Telehealth Virtual Visit Reimbursement Guide
July 2023

Pacific Basin Telehealth Resource Center

This information or content and conclusions are those of the author and should not be construed as the official position of policy of, no should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

Notice

This document is intended as a guide to assist providers in obtaining information on telehealth reimbursement. This document does not constitute legal advice. Many factors affect the appropriateness of submitting a particular claim for reimbursement. The information should be used in consultation with your billing specialist and other advisers in initiating telehealth billing.

Reimbursement information can become outdated quickly and is subject to change without notice. We recommend review of this material on a regular basis to assure the information is up to date. Please visit www.pbtrc.org to download the latest version. PBTRC does not guarantee payment for any service.

The Pacific Telehealth Resource Center is a prominent source of comprehensive knowledge on the development and operation of telemedicine and telehealth programs. PBTRC focuses on telehealth expansion and working through all areas of the community to connect those in need of telehealth support or information.

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Introduction

Many changes for telehealth coverage have occurred since the COVID-19 Public Health Emergency (PHE) was declared on January 31st, 2020 including the many updates that CMS provided at the beginning of March 2020. The continuous changes have allowed for telehealth expansion at an accelerated pace

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while also making it complex for providers and staff to understand the requirements in order to bill for telehealth services.
The Pacific Basin Telehealth Resource Center (PBTRC) has developed this informational billing guide to assist with those who have any questions concerning telehealth billing. This guide will review common terms, and policies from Medicare, Medicaid (Hawaii MedQuest), and our local commercial payers. The purpose of this guide is to provide guidance to:

- ✓ Telehealth billing (CPT codes, modifiers, POS, and other information to assist with reimbursement)
- ✓ Payer-specific policies/procedures
- ✓ Documentation requirements
- ✓ Software solutions
- ✓ Overview of bills or state-level changes that impact telehealth coverage/billing

This guide will review the permanent policies that each payer has enacted as well as provide guidance now that the PHE ended on May 11th, 2023. Since the news of the PHE ending, many payers have provided end dates to copay waivers or have stated that coverage will extend through the end of the calendar year. Some payers have come out with more stringent policies as it relates to what is covered, for a summary of all changes, refer to the next section. Please note that this information changes rapidly, we will continue to work on this guide and update it as new changes come out, including with the annual updates per Medicare guidelines that is published each November.

Summary of Changes

May 2023 Changes:

Section	Subsection (if applicable)	Changes
Notice		• Added in clarifying position about information presented in the guide
Introduction		• Updated introduction section overview • Defining PHE end date • Update to overview of what is including in the document
Common Regulatory Terms		• Originating site 'note' describing changes now that the PHE has ended • Eligible provider definition per Medicare • Hawaii criteria for eligible providers-related to previous telehealth bills in place prior to PHE
Visit Types	Telehealth	• Reporting criteria (audio-only & HIPAA-secure software) • Documentation requirements (HIPAA-compliant software) • Note on POS codes
Visit Types	Virtual Check-ins	• Reporting criteria (established patient & HIPAA-secure software) • Documentation requirements (HIPAA-compliant software)

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Visit Types	E-Visits	• Reporting criteria (established patient & HIPAA-secure software) • Documentation requirements (HIPAA-compliant software)
Visit Types	Virtual Check-in	• Reporting criteria (established patient & HIPAA-secure software) • Documentation requirements (HIPAA-compliant software)
Visit Types	Telephone Visits	• Reporting criteria (established patient & HIPAA-secure software) • Audio-only POS Note
Visit Types	Remote Patient Monitoring	• Reporting criteria (established patient & HIPAA-secure software) • Note regarding expanded coverage per CMS ending • RTM codes
Visit Types	Specialty Consults (eConsults)	• No changes
Specific Visit Type Guidance	Annual Wellness Visits	• Updates related to explanation when elements cannot be completed through telehealth; removal of the wording "could not be completed due to COVID-19".
Specific Visit Type Guidance	EPSDT Visits	• Note on lack of coverage from MedQuest • Most of the section removed for document clarity purposes
Payor Matrix		Updates are in green in the corresponding boxes
Payer Specific Guidance	Aetna	• POS 10 for Medicare Advantage • Covered CPT codes • Patient Type/Other info boxes • Virtual check-in Codes • Platform suggestions • Note on policy wording related to commercial coverage post-PHE
Payer Specific Guidance	AlohaCare	• Updated telephone coverage to match MedQuest's new policy • Updated note on policy changes; no others noted at this time
Payer Specific Guidance	Cigna	• Evisit codes and coverage update
Payer Specific Guidance	HMSA	• Updated policy link • Updated coverage for commercial plans • Remove of eVisit codes • Added RPM codes

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Payer Specific Guidance	Humana	• Removal of evisit codes
Payer Specific Guidance	Medicaid (Hawaii MedQuest):	• Changes to reflect policies in place pre-PHE • New policy introduced for audio-only behavioral health
Payer Specific Guidance	Medicare	• Notate about coverage through 2024 • Software HIPAA-compliance
Payer Specific Guidance	Ohana/WellCare	• Removal of eVisit codes • Addition to phone codes and note related to coverage circumstances aligning with MedQuest
Payer Specific Guidance	United HealthCare	• Note on when telephone only is covered • Update on audio-only coverage
Cost Sharing Waivers		• Section was removed, as waivers applied to COVID-19 and the PHE.
Telehealth Guidelines by Facility Type	Rural Health Clinics (RHCs)	• Distant site expansion through 2024 • Updates on coverage dates • Cost sharing information removed • Updated telephone coverage
Telehealth Guidelines by Facility Type	Federally Qualified Health Centers (FQHCs)	• Distant site expansion through 2024 • Updates on coverage dates • Updated telephone coverage • Removal of MedQuest policies that expired • Cost sharing information removed
Telehealth Guidelines by Facility Type	Physical/Occupational/Speech Therapy	• Updated policies/coverage by payer including CPT codes. Payers with updated information: Humana, HMSA, Medicare, United Healthcare • CAA expansion on qualifying providers through 2024
Billing Scenarios		• Removal of diagnosis code recommendations that relate to COVID-19 diagnosis for each scenario
HIPAA Compliant Software		• Introduction section • 90-day transitional period to allow for implementation of secure technologies post-PHE
Coverage in Hawaii Beyond COVID-19		• Title of the section • Geographical limitations • Out of state providers • Originating site • Facility fee • Prior relationship • Opioid prescribing

		• Copays and out of pocket line removed • Audio-only • Tech-based communication • Non-compliant software line removed • Own device line removed • Modifiers and POS removed • FQHC/RHC Section removed (redundant material • Overview of Policy QI-2306; Real-time Audio Interaction Policy After PHE
Acronyms		• New section listing all acronyms in this document
References & Resources		• Addition of new resources/embedded documents for policy changes • Added dates on links for new references

Common Regulatory terms

Originating Site	is where the patient is located when the telehealth interaction takes place. In Medicare, it is limited to both geographically and by the specific site a patient is located in at the time of the telehealth interaction (i.e. home, school, other physician's office) <u>Note:</u> The PHE allowed for flexibilities for providers to see patients across state lines, now that the PHE has ended, many states have rolled back these rules and require either a license in the state that the patient is located or participation in the interstate compact for those states that are participating.
Distant Site	a site where a health care provider who provides healthcare services is located while providing these services via a telecommunications system. The distant site can be different from the administrative location. This allows the provider to be in a location suitable to telehealth encounters but not necessarily in a clinic or facility. Medicare guidance does stipulate that the provider cannot be physically located outside of the United States when providing healthcare services.
Eligible Providers	Using the Medicare definition, there are limits to the type of providers 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), Registered Dietitians (RDs) or nutrition professionals. According to the Consolidated Appropriations Act (CAA), PT/OT/ST can continue to utilize telehealth through December 31, 2024. In the previous guidance direct from Medicare, it would allow billing up to 151 days after the PHE ended, CAA extended this flexibility.
Hawaii Criteria for Eligible Providers	Bill **§346-59.1** related to 'Coverage of Telehealth' defines healthcare provider as the following: means a provider of services, as defined in title 42 United States Code section 1395x(u), a provider of medical and other health services,

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	as defined in title 42 United States Code section 1395x(s), other practitioners licensed by the State and working within their scope of practice, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.
Coding Terminology	
Codes	Common Procedural Terminology (CPT) codes are defined as a uniform language for coding medical services and procedures. All CPT codes are 5 digits and can either be alphanumeric or numeric depending on their associated category.
Category I	These codes have descriptors that correspond to a procedure/service. Codes range from 00100-99499 and are generally ordered into subcategories based on the procedure or service type as well as anatomy.
Category II	These are alphanumeric tracking codes that are supplemental and used for performance measurement. These are not related to correct coding. The primary use for these codes are reporting quality improvement measures to payors.
Category III	These codes 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. *Modifiers:* Modifiers 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. 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. • G0 (zero): Used to identify telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke • GQ: Only used in Alaska and Hawaii. Asynchronous telehealth services • GT: Synchronous telemedicine services rendered via a real-time interactive audio and video telecommunications system. This is no longer a recognized modifier, though some private payers still use and prefer the GT modifier. • 95: Synchronous telemedicine services rendered via a real-time interactive audio and video telecommunications system. *Managed care and private plan policies vary on what modifier they require in order to bill for telehealth (GT or 95).*
Evaluation & Management 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 payors based on time or medical decision making (MDM). The CPT codes affected are: 99202-99215, only 99201 was deleted.

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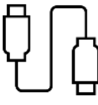
Non-telehealth Technology Services	Communication Technology Based Services (CTBS) CTBS are represented by CPTs that describe technology-based services but are not labeled “telehealth” by CMS. Because of this, providers may bill and get reimbursed for them even if the patient is at home or if they live in a city. The 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.
Remote Evaluation and Virtual Check-In	These CTBS codes were introduced in 2019 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 (for example the patient calls in and the provider calls them back)
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.

Telehealth

Definition: There are three types of telehealth services:



Asynchronous Telehealth (Store & Forward): is the transfer of digital images, sounds, or previously recorded video from one location to another to allow a consulting practitioner (usually a specialist) to obtain information, analyze it, and report back to the referring practitioner. This is a non-interactive telecommunication because the physician or health care practitioner views the medical information without the patient being present.

Synchronous Telehealth: is real-time interactive video teleconferencing that involves communication between the patient and a distant practitioner who is performing the medical service. The practitioner sees the patient throughout the communication, so that two-way communication (sight and sound) can take place.

Remote Patient Monitoring: is use of digital technologies to collect health data from individuals in one location and electronically transmit that information to providers in a different location for assessment.

Though not technically a telehealth code/definition, RPM is utilized in many telehealth settings and is a progressive way to monitor patients outside of the clinic setting.

CPT/HCPCS Codes:

- Telehealth eligible CPT/HCPCs codes vary by payor (refer to payor guidelines section for each payors policies).

Place of Service Codes

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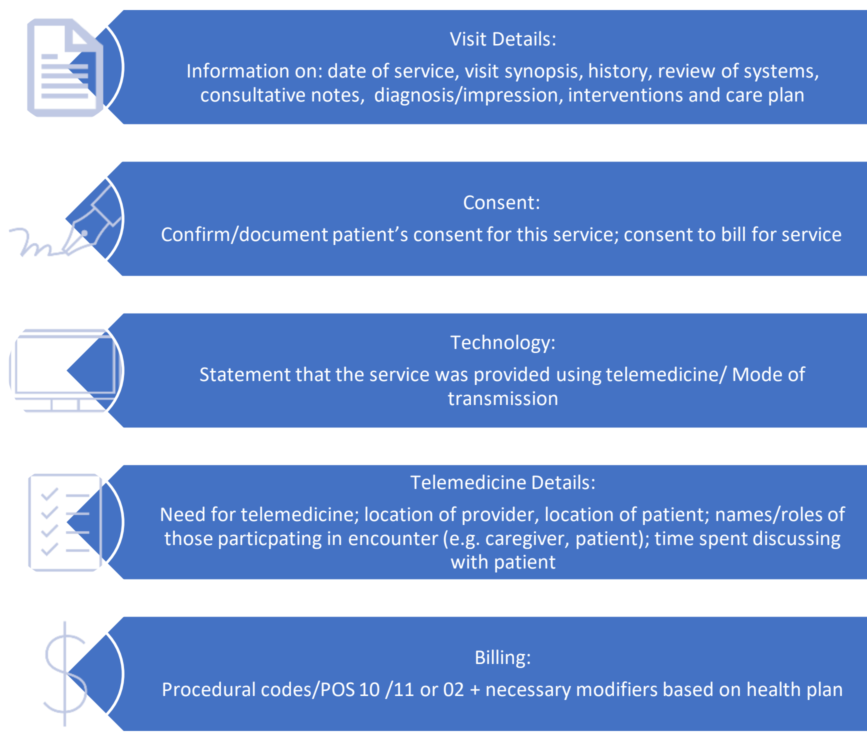
POS 02: Telehealth Provided Other than in Patient's Home*	POS 10: Telehealth Provider in Patient's Home (Effective January 1st, 2022)	POS 11: Office
• The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology. • *Note-Renamed on January 1st, 2022, previously was only called "Telehealth"	• 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	• Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

NOTE: Most payers have reverted to original telehealth POS coding to ensure that they capture the right information. During the PHE, this was waived to allow for regular office visit coding to ensure payment for telehealth services matched that of in-office visits. We recommend ensuring POS accurately reflect telehealth moving forward for accurate claim reimbursement.

Reporting Criteria:

- ✓ Report the appropriate E/M code for the professional service provided.
- ✓ Communication must be performed via live two-way interaction with both video and audio.
- ✓ Please refer to each payer guideline to ensure audio-only is covered, if that is the only option available for the patient (many have eliminated coverage after PHE end date)
- ✓ HIPAA compliant platform software must be utilized. Refer to the HIPAA Compliant section for more details.

Documentation Requirements: Documentation Requirements <u>are the same as a face-to-face encounter</u>



EVISITS

Definition:

Online Digital Evaluation and Management Services (E-Visits): are an E/M service provided by a Qualified Healthcare Professional or an assessment provided by a Qualified Nonphysician Healthcare Professional to a patient using an audio and visual software-based communication, such as a patient portal.

CPT/HCPCS Codes:

Reportable by a Qualified Healthcare Professionals:	Reportable by Qualified Nonphysician Healthcare Professionals (Physical Therapists, Occupational Therapists, Speech Language Pathologists, Clinical Psychologists Registered Dietitian, etc.):
99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes.	**G2061/98970**: Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes.
99422: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes.	**G2062/98971**: Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes.
99423: Online digital evaluation and management service, for an established patient,	**G2063/98972**: Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days,

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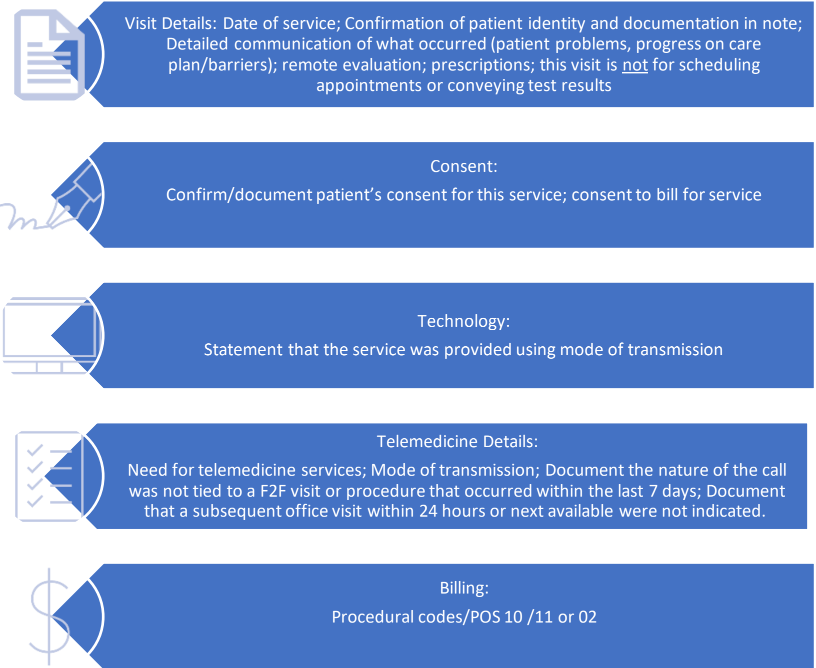
for up to 7 days, cumulative time during the 7 days; 21 or more minutes.	cumulative time during the 7 days; 21 or more minutes.

Reporting Criteria:

- ✓ Online visits must be initiated by the patient. However, practitioners can educate beneficiaries on the availability of e-visits prior to patient initiation.
- ✓ The patient must be established. During the COVID-19 pandemic Medicare and some other payors have waived this requirement, Medicare reinstated the need for establishment after the PHE end date.
- ✓ E-Visit codes can only be reported once in a 7-day period.
- ✓ Cannot report when service originates from a related E/M service performed/reported within the previous 7 days, or for a related problem within a postoperative period.
- ✓ E-Visits are reimbursed based on time.
- ✓ The 7-day period begins when the physician personally reviews the patient's inquiry.
- ✓ Time counted is spent in evaluation, professional decision making, assessment and subsequent management.
- ✓ Time is accumulated over the 7 days and includes time spent by the original physician and any other physicians or other qualified health professionals in the same group practice who may contribute to the cumulative service time.
- ✓ Does not include time spent on non-evaluative electronic communications (scheduling, referral notifications, test result notifications, etc.). Clinical staff time is also not included.

Documentation Requirements:



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VIRTUAL CHECK-IN

Definition:

	Virtual Check-in: A brief check in between a practitioner and a patient via telephone or other audiovisual device to decide whether an office visit or other service is needed. A remote evaluation is recorded video and/or images submitted by an established patient.

CPT/HCPCS Codes:

Virtual Check-ins	Remote Assessment/Brief Communication
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.	**G2250:** Remote assessment 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 service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.
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 appointment.	**G2251:** Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5?10 minutes of clinical 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
	G0071: Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or

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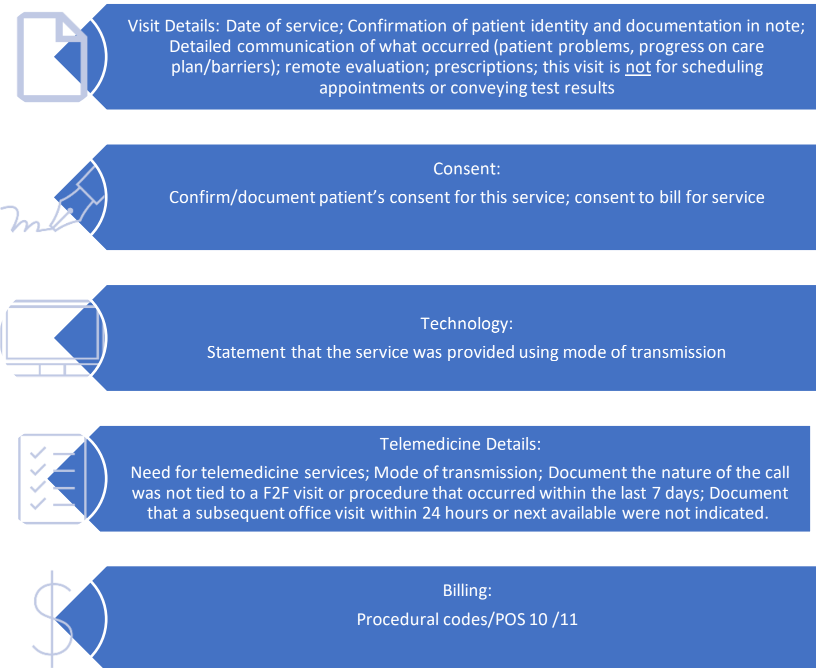
	FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; **RHC or FQHC only**.

Reporting Criteria:

- ✓ The patient must be established. During the COVID-19 pandemic Medicare and some other payors have waived this requirement, Medicare reinstated the need for establishment after the PHE end date.
- ✓ Communication must be a direct interaction between the patient and the practitioner. Not billable if performed by clinical staff.
- ✓ If the virtual check-in originates from a related E/M provided within the previous 7 days, then the service is considered bundled into that previous E/M and would not be separately billable.
- ✓ If the virtual check-in leads to an E/M within the next 24 hours or soonest available appointment, then the service is considered bundled into the pre-visit time of the associated E/M and would not be separately billable.

Documentation Requirements:



TELEPHONE

Definition:

	Telephone: A telephone visit is an evaluation and management service provided by a qualified healthcare professional or an assessment and management service provided by a qualified nonphysician health care professional via audio telecommunication.

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IMPORTANT TIP: According to CMS, these visit types are for an established patient only. The home is the eligible 'originating site'. There must have been a six-month in-person item or service provided, a 12-month subsequent in-person visit. Provider has capability to provide live video but is utilizing audio-only because patient chose or cannot use live video. A service level modifier will be created for these visits and the provider will need to document in the patient record why audio-only was used.

CPT/HCPCS Codes:

Reportable by a Qualified Healthcare Professionals:	Reportable by Qualified Nonphysician Healthcare Professionals (Physical Therapists, Occupational Therapists, Speech Language Pathologists, Clinical Psychologists Registered Dietitian, etc.)*:
99441: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an 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.	**98966:** Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management 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.	**98967:** 11-20 minutes of medical discussion.
99443: 21-30 minutes of medical discussion.	98968: 21-30 minutes of medical discussion.

**Billing is intended for the following: non-physician health care professionals (e.g. psychologist, licensed clinical social worker, occupational therapist, physical therapist, speech therapist); intended for use by practitioners who cannot separately bill E&M services; and when the visit pertains to a service that falls within the benefit category of those practitioners.*

Reporting Criteria:

- ✓ Call must be initiated by the patient.
- ✓ The patient must be established. During the COVID-19 pandemic Medicare and some other payors have waived this requirement, Medicare reinstated the need for establishment after the PHE end date.
- ✓ Communication must be a direct interaction between the patient and the healthcare professional.
- ✓ If the call originates from a related E/M or assessment provided within the previous 7 days, then the service is considered bundled into that previous E/M or assessment and would not be separately billable.
- ✓ If the call leads to an E/M or assessment within the next 24 hours or soonest available appointment, then the service is considered bundled into the pre-visit time of the associated E/M or assessment and would not be separately billable.

Documentation Requirements:

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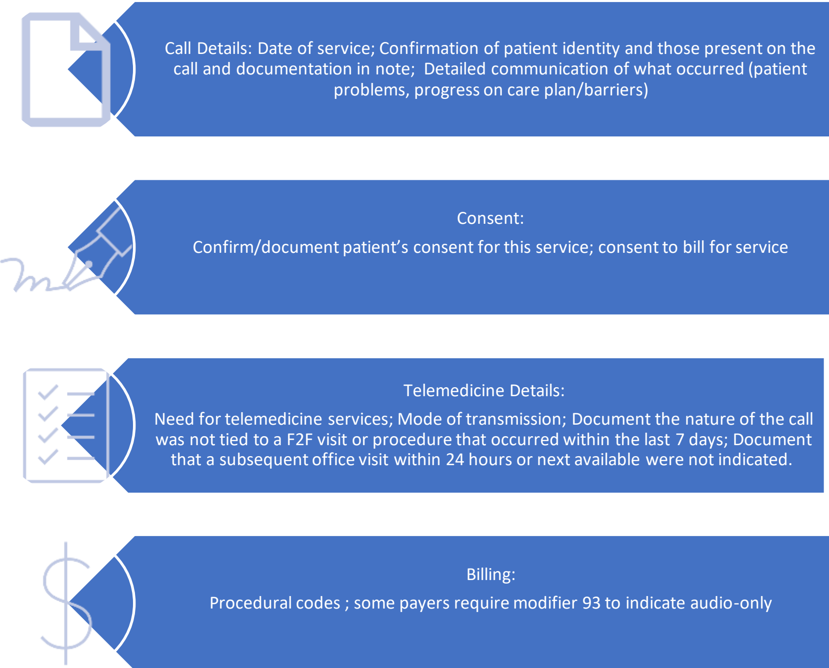

IMPORTANT TIP: According to Hawaii's MedQuest division, each phone call must provide documentation that relates to circumstances that prevented the visit form being face-to-face (patient is quarantined, state or federal guidelines that direct individuals to remain in their home, patient lives in a remote area that does not have access to internet, does not have access to telephone that has audio-visual functions or is unable to utilize those functions, etc.) must be documented.

Remote Patient Monitoring

Definition:

Remote Patient Monitoring: is the use of digital technologies to monitor and capture medical and other health data from patients and electronically transmit this information to healthcare providers for assessment and, when necessary, recommendations and instructions. Also referred to as remote physiologic monitoring.

CPT/HCPCS Codes:

99453: Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment) is valued to reflect clinical staff time that includes instructing a patient and/or caregiver about using one or more medical devices. Providing Education and Set-up of device: All auxiliary personnel (including clinical staff and non-clinical)	**99091:** Collecting and Analyzing Physiologic Data: Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 day. The code includes only

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may provide education to patients on RPM services and set up of the device under this CPT code.*	professional work and does not contain any direct practice expense (PE). The valuation for CPT code 99091 includes a total time of 40 minutes of physician or NPP work, broken down as follows: 5 minutes of preservice work (for example, chart review); 30 minutes of intra-service work (for example, data analysis and interpretation, report based upon the physiologic data, as well as a possible phone call to the patient); and 5 minutes of post-service work (that is, chart documentation).
99454: Continued Monitoring Over 16-days. Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days) is valued to include the medical device or devices supplied to the patient and the programming of the medical device for repeated monitoring.	**99457**: Management Services for Initial 20 Minutes: Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes) and its add-on code
	99458: Management Services for each Additional 20 Minutes Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/ caregiver during the month; each additional 20 minutes (list separately in addition to code for primary procedure)

**CPT code 99453 can be billed only once per episode of care which "begin[s] when the remote physiologic monitoring service is initiated and ends with attainment of targeted treatment goals''.*

IMPORTANT TIP: The above codes 99457/99458, can be billed for patients with acute and chronic conditions. The services can be ordered and billed only by physician and non-physician practitioners (nurse practitioners, physician assistants) who are eligible to bill Medicare for E/M Services. RPM services are not diagnostic tests and cannot be furnished or billed by an Independent Diagnostic Testing Facility. If more specific codes are available to describe the monitoring, then those codes should be utilized (for example, CPT code 95250 for continuous glucose monitory and CPT codes 99473 & 99474 for self-measured blood pressure monitoring.

95250: is used for the technical component of CGM, and covers patient training, glucose sensor	**99473:** can be used when a patient receives education and training (facilitated by clinical

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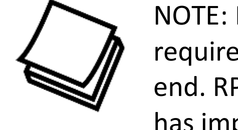
placement, monitor calibration, use of a transmitter, removal of sensor, and downloading of data. CPT code 95250 may be appropriate for retrospective CGM and for the initial training, hookup, download, etc.	staff) on the set-up and use of a SMBP measurement device validated for clinical accuracy, including device calibration. 99473 can only be reported once per device.
	99474: can be used for SMBP data collection and interpretation when patients use a BP measurement device validated for clinical accuracy to measure their BP twice daily (two measurements, one minute apart in the morning and evening), with a minimum of 12 readings required each billing period.



NOTE: Now that the PHE has ended, the below CMS temporary modifications to RPM requirements to enable individuals to receive care virtually during the PHE will come to an end. RPM services will once again only be provided to established patients. If your practice has implemented any procedures related to these modifications, we suggest reverting to original workflows until CMS makes permanent changes to reflect expansion in this area.

- New patients can receive RPM services without an in-person visit.
- Those who have contracted with a billing physician or practitioner to provide RPM services may obtain consent directly from individuals receiving care. Consent can also be obtained at the time services are provided.
- Monitoring days have been decreased from 16 to 2 allowing individuals who would benefit from shorter periods of monitoring to receive care. In many cases, short-term monitoring that traditionally occurs in-person can be provided virtually.

NOTE: is related to Remote Therapeutic Data from a connected device; the allowed codes are as follows:

- Respiratory Monitoring (98976)
- Musculoskeletal Monitoring (98977)
- Cognitive Behavior Monitoring (989X6)

The above codes must be billed by qualified providers outside of physicians/NPP (E.g. PT, RD, and clinical psychologists). RTM reimbursement and requirements are generally aligned with RPM codes as discussed in this section: a device code (16 measurement-days required) and a 20-minute care management code.

Reporting Criteria:

- ✓ Consent is required to be obtained prior to use of any RPM services.
- ✓ The patient must be established. During the COVID-19 pandemic Medicare and some other payors have waived this requirement, Medicare reinstated the need for establishment after the PHE end date.
- ✓ Documentation of the device utilized

Documentation Requirements:

Each service has specific documentation requirements depending on what is being measured, at bare minimum the time spent, consent, data reviewed are required. Please refer to the clinical coverage policies of each payer to remain compliant with this service.

eConsults (Specialty Consults)

Definition:

eConsults: An econsult is a modality in the field of telehealth that falls under the category of "store and forward." The primary care provider (or other continuity provider) initiates the econsult through a traditional referral pathway, ideally supported by clinical checklists. The specialist then gives advice or renders an opinion that the primary care provider (PCP) receives and acts on. An econsult can be as simple as a "curbside" opinion between the specialist and PCP that is intentionally general, but most e-consults include signed, patient-specific clinical advice. Unlike a traditional consult, the patient does not have direct contact with the specialist at this point in the process. Oftentimes, the clinical question is answered solely via econsult, although the specialist will sometimes eventually see the patient in a face-to-face encounter. The rate of conversion to face-to-face depends on the clinical condition. When a face-to-face is required, only one visit will often be needed thanks to the pre-visit preparation completed via econsult.

CPT/HCPCS Codes:

99446 written report with discussion, 5-10 minutes. "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; 5-10 minutes of medical consultative discussion and review"	**99449** written report with discussion, 31+ minutes. 31 minutes or more of medical consultative discussion and review
99447 written report with discussion, 11-20 minutes. 11-20 minutes of medical consultative discussion and review	**99451** 5+ minutes. 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 or more minutes of medical consultative time.
99448 written report with discussion, 21-30 minutes. 21-30 minutes of medical consultative discussion and review	**99452** More than 16 minutes (PCP code only). Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes

Reporting Criteria:

- ✓ These are not considered telehealth services yet they utilize the same technology. They use store/forward technology and not interactive, real-time, audio visual communication. Do not use POS 02 or modifier 95 when billing Medicare.

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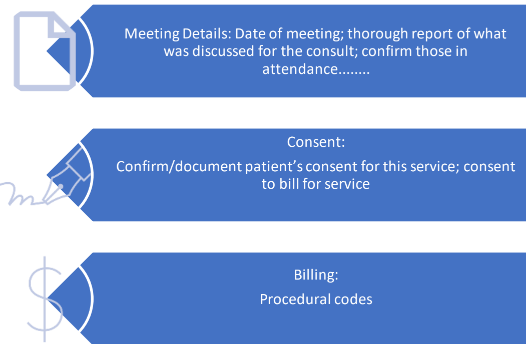
- ✓ For codes 99446–99449, and 99451 the CPT definition specifically says consulting physician, not "or other qualified health care professional"
- ✓ Following CPT rules, do not bill the above codes for services performed by a nurse practitioner or physician assistant
- ✓ Treating physician/NP/PA requests the opinion and/or treatment advice of a physician with specific specialty expertise to assist in diagnosis or management of the patient's problem without seeing the patient
- ✓ May be a new or established patient to the consultant, for a new or existing problem
- ✓ Consultant may not have had a face-to-face service with the patient in the last 14 days
- ✓ May not bill if review leads to a face-to-face service with the patient in the next 14 days
- ✓ Majority of the time must be medical consultative verbal or internet discussion (greater than 50%)
- ✓ For 99446, 99447, 99448, 99449, if greater than 50% is in data review and/or analysis, do not bill those codes; according to CPT, this doesn't qualify
- ✓ 99451 may be billed if more than 50% of the 5-minute time is data review and/or analysis
- ✓ Do not report these codes more than once in a 7-day period
- ✓ Do not use for a transfer of care
- ✓ Written or verbal request should be documented in the patient's medical record, including the reason for the consult
- ✓ According to CMS, these codes are payable in both a facility and non-facility setting
- ✓ Code 99452 may be reported by a physician, NP, PA
- ✓ Use for time of 16-30 minutes in a service day preparing for the referral and/or communicating with the consultant
- ✓ May report face-to-face prolonged care codes with this service if an E/M service is also provided and the time exceeds 30 minutes beyond the typical time
- ✓ If the patient is not present, may report non-face-to-face prolonged codes if the time spent in the day exceeds 30 minutes

Documentation Requirements: Consent is required. Time spent is required to be documented and a written report.



Annual Wellness Visits (AWV)

Within this section, we will focus more on tips on how to complete comprehensive visits remotely and touch upon some billing/coding elements.

How to perform and AWV remotely:

- ✓ Ensure all documentation related to consent, billing, and modality are documented.

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- ✓ Perform a Health Risk Assessment (HRA) For a sample HRA, go to the resources section of this document where there is a link to a recommended HRA from the American Academy of Physicians.
    - o The provider (or provider's staff) should complete the HRA with the patient during the exam, through the patient portal before the exam, or over the phone beforehand.
    - o Ensure that this screening includes how the patient is feeling about their health in general.
- ✓ Compile the patient's personal medical history and their family history
    - o Can be done during the HRA
- ✓ Reconcile all medications, immunizations
    - o Can be done during the HRA
- ✓ Establish a list of their current providers and healthcare suppliers
    - o Can be done during the HRA
- ✓ Measure their vitals to the best of your ability
    - o Routine measurements like height, weight, body mass index (BMI), blood pressure, pulse, and temperature, and pain assessment are documented as "patient-reported" or "unable to obtain due to …." if they could not be measured. This information can also be collected at subsequent visits to allow for some narrative about changes in these measures.
- ✓ Screen for any concerning cognitive impairments, utilizing the Mini-Cog, Functional Activities Questionnaire, St. Louis University Mental Status Examination (SLUMS) or other screenings recommended by the USPSTF.
- ✓ Review potential risk factors for depression or other behavioral health concerns
    - o a PHQ-2 or PHQ-9 test can be administered for depression screening
    - o a GAD-7 test can also be administered for anxiety
- ✓ Review functionality, balance, fall risk, and level of safety in their environments
    - o This can be done by having the patient show you areas of their house and also set up a chair for a balance exercise.
    - o Balance/gait questions can be asked during this time to evaluate fall risk
    - o A questionnaire on Activities of Daily Living (ADLs) can be reviewed to assess risk
    - o Lastly, if any of these things cannot be documented the provider can use "unable to obtain due to …"
- ✓ Devise an appointment schedule for the next 5 to 10 years
    - o This relates to all required screenings and immunizations
- ✓ Offer health advice and referrals for health education or preventive counseling services or programs based on the patient's needs
- ✓ Establish the risk factors and conditions for which primary, secondary, or tertiary interventions may be necessary or are already in motion
- ✓ Discuss advance care planning services
    - o This can be done in conjunction with the HRA and additional education related to advanced care planning can be documented (and billed for, there are 2 time-based codes)

HIPAA-Compliant platforms to conduct AWVs:

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Skype for Business	Doxy.me
Updox	Google G Suite Hangouts Meet
VSee	Health plan hosted solutions
Zoom for Healthcare	EHR solutions embedded into the physician's infrastructure

Codes:

G0438	GO439	G0468
Annual wellness visit, including a personalized prevention plan of service (PPPS), first visit.	Annual Wellness visit, including a personalized prevention plan of service (PPPS), subsequent visit.	Federally qualified health center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV

Note: All of the above codes require a modifier to indicate that the visit was done via telehealth

EPSDT/ Well Child Visits

Now that the PHE has ended, MedQuest will no longer cover these visits through telehealth, as the policy that was instated expired. Some components like screenings can be done remotely, if necessary. Additionally, these codes represent 'physical exams,' therefore most payers have aligned with MedQuest in reinstating the need for face to face visits for EPSDT and Well Child visits. The FAQ in this section has been removed for document clarity purposes.

PAYOR MIX (Coverage)

Payor	eVisit	Telehealth	Virtual Check-in	Telephone	Remote Patient Monitoring	Specialist Consults
Aetna	Covered	Covered Do not cover asynchronous telehealth services	Covered	Covered; for Acute E/M; BH only	Certain ones are covered if deemed medically necessary, like BP monitoring, glucose monitoring. For MA plans, follows Medicare guidelines	Varies by plan
AlohaCare	Covered	Covered	Covered	BH only covered	Covered	Covered
Cigna	Covered	Covered *No longer covered by urgent care centers starting 3/13/22	Covered Both G2010 and G2012	Covered	Covered 99091, 99457-99458, 99473-99474, 99493-99494	Covered

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HMSA	Covered Not covered for commercial plans	Covered	Covered Not covered for commercial plans	Covered for MA and Quest (BH only); Commercial varies, refer to HHIN	Covered Covers 99091, 99457-99458, 99473-4, 99493-4**	Commercial is not covered; Quest is allowed for codes 99446-99449 through the end of the PHE
Humana	Covered	Covered Humana requires providers to utilize modifier 93 if using audio-only	Covered	Covered	Covered	MA is covered
Medicaid Post PHE, MedQuest will be reverting to regular coverage policies.	Covered* Per policy QI-2139, these codes are not covered.	Covered Per Policy QI-2306, audio-only visits will be covered for mental health only	Covered* Per policy QI-2139, these codes are not covered	Covered through PHE Per QI-2306, audio-only visits will be covered for mental health only	Covered	Covered
Medicare	Covered	Covered Audio-only covered through 2024	Covered	Covered Through 2024	Yes; 20% cost share	Covered
Ohana (Wellcare)	Covered	Covered	Covered	Not Covered	Based on medical necessity	Covered
United Healthcare	Covered	Covered	Covered	Covered	Covered	Covered

** Effective Jan. 1, 2021, commercial plans no longer separately reimburse for remote patient monitoring codes 99091, 99473- 99474,99493-99494.

Payor Specific Key Points

Aetna

Visit Type	Codes + Modifier	Effective Date	Patient Type/Other Info
E-Visits	99421-99423, 98970-98972, G2061-G2063		Noted that for commercial plans, there may be limitations once the PHE ends
eConsults	99446-99449; 99451, 99452		Noted that for commercial plans, there may be limitations once the PHE ends
Telephone	99441-3		For acute E/M or BH only
Virtual Check-in	G2010, G2012 G2250, G02251, G2252	March 6th, 2020	Established only
Telehealth	Office visit codes + Commercial: POS 02* with Modifier GT or 95 Medicare Advantage:	Aetna updated their list of covered CPT codes	Aenta does not pay for asynchronous visits for all plans

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	POS 10 for telehealth provided in patient's home or other POS that correctly identifies where the patient is during telehealth appointment.	effective now.	
Remote Patient Monitoring	99453-4; 99457-8	2022	Established only

** Urgent Care Centers should continue to use POS 20. All other facilities should continue to use their respective POS; CPTs and the telemedicine modifiers must be noted on the UB-04 and HCFA 1500 forms as the Rev Code will not be sufficient.*

Aetna has mentioned that their policies are currently expanded due to the PHE and that once it ends, there may be more limits on telehealth coverage.

Platforms: Aenta allows providers to utilize their own platforms for telehealth but also partners with Teladoc as their service provider. Providers must use secure platforms now that the PHE has ended. For options, refer to the HIPAA-compliant software section.

AlohaCare

Visit Type	Codes	Effective Date	Patient Type/Other Info
E-Visits	99421-99423; G2061-G2063; 98970-98972		New or established
eConsults	99446-99449; 99451, 99452		New or established
Telephone	Covered for BH only		
Virtual Check-in	G2012, G2252, G2251, G2010, G2250		New or established
Telehealth	99201-99215; G0425-G0427; G0406-G0408		New or established
Remote Patient Monitoring	99091, 99457-99458, 99473-99474, 99493-99494		Established

Platforms: Alohacare allows providers to utilize their own platforms for telehealth. They also provide Alohacare Telehealth Connect for their members.

AlohaCare will update their coverage for telehealth later on this year after annual review of coverage policies.

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Cigna

Visit Type	Codes	Effective Date	Patient Type/Other Info
E-Visits	99422-3		N/A
eConsults	99446-99452		New or established
Telephone	99441-99443		New or established
Virtual Check-in	G2010, G2012		New or established
Telehealth	99201-99215		The patient's clinical condition is of low to moderate complexity, and while it may be an urgent encounter, it should not be an emergent clinical condition
Remote Patient Monitoring	99091, 99457-99458, 99473-99474, 99493-99494		

Platforms: Cigna allows providers to utilize their own platforms for telehealth as long as it a HIPAA-compliant/secure solution.

Cigna has come out with no changes as their Virtual Care Policy implemented in January 2021 was a new standard of care moving forward. One important note is regarding POS coding: Effective 7/1/22, POS code POS 02 should be billed for virtual care services, do not bill pos 10 until further notice.

Humana

Visit Type	Codes	Effective Date	Patient Type/Other Info
E-Visits	99421-99423; 98970-98972		New or established
eConsults	99446-99449; 99451, 99452		New or established
Telephone	99441-99443; 98966-98968		New or established
Virtual Check-in	G2012, G2252, G2251, G2010, G2250		New or established
Telehealth	99201-99215; G0425-G0427; G0406-G0408 For audio-only visits, modifier 93 must be utilized.		New or established
Remote Patient Monitoring	99091, 99457-99458, 99473-99474, 99493-99494		Established only

Platforms: Humana allows providers to utilize their own platforms for telehealth as long as it a HIPAA-compliant/secure solution.

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HMSA

Visit Type	Codes	Effective Date	Patient Type/Other Info
E-Visits	99421-99423; 98970-98972** G0071-for FQHCs & RHCs	1/1/21; commercial plans no longer separately reimburse for eVisits	For new or established patients; **G2061-G2063 have been canceled as of 12/31/20. Replacement codes are 98970-98972 for MA and Quest members
eConsults	99446-99449; 99451, 99452		These codes are not a benefit of commercial plans. Quest coverage is for 99446-99449 and only through the PHE period.
Telephone	99441-99443; 98966-98968	Effective service dates: 8/1/21-5/31/22	Coverage varies, refer to HHIN for commercial plans; for Medicare is covered through 2024; for Quest Integration-BH only
Virtual Check-in	G2012, G2252, G2251, G2010, G2250		For new or established patients. G2251, G2250 are for Medicare use only These codes are not a benefit of commercial plans.
Telehealth	99201-99215; G0425-G0427; G0406-G0408 Bill with appropriate place of service (02) or 10 modifier (95, GT, GQ or G0).		For new or established patients; after PHE ends, prior relationships must be substantiated
Remote Patient Monitoring	99091, 99457-99458, 99473-99474, 99493-99494, 99453-99454		For new or established patients. Effective 1/1/21, commercial plans no longer separately reimbursing for the following RPM codes: 99091, 99473-99474, 99493-99494

Platforms: HMSA allows providers to utilize their own platforms for telehealth. HMSA also offers HMSA Online Care where patients can access their providers on the platform as well as other providers.

Beyond the coverage listed above, HMSA has the following within their policy: Medicare providers should continue to follow CMS guidelines. Quest integration providers should could continue to follow MedQuest guidelines.

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Medicare

Visit Type	Codes	Effective Date	Patient Type/Other Info
eConsults	99446-99449, 99451, 99452		
E-Visits	99421-99423, G2061-G2063		
Telephone	99441-99443, 98966-98968		These visits are covered through 2024
Virtual Check-in	G2010, G2012, G2250-G2251, G2252		
Telehealth	99202-99215		Site and provider flexibilities covered through 2024.
Remote Patient Monitoring	99453, 99454, 99457, 99458, 99473, 99474, 99091		There are additional codes covered depending on medical necessity. Patients must be established effective 5/11/2023.

Platforms: Medicare allows providers to utilize their own platforms for telehealth that are HIPAA-compliant solutions. Per the latest guidance, these solutions must be in place at the end of the PHE. CCA has allowed for a 90-day transitional period to implement these secure technologies.

Ohana (Wellcare)

Visit Type	Codes	Effective Date	Patient Type/Other Info
E-Visits	99421-99423; 98970-98972		
eConsults	99446-99449, 99451, 99452		
Telephone	99441-99443		Behavioral Health only for MedQuest members
Virtual Check-in	G2010, G2012, G2250, G2251, G2252		
Telehealth	99201-99215; 99241-99245		New or established; provider must be in network to establish care
Remote Patient Monitoring	99453, 99454, 99457, 99458, 99473, 99474, 99091		

Platforms: Ohana allows providers to utilize their own platforms for telehealth. Also available to members is MDLive

United Healthcare

Visit Type	Codes	Effective Date	Patient Type/Other Info

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E-Visits	99421-99423; 98970-98972	Permanently allowable per UHC Telehealth/Telemedicine Policy effective 01/01/2021	The member must generate the initial inquiry and communications can occur over a 7 day period.
eConsults	99446-99449, 99451, 99452	Permanently allowable per UHC Telehealth/Telemedicine Policy effective 01/01/2021	
Telephone	99441-99443		Audio-Only Telehealth UnitedHealthcare aligns with the AMA and ***will consider for reimbursement*** the services, which are appropriate for reporting real-time, interactive audio-only telehealth, when appended with modifier 93, and reported with POS 02 or 10. CPT codes reported with modifier 93 that are not included United's CPT code set will not be eligible for reimbursement.
Virtual Check-in	G2010, G2012, G2250, G2251, G2252	Permanently allowable per UHC Telehealth/Telemedicine Policy effective 01/01/2021	
Telehealth	Codes vary, refer to CMS fee schedule		See above note within the telephone box.
Remote Patient Monitoring	99453, 99454, 99457, 99458, 99473, 99474, 99091 RPM services are never rendered in-person and therefore should not be reported with POS 02 or 10 and/or a Telehealth modifier (95, GT, GQ or G0).	Permanently allowable per UHC Telehealth/Telemedicine Policy effective 01/01/2021	Refer to CMS for additional guidance on the use of these codes

Platforms: United Healthcare allows providers to utilize their own platforms for telehealth.

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Modifiers 95, GT, GQ and G0 are not required to identify Telehealth services but are accepted as informational if reported on claims with eligible Telehealth services.

Cost Sharing Waiver (Copay/Coinsurance/Deductible)

Now that the PHE is ending, cost sharing waivers are coming to a close. Please refer to each plan benefit design for any cost sharing guidance. We have removed this section for document clarity.

Guidelines by Facility Type

Rural Health Clinics (RHCs)

As part of the CARES Act, Congress has authorized RHCs to be a "distant site" for telehealth visits, therefore allowing RHC practitioners to provide telehealth services. According to the CCA, this will continued to be allowed through the end of 2024.

Allowable Telehealth Codes: Through the end of 2024, providers can provide any telehealth service that is approved as a Medicare telehealth service under the Medicare Professional Fee Schedule (PFS).

Billing FAQs:

RHC Claims for Telehealth Services from 1/27/2020 through 12/31/2024		
Revenue Code	HCPCS Code	Modifiers
052X	G2025	CG (required) 95
RHC Claims for Telehealth Services starting 12/31/2024		
Revenue Code	HCPCS Code	Modifiers
052X	G2025	95

- Claims will automatically reprocess in July when the Medicare claims processing system is updated with the new payment rate.
    - RHCs do not need to resubmit these claims for the payment adjustment.
- Reimbursement: The RHC telehealth payment rate is set at $92.03 per visit, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS. This rate will apply to telehealth visits performed by independent or provider based RHCs.
- Telephone Services: Effective March 1st, 2020 RHCs can perform audio only telephone E/M services utilizing CPT codes 99441, 99442, and 99443. Note, these codes are covered with Medicare through 2024 and for MedQuest, only BH is covered.
- Virtual Check-Ins & E-Visits: Medicare will allow RHCs to perform E-Visits (CPT codes 99421-99423), which are online digital E/M services that utilize a secure patient portal. Medicare will also allow RHCs to perform Virtual Check Ins (HCPCS G2012 and G2010).
    - RHCs should bill HCPCS G0071 if E-Visit or Virtual Check-In services are performed
    - G00071 is bundled into CPT Codes 99421, 99422, and 99423

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Federally Qualified Health Centers (FQHCs)

As part of the CARES Act, Congress has authorized FQHCs to act as a "distant site" for telehealth visits, therefore allowing FQHC practitioners to provide telehealth services. According to the CCA, this will continued to be allowed through the end of 2024.

Allowable Telehealth Codes: Through the end of 2024, FQHCs can furnish any telehealth service that is approved as a Medicare telehealth service under the PFS.

Billing:

FQHC Claims for Telehealth Services from 1/27/2020 through 12/31/2024		
Revenue Code	HCPCS Code	Modifiers
052X	FQHC Specific Payment Code- G0466, G0467, G0468, G0469, G0470	None
052X	FQHC PPS Qualifying Payment Code	95
052X	G2025	95
RHC Claims for Telehealth Services starting 12/31/2024		
Revenue Code	HCPCS Code	Modifiers
052X	G2025	95

- Claims will be automatically reprocessed beginning July 1st, 2020 at the $92.03 rate.
  - FQHCs do not need to resubmit these claims for payment adjustment.
- Reimbursement: The FQHC telehealth payment rate is set at $92.03 per visit, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS.
- Telephone Services: Effective March 1st, 2020 RHCs can perform audio only telephone E/M services utilizing CPT codes 99441, 99442, and 99443. Note, these codes are covered with Medicare through 2024 and for MedQuest, only BH is covered.
- RHCs and FQHCs can bill for online digital evaluation and management services using the HCPCS code G0071 effective March 1, 2020. Code G0071 is bundled into CPT codes 99421, 99422, and 99423

PPS Payment Scenarios (PPS will be paid as follows as set forth by MQD)

Originating site (patient location)	Distant site (provider of FQHC service location)	Payment model
• FQHC • Patient residence	• FQHC	PPS
• Not above	• FQHC	FFS

Physical Therapy, Occupational Therapy, Speech Therapy (PT/OT/ST)

Virtual visits for physical therapy, occupational therapy, and speech therapy have been a point of confusion for many hospitals and independent therapists. The two main points of misunderstanding are:

1) If PT/OT/ST therapists are considered by the payor a provider qualified to perform telehealth services.
2) If hospital-based PT/OT/ST therapists that bill for services on a UB-04 under the hospital NPI can perform virtual visits.
   a. See the below matrix to determine what is covered by payer

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b. Telephone codes are not represented within the below matrix, as most payers have determined that PT/OT/ST services must be furnished via an audiovisual connection.

Payer	Telehealth Coverage	E-Visits
Aetna	Certain OT is covered; policy is posted in the Availity portal and updated annually	Individual therapists can bill CPT 98970-98972 or G2061-G0263 for evisits 97161-97167
Alohacare	PT/OT/ST covered through virtual visits covered temporarily	Reach out to your provider representative for expansion guidance
Cigna	PT/OT/ST covered through virtual visits	Individual therapists can bill CPT 97161-97168, 97110, 97116, 97530, 97112, 97535, 92507, 92521-92524, 92526, 96105, 97129-97130
HMSA	PT/OT/ST covered through virtual visits	Individual therapists can bill CPT 97161-97168, 97110, 97116, 97530, 97112, 97535, 92507, 92521-92524, 92526, 96105, 97129-97130 HMSA: Independent PT, OT, ST providers must append modifier GO, GP, or GN when billing for G2010, G2012, G2061, G2062, G2063, G2251, G2252 and 98966–98968. Codes are considered “sometimes therapy” codes.
Humana	PT/OT/ST covered through virtual visits covered temporarily	97161-97168, 97110, 97530, 92507, 92521-92524
Medicaid	PT/OT/ST covered through virtual visits	
Medicare	97161-97164 are allowed to be billed through telehealth through December, 31, 2023. According to the CAA, PT/OT/ST can continue to utilize telehealth through December 31, 2024. In the previous guidance direct from Medicare, it would allow billing up to 151 days after the PHE ended, CAA extended this flexibility.	Allowable codes located on the 2022 CMS Fee Schedule

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Ohana	PT/OT/ST covered through virtual visits covered temporarily	Refer to the Ohana Provider Guide
United Healthcare	PT/OT/ST covered through virtual visits	Individual therapists can bill CPT 97161-97168, 97110, 97116, 97112, , 92507, 92521-92524, 92526, 97750, 97755, 97760-97761 The appropriate place of service code 02 or 10 in Box 24B. All PT/OT/ST Telehealth visits must be performed using live, interactive video conferencing that involves the presence of both parties at the same time and a communication link between them that allows a real-time audio and visual interaction to take place. E-mailing "stored" exercise videos and discussing or reviewing by phone is not reimbursable.

Billing Scenarios

Billing can be confusing as providers navigate temporary waivers and changing rules. Compiled below are a few billing scenarios to assist with some lingering questions.

Patient Scenario	Visit	Billing	
		Medicare	Commercial & Medicaid
Est. patient arrives for a telehealth visit (audio + video) using HIPAA-compliant software	→ Scheduled visit with est. patient →Use of software (and documentation of software utilized) →Care is delivered and documented	**Step 1:** Use appropriate office code (99211-99215) **Step 2:** Use POS that would have been utilized if the service had been furnished in person **Step 3:** Use 95 modifier	**Step 1:** Use appropriate office code (99211-99215) **Step 2:** Use of Telehealth POS 02 or POS 10 **Step 3:** No modifier required
New patient arrives for telehealth visit (audio + video) using HIPAA-compliant software	→ Scheduled visit with est. patient →Use of software (and documentation of software utilized)	**Step 1:** Use appropriate office code (99202-99205) **Step 2:** Use POS that would have been utilized	**Step 1:** Use appropriate office code (99202-99205) **Step 2:** Use of Telehealth POS 02 or 10

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	→Care is delivered and documented	if the service had been furnished in person **Step 3:** Use 95 modifier	**Step 3:** No modifier required
Est. patient sends message (e-visit) through the online patient portal or some other secure platform	→Patient initiatives an e-visit on an issue/concern through the provider's online patient portal to the Physician, NP, or PA	**Step 1:** Use appropriate CPT code (99421-99423) **Step 2:** Use appropriate POS **Step 3:** No modifier required for Medicare Advantage, Medicaid	
Est. patient sends message (e-visit) through the online patient portal or some other secure platform	→Patient initiatives an e-visit on an issue/concern through the provider's online patient portal to PT/OT/ST therapist	**Step 1:** Use appropriate CPT code (98970-98972) **Step 2:** Use appropriate POS **Step 3:** No modifier required for Medicare Advantage, Medicaid	
Est. patient connects for a brief check-in by audio only.	→Patient initiates a phone call with Physician, NP or PA →Issue is not related to a medical visit within the last 7 days and not resulting in a medical visit within the next 24 hours	**Step 1:** Use appropriate HCPCS code (G2012, G2252) **Step 2:** Use appropriate POS **Step 3:** No modifier required for Medicare Advantage, Medicaid	
Est. patient connects for a brief check-in by audio only.	→Patient initiates a phone call with PT/OT/ST therapist →Issue is not related to a medical visit within the last 7 days and not resulting in a medical visit within the next 24 hours	**Step 1:** Use appropriate HCPCS code (G2251) **Step 2:** Use appropriate POS **Step 3:** No modifier required for Medicare Advantage, Medicaid	
Est. patient sends picture for evaluation using a brief check-in	→Patient sends a picture for evaluation to Physician, NP, or PA →Issue is not related to a medical visit within the last 7 days and not resulting in a medical visit within the next 24 hours	**Step 1:** Use appropriate HCPCS code (G2010) **Step 2:** Use appropriate POS **Step 3:** No modifier required for Medicare Advantage, Medicaid	
Est. patient sends picture for evaluation using a brief check-in and provider follows up	→Patient sends a picture for evaluation to PT/OT/ST therapist →Issue is not related to a medical visit within the last 7 days and not resulting in a medical	**Step 1:** Use appropriate HCPCS code (G2250) **Step 2:** Use appropriate POS **Step 3:** No modifier required for Medicare Advantage, Medicaid	

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	visit within the next 24 hours	
Est. patient requests eConsult to evaluate the need for specialist intervention.	→Patient requests eConsult, consents to service	**Step 1:** Use appropriate CPT code (99451-99453) **Step 2:** Use appropriate POS **Step 3:** No modifier required for Medicare Advantage, Medicaid

HIPAA Compliant Software

Starting 5/11/23, Medicare will no longer allow the use of non-secure platforms for telehealth, the CCA has allowed for a **90-day transitional period** to implement these technologies. Most other payers eliminated the coverage of these platforms over the last few years. For additional information by payer, refer to the HIPAA compliant statement within each payor section, or if the payor is not listed within this guide, reach out to the payor to verify their telehealth platform requirements.

IMPORTANT TIP: Public facing platforms are NOT allowed, such as Facebook Live, TikTok, Snapchat, etc.

HHS Resource for HIPAA Compliant Software

Below we have compiled some tips for HIPAA-compliant software usage/selection.

Choose a platform that fits the services you will deliver. Then, ensure the platform meets minimum requirements. Outside of the current PHE, the telehealth platform must be a HIPAA-compliant telehealth technology that meets HIPAA security and privacy standards, supported by a Business Associates Agreement(s) (BAA), and encrypted end-to-end.

What technology do I need to use a telehealth platform?

Equipment can vary depending on what telehealth vendor you select. Most telehealth technologies require the following items.

- ✓ **A computer or mobile device.** Ask your telehealth vendor which specific device(s) their software will run on.
- ✓ **An integrated or external microphone.**
- ✓ **An integrated or external camera.**
- ✓ **Access to broadband internet.** You'll need enough bandwidth (both patient and provider) to transmit audio and video data. Be sure to check your bandwidth before beginning a visit.
- ✓ **Video connection/platform video interface.**
- ✓ **Headphones.** To maintain privacy on the telehealth visit, we recommend wearing headphones.

What does the patient need to use the platform?

- ✓ **Instructions on how to use the platform.** Instructions will vary based on the platform.
- ✓ **A laptop or desktop computer, smart phone, or smart device with a camera.**
- ✓ **Headphones.** Are recommended.
- ✓ **Access to broadband internet.**
- ✓ **A private area.**

More information on selecting platforms:

Guidance on BAAs, including sample BAA provisions, is available at this resource.

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Additional information about HIPAA Security Rule safeguards is available at here.
Resources on telehealth vendors and guidance is available at this website.

Coverage in Hawaii Beyond COVID-19:

Please keep in mind that events and policies are changing now that the PHE has ended and Medicare has issued new guidance; this document will be updated at minimum annually as new information and policies become available/are enacted. The table below synopsizes where policies currently stand for Medicare fee-for-service, Med-QUEST, and commercial carriers in Hawaii.

Key Policy Considerations	Medicare	MedQuest (Medicaid)	Private Payers
No geographic limitations for telehealth services (e.g. service not limited to rural or non-metropolitan service area locations)	Yes According to the Section 4113a of the CCA, the distant site locations are allowed through 12/31/2024	Yes	Yes
Out of state providers allowed	Yes	No; HB666 is proposed allowing expansion of out of state providers to see in-state patients	No; HB666 is proposed allowing expansion of out of state providers to see in-state patients
Patient home is eligible originating site	Yes According to the Section 4113a of the CCA, the distant site locations are allowed through 12/31/2024	Yes	Yes
Other non-healthcare facilities are eligible originating sites (e.g. schools, libraries)	Yes According to the Section 4113a of the CCA, the distant site locations are allowed through 12/31/2024	Yes	Yes
Originating sites other than patient homes can bill a facility fee	Rural: Yes Urban, Metro: No	No	No Varies by payer
Prior existing relationship with patient is required	No Certain codes require it, like RPM codes post-PHE	No	No
Any provider type eligible to use telehealth, as long as practicing withing scope	No According to the CCA, the additional provider types like PT/OT/ST are allowed through 12/31/2024	Yes	No Varies by payer

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DEA-registered practitioners may issue prescriptions for controlled substances without requiring in-person medical evaluation	Yes Certain provisions for opioids are required	Yes Certain circumstances for opiates, not covered for medical cannabis, HRS 453-1.3(c)	Yes Certain circumstances for opiates, not covered for medical cannabis, HRS 453-1.3(c)
Any eligible member service can be provided via telehealth when medically necessary and appropriate	No	Yes	Yes Varies by payer
Prior authorizations not required for telehealth services, unless in-person service also requires prior authorization	Yes	Yes	Yes
Providers can use all telehealth modalities to deliver services (live video, store-and-forward, remote patient monitoring)	Yes	Yes	Yes (ensure medical necessity for RPM)
Providers paid for telephone/audio only visits (virtual check-ins; eConsults)	Yes Only covered through 2024	No Telephone is BH only no other audio-only covered	Yes Varies by payer
Providers can deliver services via technology-based communications that are not typically considered telehealth – _i.e. virtual check-ins, interprofessional internet consultations (eConsults), remote monitoring services (CCM, Complex CCM, TCM, Remote PM, PCM), online digital evals (see CCHP Telehealth Policies for specific codes and criteria)	Yes Virtual Check-ins G2010, G2012 G0071 (FQHCs) eConsults 99446-99449, 99551-99452 e-Visits 99421-99423 G2061-G2063	Yes Virtual Check-ins G2010, G2012, G2251, G2252 eConsults 99451-99452 e-Visits 99421-99423 98970-98972 Remote Mon. 99453, 99454, 99457, 99458	Yes Virtual Check-ins, e-Visits Varies by Payer; some only cover Medicaid and Medicare patients and not commercial
Patient consent is required, however verbal consent is acceptable (i.e. written consent not required)	Yes	Yes	Yes Varies by payer

A new policy came out shortly after the PHE-ended from MedQuest. Below is an overview of that policy:

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HB907/QI-2306: Real-Time Audio-Only Interaction Policy After The Federal Public Health Emergency Related To The COVID-19 Pandemic Expires

MQD will continue to reimburse select healthcare services delivered through audio-only communication technology after the Federal PHE expires. The following guidance is in effect until December 31, 2025. Reimbursement for services provided through telehealth via an interactive telecommunications system shall be equivalent to reimbursement for the same services provided via in-person contact between a health care provider and a patient; provided that reimbursement for the diagnosis, evaluation, or treatment of a mental health disorder delivered through an interactive telecommunications system using two-way, real-time audio-only communication technology shall meet the requirements of title 42 Code of Federal Regulations section 410.78.

Covered codes: 90847, 90853
Non-covered codes: 90875, 90901

Acronyms:

ACP	Advanced Care Planning	HMSA	Hawaii Medical Services Association
AWV	Annual Wellness Visit	HRA	Health Risk Assessment
BAA	Business Associates Agreement	HRSA	Human Resource Services Administration
BH	Behavioral Health	IPPE	Initial Preventative Physical Examination
CCA	Consolidated Appropriations Act	MQD	MedQuest Department
CCM	Chronic Care Management	NP	Nurse Practitioner
CMS	Center for Medicare & Medicaid Services	OT	Occupational Therapy
CNSs	Clinical Nurse Specialists	PA	Physician's Assistant
CP	Clinical Psychologist	PBTRC	Pacific Basin Telehealth Resource Center
CPT	Current Procedural Terminology	PE	Physical Expense
CSW	Clinical Social Workers	PFS	Physicians Fee Schedule
CTBS	Communication Technology Based Services	PHE	Public Health Emergency
DEA	Drug Enforcement Administration	PHQ2/PHQ9	Patient Health Questionnaire (depression screening)
E/M	Evaluation & Monitoring Codes	POS	Point of Service
EPSDT	Early, Periodic, Screening and Diagnostic Testing	PPPS	Personalized Prevention Plan of Service
F2F	Face to Face	PT	Physical Therapy
FAQ	Frequently Asked Questions	QI	Quest Integration
FFS	Fee For Service	RD	Registered Dietitian

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FQHC	Federally Qualified Health Clinic	Rev Code	Revenue Code
FQHC PPS	Prospective Payment System	RHC	Rural Health Clinic
GAD7	General Anxiety Disorder (screening)	RPM	Remote Patient Monitoring
HCFA	Claim Type	ST	Speech Therapy
HCPCS	Healthcare Common Procedure Coding System	TCM	Transitional Care Management
HHS	Health and Human Services	UB-04	Claim type also known as CMS 1450
HIPAA	Health Insurance Portability and Accountability Act		

Resources:

AAMC Regulatory Resource on 2021 Medicare Coverage of Remote Physiologic Monitoring
https://www.aamc.org/media/55306/download
Licensure Requirements
https://www.cchpca.org/resources/state-telehealth-laws-and-reimbursement-policies-report-fall-2021/
Specialist Consult Workflow
https://www.caltrc.org/wp-content/uploads/2018/07/MCEIStandardWorkflowv1.pdf
eConsults
https://www.apg.org/wp-content/uploads/2019/07/eConsults-Improve-Patient-Access-Lower-Costs-07.11.19.pdf
AWVs
https://medicare.pacificsource.com/Base/DocumentContent/DCmSylNJP-fHIAYnItQXa75QJYTHjSTsJ1H8-v7u13OPkGj_Ex0xMp-LDLVtG-NB/Medicare%20AWV%20Telehealth%20Component%20Guide
and
https://edhub.ama-assn.org/steps-forward/module/2757861

Health Risk Assessment Samples
https://www.in.gov/health/files/HRA.pdf
https://www.aafp.org/fpm/2012/0300/fpm20120300p11.pdf
https://www.uthscsa.edu/sites/default/files/HRA%20Template.pdf

EPSDT
https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf
and
https://www.gatewayhealthplan.com/Portals/0/provider_forms/PediatricTelehealthGuide.pdf
Physical Therapy Guidance (2023)
https://www.outsourcestrategies.com/blog/how-to-bill-physical-therapy-telehealth-services-in-2023/#:~:text=Physical%20therapists%20can%20bill%20for,(including%20the%20beneficiary%27s%20home).
PHE-ending Guidance (CCA)

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https://www.hklaw.com/en/insights/publications/2023/05/covid19-phe-ends-may-11-what-it-means-for-the-provision-of

Aetna:
https://www.aetna.com/health-care-professionals/covid-faq/telemedicine.html

2023 Guidance:
https://lakelandcare.com/sites/lakelandcare.com/files/attachments/Aetna%20Telemedicine%20and%20Direct%20Patient%20Contact%2006_21.pdf

AlohaCare:
https://health.hawaii.gov/bhhsurg/files/2020/04/AlohaCare-Telehealth-Reference-Payment-Policy-200320.pdf

Cigna

2023 Guidance
https://www.cigna.com/assets/docs/pcomm/virtual-care-reimbursement-policy.PDF
https://medicareproviders.cigna.com/static/medicareproviders-cigna-com/docs/coronavirus-billing-guidelines-faq.pdf
https://drive.google.com/file/d/1rPvQ_PvqOWtxAQgkMAAq0UtSkMkPL7iP/view?usp=sharing

HMSA
https://cdn1-originals.webdamdb.com/14017_117572234?cache=1646782791&response-content-disposition=inline;filename=COVID-19%2520Coding%2520Guide%2520for%2520Providers%25202022_v4_2022-0307.pdf&response-content-type=application/pdf&Policy=eyJTdGF0ZW1lbnQiOlt7IlJlc291cmNlIjoiaHR0cCo6Ly9jZG4xLW9yaWdpbmFscy53ZWJkYW1kYi5jb20vMTQwMTdfMTE3NTcyMjM0P2NhY2hlPTE2NDY3ODI3OTEmcmVzcG9uc2UtY29udGVudC1kaXNwb3NpdGlvbj1pbmxpbmU7ZmlsZW5hbWU9Q09WSUQtMTklMjUyMENvZGluZyUyNTIwR3VpZGUlMjUyMGZvciUyNTIwUHJvdmlkZXJzJTI1MjAyMDIyX3Y0XzIwMjItMDMwNy5wZGYmcmVzcG9uc2UtY29udGVudC10eXBlPWFwcGxpY2F0aW9uL3BkZiIsIkNvbmRpdGlvbiI6eyJEYXRlTGVzc1RoYW4iOnsiQVdTOkVwb2NoVGltZSI6MjE0NzQxNDQwMH19fV19&Signature=GGj~kpa6gZGhBpRxnLM~Tds8Av~BojShRhm0PuDbvMzhAygzB0omIcGAnsQZ6KOcl2PfW4N25~9GpR7R5fckyfJcqrBuYT92NMoPkImQj62Rm~xskFPiyyhSsLiZ6362K5hg5Y5rob-~XjrZMxCKw1-OSgFq9zD28lMW4PRabrethqgbn3ed6amf48F0kOIvxZKlYmvS6KTN~r2EVIl1ZD4XahfeVV6s3jk9Xvo0eRHa-CRzwvp3lpC3KF-ITKf7J1rVLtm9w2722n4MAHZXP6c0gSzZILd0ekFl8Yh21jja33ujtGcNFy-94SVJ~ugynhngyonwnKQKEM1UAD5CAQ__&Key-Pair-Id=APKAI2ASI2IOLRFF2RHA

Humana
https://drive.google.com/file/d/1k4W7JgQxK_XBZE6AW_k8j6foYzyVqNnE/view?usp=sharing
https://drive.google.com/file/d/1DkwPFyS1czSUoHWdS1aPIcsvxyVcFQUj/view?usp=sharing

Ohana (WellCare)

2023 Guidance
Medicare Advantage
https://www.wellcare.com/-/media/PDFs/Hawaii/Provider/2023/HI_Care_Medicare_Advantage_Provider_Manual_2023_R.ashx

Medicaid
https://www.ohanahealthplan.com/content/dam/centene/wellcare/hi/pdfs/HI_Caid_Prov_2022_Medicaid_Provider_Manual_2023_R.pdf

United Healthcare
https://www.uhcprovider.com/content/dam/provider/docs/public/resources/news/2020/Telehealth-Patient-Scenarios.pdf

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