gov/Medical_Policies/telehealth_policy.php), April 7, 2020; [CDI Notice](https://www.cdipolicy.ca.gov/), March 30, 2020)

**Use Cases**

- **Example 1**: A physician contracted with a DMHC-licensed plan conducts a routine office visit for 30 minutes (99203) with her patient using live video. Her current contract with the plan does not specify whether she can bill for services provided via live video.

  **Outcome**: The physician can bill for the service.

- **Example 2**: Same scenario as above, except the payer is a CDI-regulated insurer.

  **Outcome**: The physician should check the insurer’s billing policies. The insurer is not required to pay for telehealth.
What rate do commercial health plans have to pay providers for telehealth services?

**Answer**

DMHC is requiring licensed commercial plans to pay for telehealth services, including telephone, at the same rate as their in-person equivalent. This applies even if the current contract does not specify whether telehealth services can be provided, and at what rate.

CDI has not mandated payment parity. However, CDI has notified insurers that they should implement reimbursement rates that mirror those for equivalent in-person visits.

Note that both DMHC and CDI commercial plans will be subject to telehealth payment parity requirements for contracts executed on or after January. *(DMHC APL 20-013, April 7, 2020; CDI Notice, March 30, 2020)*

**Use Cases**

*Example 1:* A physician contracted with a DMHC-licensed plan conducts a store-and-forward evaluation of a patient’s skin rash (99203). The physician’s contract does not specify whether she can provide telehealth services or at what rate.

*Outcome:* The plan must reimburse her at the same rate as an in-person office visit. She should attach modifier GQ.

*Example 2:* Same scenario as above, except the payer is a CDI-regulated insurer.

*Outcome:* The physician should check the insurer’s billing policies. The insurer is not required to pay for telehealth.
How do I bill self-insured employer plans for telehealth?

**Answer**

This depends entirely on the self-insured employer’s telehealth billing policy. These self-insured plans are not subject to state coverage mandates. Even though many third-party administrators with state-regulated lines of business cover telehealth, their contracted employers may not.

**Use Cases**

*Example 1:* A physician contracted with a self-insured employer’s HMO conducts a store-and-forward evaluation of a patient’s skin rash (99203). The physician’s contract does not specify whether she can provide telehealth services or at what rate.

*Outcome:* The physician should check the plan’s billing policies. The plan is not required to pay for telehealth.
Key Considerations

- Check CMS, DHCS, DMHC or other agency guidelines for billing updates
- Reference payer policies for any plan-specific billing policies
- Review CPT and HCPCS code descriptors carefully to understand whether the telehealth services meets the requirements
- Understand which of your providers will be providing telehealth, and for what services
- Document all visits in the patient medical record
- If in doubt, submit the claim. You can always appeal on the basis of the denial code and start a conversation with your payers
Facilitated question and answer

Please submit your questions in the Q&A box.