portland ipa
doctors making a difference

TEMPORARY VIRTUAL CARE GUIDELINES IN RESPONSE TO COVID-19 (AS OF 03/23/2020)

Payer	Virtual Care Policy Title(s)	Policy and Additional Information (Link to Website or Attachment)	Types of Visits Covered (Most Common Visits - See Policy for All Inclusive List of Codes)	Details
Traditional Medicare	Medicare Telemedicine Health (Updated 3/17/2020)	https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet For HIPAA Discretion Policy, visit: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html	Telehealth Visits for new or established patients: 99201-99215 E-Visits for established patients: 99421, 99422, 99423, G2061, G2062, G2063	Services must be initiated by the patient. Penalties waived for HIPAA violations against health care providers that serve patients in good faith through everyday communication technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency.
Aetna	Telemedicine and Direct Patient Contact (Updated 1/1/2020)	See Attached https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html#acc_link_content_section_responsivegrid_copy__responsivegrid_accordion_11	Commercial: Telehealth Visits for new or established patients: 99201-99215, 99241-99245 Telehealth Visits for established patients: G0438, G0439, G2061-G2063, G2012, 99421-99423, 99441-99443 Medicare: Follow CMS guidelines	Append with Modifier GT or 95 Until June 4, 2020, Aetna will cover minor acute evaluation and management care services rendered via telephone. For general medicine and behavioral health visits – a synchronous audiovisual connection is still required
CareOregon	Codes for Telehealth and other Communication-Based Services in Response to COVID-19 (Updated 3/6/2020)	See Attached	Medicaid: Telehealth Visits for new or established patients for Qualified Providers: 99441-99443 Medicare: Qualified Providers: 99421-99423	Services must be initiated by the patient
Cigna	Cigna Coronavirus (COVID-19) Interim Billing Guidance for Providers (Updated 3/17/2020)	See Attached	99241 will be reimbursed for real-time virtual visits when billed with POS 11 G2012 can be used for brief technology-based communication between provider and established patient	Permanent Virtual Care Reimbursement Policy is being developed at this time; current policy provided is in effect until at least May 31, 2020

portland ipa
doctors making a difference

TEMPORARY VIRTUAL CARE GUIDELINES IN RESPONSE TO COVID-19 (AS OF 03/23/2020)

Payer	Virtual Care Policy Title(s)	Policy and Additional Information (Link to Website or Attachment)	Types of Visits Covered (Most Common Visits - See Policy for All Inclusive List of Codes)	Details
Health Net	Telehealth Guidance (Updated 3/23/2020) Oregon Health Authority Guidelines (Received 3/23/2020)	See Attached	Commercial: Virtual Care services G2061-G2063, 99441-99443, 99201-99203, 99212-99214, G2061-G2063 Medicare and Medicaid: Follow CMS Guidelines	Commercial: Follow Oregon Health Authority Guidelines
Humana	Telehealth Services (Updated 12/2019)	See Attached	Commercial: Telehealth and internet assessment management services are covered with the **exception** of 99421-99423, 93444 and 98969-98972 Medicare: Follow CMS Guidelines and the following additional services are covered: 99201-99215, 99421-99423, 99441-99443, G0438, G0439	Commercial: Append with Modifier GT or 95 Use POS 02 Medicare: Use POS 02
Moda	Telehealth and Telemedicine (Updated 2/12/2020)	See Attached	Commercial: Audio/video real-time telemedicine visit for established patients: 99444, 99421-99423 Medicare: Follow CMS Guidelines	Commercial: Append with Modifier GQ, 95 or GT Use POS 02
PacificSource	Telemedicine (Policy Date Unknown)	See Attached	Telemedicine (phone or video) codes covered: 98966-98969, 99441-99444	Append with Modifier GT

portland ipa
doctors making a difference

TEMPORARY VIRTUAL CARE GUIDELINES IN RESPONSE TO COVID-19 (AS OF 03/23/2020)

Payer	Virtual Care Policy Title(s)	Policy and Additional Information (Link to Website or Attachment)	Types of Visits Covered (Most Common Visits - See Policy for All Inclusive List of Codes)	Details
Providence	Telehealth Services During COVID-19 Crisis (Updated 3/6/2020) Online Digital E&M Services Policy 53 (Updated1/2020) Telephone Services Policy 92 (Updated 1/2020)	See Attached	Telehealth services (provided through June 30, 2020, after then, regular polices may apply): 99201-99215, 99421-99423, 99441-99443, G0438-G0439	Providence has suspended the requirement of completing the *Telehealth Services - Provider Attestation of HIPAA Compliance* and the Contract Amendment required for Web-based services to be covered/reimbursed Services must be initiated by the patient Telehealth Services: Append with Modifier GQ Use POS 02 Online Digital Services: Use POS 99
Regence	Virtual Care (3/19/2020) Coronavirus (COVID-19) (Updated 3/17/2020)	https://www.regence.com/provider/library/whats-new/covid-19#temporary-updates-to-telehealth	Virtual care services:99441-99443, 99421-99423, 98966-98968, 98969, 99201-99203, 99212-99214, G2012	Append with Modifier GT Use POS 11 or IOP Claims can be submitted on or after Tuesday, March 24, 2020, for date of service beginning on March 19, 2020.
United	Provider Telehealth Policies (Updated 3/19/2020) Telehealth and Telemedicine Policy, Professional (Updated 3/6/2020)	https://www.uhcprovider.com/en/resource-library/news/provider-telehealth-policies.html	99499, 99421-99423, G2061-G2063	CMS Originating Site restrictions are waived until 6/18/2020 for Commercial, Medicaid, and Medicare products Commercial: Append with Modifier GT, GQ, or 95 Medicaid: Append with Modifier GT, GQ, or 95 Medicare: Append with modifier GT or GQ

Payment Policy Table of Contents

Telemedicine and Direct Patient Contact

Policy Type:	Revised
Applies to:	• All Medical Products (including Commercial & Medicare) • All participating and nonparticipating physicians, facilities, and other qualified health care professionals
Policy Implementation:	Date of Service
Policy Revision Date:	Click Here
Last Review:	December, 2019
Next Review	December, 2020

Our payment policies ensure that we pay providers based on the code that most accurately describes the procedure performed. We include CPT/HCPCS, CMS or other coding methodologies in our payment policies when appropriate. Unless noted otherwise, payment policies apply to all professionals who deliver health care services. When developing payment policies, we consider coding methodology, industry-standard payment logic, regulatory requirements, benefits design and other factors.

Table of Contents

Overview

This policy addresses our guidelines regarding payment for telehealth, telemedicine, direct patient contact, care plan oversight, concierge medicine, and missed appointments.

Refer to Expanded Claim Edits for additional coding and reimbursement policies that may apply separately from the policy detailed below.

Definitions/Glossary

Term	Definition
Asynchronous Telecommunication	Telecommunication systems that store medical information such as diagnostic images or video and forward it from one site to another for the physician or health care practitioner to view in the future at a site different from the patient. This is a non-interactive telecommunication because the physician or health care practitioner views the medical information without the patient being present.
Synchronous Interactive Audio and Video Telecommunication, Interactive Audio and Visual Transmissions and Audio-Visual Communication Technology	Real-time interactive video teleconferencing that involves communication between the patient and a distant physician or health care practitioner who is performing the medical service. The physician or health care practitioner sees the patient throughout the communication, so that two-way communication (sight and sound) can take place.

Telehealth	Telehealth is broader than telemedicine and takes in all health care services that are provided via live, interactive audio and visual transmissions of a physician-patient encounter. These health care services include non-clinical services, such as provider training, administrative meetings and continuing medical education; in addition to clinical services. Telehealth may be provided via real-time telecommunications or transmitted by store-and-forward technology.
Telemedicine	Telemedicine services involve the delivery of clinical medicine via real-time telecommunications such as telephone, the internet, or other communications networks or devices that do not involve in person direct patient contact.

Payment Guidelines

Telemedicine for Commercial Plans	
Two-way, Synchronous (i.e. real-time) Audiovisual Interactive Medical Service **Modifiers GT, 95**	We pay for two-way, synchronous (i.e. real-time) audiovisual interactive medical services between the patient and the provider. We consider services recognized by The Centers for Medicare and Medicaid Services (CMS) and appended with modifier GT, as well as services recognized by the AMA included in Appendix P of the CPT® Codebook and appended with modifier 95. A list of eligible CPT/HCPCS codes is available here. When a provider reports modifier GT or 95, it certifies the patient received services via an audiovisual telecommunications system. • GT: Telehealth service rendered via interactive audio and video telecommunications system • 95: Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system Click here for more information about our telemedicine visit co-pay liberalization in response to the Coronavirus COVID-19 outbreak.

Asynchronous Telecommunication **Modifier GQ**	We don't pay for asynchronous telemedicine services. • These services are considered incidental to the overall episode of care for the member. • When providers report modifier GQ it certifies the patient received services via an asynchronous method. Click here for more information about our telemedicine visit co-pay liberalization in response to the Coronavirus COVID-19 outbreak.
Tele-Stroke Services **Modifier G0**	We pay for tele-stroke services when appended with modifier G0. • G0: Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke

Telemedicine for Medicare Advantage Plans	
Telemedicine for Medicare Members/Plans	Medicare Advantage members may be eligible for telemedicine services in accordance with CMS regulations. We follow CMS policy. www.cms.gov

Direct Patient Contact	
Direct Patient Contact	Other than two-way synchronous (i.e. real time) audio visual interactive medical services, and tele-stroke services, as above, we don't pay for medical services that don't include direct in-person patient contact. Payment for these services is considered incidental to the overall episode of care for the member. One example of time spent without direct patient contact is physician standby services. We consider services payable only when provided in-person face-to-face.

Telehealth Transmission Fees	
Telehealth Transmission Fees **HCPCS codes Q3014 and T1014**	Charges for telehealth services or transmission fees aren't eligible for payment. These services are incidental to the charges associated with the evaluation and management of the patient.

Care Plan Oversight	
Care Plan Oversight	Care plan oversight is not eligible for payment. Care plan oversight is billed for physician supervision of patients under the care of home health agencies, hospice or nursing facilities. It includes the time spent

	reviewing reports on patient status and care conferences. We do not pay for time without direct patient contact. *Note:* Care plan oversight is eligible for payment on case management exceptions authorized by Patient Management.

Concierge Medicine or Boutique Medicine	
Concierge Medicine or Boutique Medicine	Concierge medicine, also called boutique medicine is a fee charged for services a patient receives outside of direct patient contact. These services are considered above and beyond the usual, such as scheduling preference or return phone calls from the provider. These services do not represent treatment of disease or injury. They are standard administrative services that are included in the evaluation & management service, we don't allow separate payment. No specific code exists for these services. Services may be billed with a written description, such as "Concierge Services" or "Administrative Services."

Missed Appointments	
Missed Appointments	We don't cover missed appointments because no direct or indirect medical care was rendered to the patient. Charges due to a missed appointment are the responsibility of the member.

List of Eligible CPT/HCPCS for two-way, synchronous

Eligible Code Description	Eligible CPT/HCPCS
Psychiatric diagnostic interview examination	90791, 90792
Individual psychotherapy	90832, 90833, 90834, 90836, 90837, 90838
Psychotherapy for crisis; first 60 minutes; or each additional 30 minutes	90839, 90840
Psychoanalysis	90845
Family or group psychotherapy	90846, 90847, 90853
Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	90863
End-Stage renal disease (ESRD) related services	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964,

	90965, 90966, 90967, 90968, 90969, 90970
Remote imaging for detection of retinal disease	92227
External mobile cardiovascular telemetry with ECG recording	93228, 93229
External patient and when performed auto activated ECG rhythm derived event recording	93268, 93270, 93271, 93272
Medical genetics and genetic counseling services	96040
Neurobehavioral status examination	96116
Administration of patient-focused health risk assessment instrument with scoring and documentation or for the benefit of the patient, per standardized instrument	96160, 96161
Individual and group medical nutrition therapy	97802, 97803, 97804; G0270
Education and training for patient self-management by a qualified, non-physician health care professional	98960, 98961, 98962
Office or other outpatient visits or consults	99201 – 99205, 99211 – 99215, 99241 – 99245
Subsequent hospital care services, with the limitation of 1 Telehealth visit every 3 days	99231, 99232, 99233
Inpatient consultation for a new or established patient	99251 - 99255
Subsequent nursing facility care services, with the limitation of 1 Telehealth visit every 30 days	99307, 99308, 99309, 99310
Prolonged service, inpatient or office	99354, 99355, 99356, 99357
Smoking and tobacco use cessation counseling visit	99406, 99407, G0436, G0437
Alcohol and substance screen and intervention	99408, 99409
Transitional care management services	99495, 99496
Advanced care planning	99497, 99498
Interactive complexity	90785
Individual and group diabetes self-management training services	G0108, G0109
Counseling visit to discuss need for lung cancer screening using low dose CT scan	G0296
Alcohol and/or substance abuse structured assessment	G0396, G0397
Follow-up inpatient Telehealth consultations furnished to beneficiaries in hospitals or SNFs	G0406*, G0407*, G0408*
Telehealth consultations, emergency department or initial inpatient	G0425*, G0426*, G0427*
Annual Wellness Visit, includes a personalized prevention plan of service	G0438, G0439
Alcohol misuse screening, counseling	G0442, G0443
Annual depression screening	G0444

High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior	G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease	G0446
Face-to-face behavioral counseling for obesity	G0447
Telehealth Pharmacologic Management	G0459
Comprehensive assessment of and care planning for patients requiring chronic care management services	G0506
Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient via telehealth; subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	G0508*, G0509*
Prolonged preventive service	G0513, G0514
Opioid treatment	G2086, G2087, G2088

*Modifier GT, 95 not required

Questions and Answers

Beginning **March 6, 2020**, Aetna will offer zero co-pay telemedicine visits for any reason for **90 days**. We will waive the cost share for all video visits through the Aetna-covered Teladoc offerings and in-network providers delivering synchronous virtual care (live video-conferencing) for all Commercial plan designs*. Self-insured plan sponsors can opt-out of this program at their discretion.

*We will also cover HCPCS G2010 and G2012 during the 90-day period.

For more information, see our press release.

Additional References

N/A

Policy Revision Date

- Effective 01/01/20: Added coverage details for Commercial Plans and Medicare Advantage Plans
- 08/30/18 Update: Removed "Telemedicine for Consumer Business/Aetna Leap℠ Plans" section. Plans are no longer active as of 01/01/2018.
- 07/05/18 Update: Removed Medicare from the "Applies to" section. Medicare Advantage follows CMS guidelines for telemedicine as of January, 2012.
- Effective 03/08/17: Existing stand-alone policy "Concierge Medicine or Boutique Medicine" added to Telemedicine and Direct Patient Contact Policy. No change in policy.
- Effective 01/26/17: Added Modifier 95.
- Effective 01/01/17: Added Telemedicine Policy for Consumer Business/Aetna Leap℠ Plans.
- Effective 05/01/12: Exception removed from Direct Patient Contact Policy to allow

payment when precertified.

- Effective 07/23/09: Charges for coordination of care under the “Patient-Centered Medical Home” model are eligible for payment.
- Effective 05/22/07: Charges for an online medical evaluation (e.g. eHealth visit) may be eligible for payment.

Primary Care

Codes for Telehealth and Other Communication-Based Services in Response to COVID-19

In response to the COVID-19 situation, CareOregon is temporarily adjusting telehealth/telemedicine requirements per CMS and OHA guidance. Providers may render services to members via telehealth modalities, telephone, OR two-way audio and visual, in any geographic area and from a variety of places, including members' homes. With this flexibility, CareOregon members can receive clinically appropriate services without coming into the clinic.

Summary

- CareOregon can adjudicate all telehealth/telemedicine claims that are properly submitted per temporary CMS and OHA guidelines.
- Providers are responsible and accountable for appropriate use of CPT and HCPCS codes, diagnosis codes, modifiers and claim form completion that support the provided services.
- Provider contracts do not need to be updated or amended to allow for reimbursement of telehealth services.

Guidance for rendering services via telehealth modalities

Telephone calls and online assessments:

- These visits must be initiated by established patients.
- Given the extenuating circumstances, we are allowing these services for unestablished patients for a limited time.
- The provider may educate members on the availability of this kind of service prior to patient initiation.
- A claim with the appropriate CPT/HCPCS code for service, submitted by an authorized provider, is required.
- Submit claims with the Place of Service (POS) that corresponds to the rendering provider's location.

Medicaid: CPT and HCPCS codes for authorized providers

Qualified health care professionals – Those who can bill for E&M services	
CPT	Description
99441	Telephone evaluation and management service provided by a physician 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.
99442	Telephone evaluation and management service provided by a physician 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.
99443	Telephone evaluation and management service provided by a physician 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; 21-30 minutes of medical discussion.

Qualified non-physicians – Those who bill incident to	
CPT	Description
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.

Qualified non-physicians – Those who bill incident to	
CPT	Description
98967	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; 11-20 minutes of medical discussion.
98968	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; 21-30 minutes of medical discussion.

Medicare: CPT and HCPCS codes for authorized providers

Qualified health care professionals – Those who can bill for E&M services	
CPT	Description
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.
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
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
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
99423	Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 21 or more minutes

Qualified non-physicians – Those who bill incident to	
CPT	Description
G2061	Qualified non-physician health care professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes.
G2062	Qualified non-physician health care professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes.
G2063	Qualified non-physician health care professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes

*Telephone services cannot be reported with Care Plan Oversight CPT codes (99339-99340, 99374-99380) or anticoagulation management CPT codes (99363-99364).

CareOregon

Synchronous Communication:

Two-Way Audio and Video Visit in Real-Time

- These visits may be for established or unestablished members, depending on CPT or HCPCS code.
- Claims must have a CPT/HCPCS code on the CMS 2020 telehealth approved code list (see chart below), rendered by an authorized provider.
- The claim must have the correct Place of Service (POS) 02 – Telehealth and any appropriate modifiers.
- Documentation must meet the same standards as face-to-face visits.
- Authorized providers include qualified health care professionals and qualified non-physicians (where appropriate).

CPT & HCPCS codes accepted for two-way audio and video visits:

Centers for Medicare & Medicaid Services - Approved telehealth services for 2020			
Code	Short descriptor	Code	Short descriptor
90785	Psytx complex interactive	99215	Office/outpatient visit est
90791	Psych diagnostic evaluation	99231	Subsequent hospital care
90792	Psych diag eval w/med srvcs	99232	Subsequent hospital care
90832	Psytx pt&/family 30 minutes	99233	Subsequent hospital care
90833	Psytx pt&/fam w/e&m 30 min	99307	Nursing fac care subseq
90834	Psytx pt&/family 45 minutes	99308	Nursing fac care subseq
90836	Psytx pt&/fam w/e&m 45 min	99309	Nursing fac care subseq
90837	Psytx pt&/family 60 minutes	99310	Nursing fac care subseq
90838	Psytx pt&/fam w/e&m 60 min	99354	Prolonged service office
90839	Psytx crisis initial 60 min	99355	Prolonged service office
90840	Psytx crisis ea addl 30 min	99356	Prolonged service inpatient
90845	Psychoanalysis	99357	Prolonged service inpatient
90846	Family psytx w/o patient	99406	Behav chng smoking 3-10 min
90847	Family psytx w/patient	99407	Behav chng smoking > 10 min
90951	Esrd serv 4 visits p mo <2yr	99495	Trans care mgmt 14 day disch
90952	Esrd serv 2-3 vsts p mo <2yr	99496	Trans care mgmt 7 day disch
90954	Esrd serv 4 vsts p mo 2-11	99497	Advncd care plan 30 min
90955	Esrd srv 2-3 vsts p mo 2-11	99498	Advncd are plan addl 30 min
90957	Esrd srv 4 vsts p mo 12-19	G0108	Diab manage trn per indiv
90958	Esrd srv 2-3 vsts p mo 12-19	G0109	Diab manage trn ind/group
90960	Esrd srv 4 visits p mo 20+	G0270	Mnt subs tx for change dx
90961	Esrd srv 2-3 vsts p mo 20+	G0296	Visit to determ ldct elig
90963	Esrd home pt serv p mo <2yrs	G0396	Alcohol/subs interv 15-30mn
90964	Esrd home pt serv p mo 2-11	G0397	Alcohol/subs interv >30 min
90965	Esrd home pt serv p mo 12-19	G0406	Inpt/tele follow up 15
90966	Esrd home pt serv p mo 20+	G0407	Inpt/tele follow up 25
90967	Esrd home pt serv p day <2	G0408	Inpt/tele follow up 35
90968	Esrd home pt serv p day 2-11	G0420	Ed svc ckd ind per session
90969	Esrd home pt serv p day 12-19	G0421	Ed svc ckd grp per session
90970	Esrd home pt serv p day 20+	G0425	Inpt/ed teleconsult30
96116	Neurobehavioral status exam	G0426	Inpt/ed teleconsult50
96160	Pt-focused hlth risk assmt	G0442	Annual alcohol screen 15 min
96161	Caregiver health risk assmt	G0443	Brief alcohol misuse counsel
97802	Medical nutrition indiv in	G0444	Depression screen annual
97803	Med nutrition indiv subseq	G0445	High inten beh couns std 30m
97804	Medical nutrition group	G0446	Intens behave ther cardio dx
99201	Office/outpatient visit new	G0447	Behavior counsel obesity 15m

Centers for Medicare & Medicaid Services - Approved telehealth services for 2020			
Code	Short descriptor	Code	Short descriptor
99202	Office/outpatient visit new	G0459	Telehealth inpt pharm mgmt
99203	Office/outpatient visit new	G0506	Comp asses care plan ccm svc
99204	Office/outpatient visit new	G0508	Crit care telehea consult 60
99205	Office/outpatient visit new	G0509	Crit care telehea consult 50
99211	Office/outpatient visit est	G0513	Prolong prev svcs, first 30m
99212	Office/outpatient visit est	G0514	Prolong prev svcs, addl 30m
99213	Office/outpatient visit est	G2086	Off base opioid tx first m
99214	Office/outpatient visit est	G2087	Off base opioid tx, sub m
		G2088	Off opioid tx month add 30

Modifiers and Place of Service codes:

1. A Place of Service (POS) code is required on professional claims for all services, telehealth or otherwise.

2. Effective January 1, 2018, CMS largely eliminated the requirement to use the GQ and GT modifiers on telehealth claims. Instead of using the GQ and GT modifiers, providers must mark their telehealth services claims with "Place of Service (POS) 02."

3. Critical access hospitals (CAHs) billing for distant site practitioners under Method II must continue to use the GT modifier on institutional claims, because institutional claims do not use a POS code.

    - The GQ modifier is used to indicate telehealth services delivered via asynchronous telecommunications systems. Except for demonstrations in Alaska and Hawaii, all telehealth must be interactive.

    - The GT modifier is used to indicate telehealth services rendered via synchronous telecommunication. Except for demonstrations in Alaska and Hawaii, all telehealth must be interactive.

CIGNA CORONAVIRUS (COVID-19) INTERIM BILLING GUIDANCE FOR PROVIDERS

Updated as of March 17, 2020

As the COVID-19 pandemic continues to spread throughout the United States, we appreciate that providers across the country are on the front line to offer dedicated care to our customers and help protect local communities.

We also know it's more important than ever for Cigna to be committed to our customers' health and to remove the barriers you face in delivering safe, efficient, and quality care.

To honor this commitment, Cigna recently announced that we will:

- Waive customer cost-sharing for office visits related to COVID-19 screening and testing through May 31, 2020
- Waive customer cost-sharing for telehealth screenings for COVID-19 through May 31, 2020
- Make it easier for customers to be treated virtually for routine medical examinations by in-network physicians
- Provide free home delivery of up to 90-day supplies for Rx maintenance medications available through the Express Scripts Pharmacy and 24/7 access to pharmacists

To further this commitment, we are providing this COVID-19 Billing and Reimbursement Guidance to help ensure you can keep delivering the care you need to – in the office, at a facility, or virtually – all while getting properly reimbursed for the services you provide our customers.

To allow accurate and timely reimbursement for COVID-19 related services, Cigna is requesting that health care providers submit claims using specific codes that our claim systems will recognize. If these recommended codes are used it will facilitate proper payment and help avoid errors and reimbursement delays.

Please note that this billing guidance document will continually be updated. Please check this document daily for updates, clarifications, and additional frequently asked questions.

Table of Contents

Interim Billing Guidelines for Coronavirus (COVID-19)

Updated March 17, 2020

- Please note that state and federal mandates may supersede these guidelines.
- These guidelines apply to fully insured clients and those self-funded clients who have chosen to follow these guidelines
- Cigna claims processing systems will be able to accept this coding guidance on April 6, 2020 for dates of service on or after March 2, 2020.
- Cigna will reimburse in person visits, phone calls, real-time synchronous virtual visits, and testing for COVID-19 without copay or cost share for all individuals covered under a fully-insured Cigna medical benefit plan and when billed according to the following guidelines:

Testing for COVID-19

a. Cigna will reimburse COVID-19 testing without customer copay or cost-share.
b. Kits approved through the CDC and/or the FDA approval process are eligible for reimbursement and should be billed with one of the following codes: HCPCS code U0001 (CDC kit), HCPCS codes U0002, or CPT code 87635 (FDA).
c. This billing requirement and associated reimbursement applies to services submitted on CMS1500 or UB04 claim forms and all electronic equivalents

Phone calls for COVID-19 (e.g.: 5-10 min virtual visit with or without video with the licensed health care provider)

a. HCPCS code G2012 will be reimbursed without customer copay or cost-share
b. In agreement with CDC recommendations one of the following ICD10 diagnosis codes should be billed:

    - For cases where there is a concern about a possible exposure to COVID-19, <u>but this is ruled out after evaluation</u>, it would be appropriate to assign the code Z03.818: Encounter for observation for suspected exposure to other biological agents ruled out.
    - For cases where there is an <u>actual exposure to someone who is confirmed to have COVID-19</u>, it would be appropriate to assign the code Z20.828: Contact with and (suspected) exposure to other viral communicable diseases.
    - This billing requirement and associated reimbursement applies to claims submitted on CMS 1500 claim forms or its electronic equivalent only.

All other virtual visits

a. CPT® code 99241 will be reimbursed for all other synchronous real-time virtual visits when billed with Place of Service 11.
b. If the visit is related to COVID-19, the above-mentioned ICD10 diagnosis codes (Z03.818 or Z20.828) are required to be billed and reimbursement will be without customer copay/cost-share.
c. If the virtual visit is not related to COVID-19, the ICD10 code for the visit should be billed and reimbursement will be made according to applicable benefits and related cost share.
d. No virtual care modifier should be billed
e. This billing requirement and associated reimbursement applies to services submitted on CMS1500 claim forms or its electronic equivalent only.

COVID-19 in person office visits, urgent care and emergency room visits

a. Cigna will reimburse in person office visits, urgent care and other outpatient visits for COVID-19 without customer cost share when one of the following appropriate ICD10 diagnosis code is billed:

- For cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation, it would be appropriate to assign the code Z03.818: Encounter for observation for suspected exposure to other biological agents ruled out.
- For cases where there is an actual exposure to someone who is confirmed to have COVID-19, it would be appropriate to assign the code Z20.828: Contact with and (suspected) exposure to other viral communicable diseases.
- This billing requirement and associated reimbursement applies to claims submitted on CMS1500 or UB04 claim forms and all electronic equivalents

Reimbursement for treatment of confirmed cases of COVID-19

Should be billed with ICD10 code B97.29: Other coronavirus as the cause of diseases classified elsewhere. Customer cost share applies to these claims.

Testing	
Code	**Description**
U0001	2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel
U0002	2019-nCoV Coronavirus, SARS COV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets)
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
Virtual Visits	
Code	**Description**
99241	Office consultation for a new or established patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care providers, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care provider 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

PROVIDER FREQUENTLY ASKED QUESTIONS FOR CORONAVIRUS (COVID-19)

Updated as of March 17, 2020

Key information

- In December 2019, a new kind of coronavirus, COVID-19, was identified as the cause of various cases of pneumonia in Wuhan City, Hubei Province of China. The virus is present in many locations around the world, including in the United States.

- On March 5, 2020, Cigna posted a press release announcing we will waive all co-pays and customer cost-share for COVID-19 testing.

- On March 13, 2020, Cigna posted a new press release announcing we will waive customers' out-of-pocket costs for COVID-19 testing-related visits with in-network providers, whether at a doctor's office, urgent care clinic, emergency room or via telehealth, through May 31, 2020.

- Due to the speed at which information related to COVID-19 is being released, this document will continually be updated as appropriate.

Key policy guidance at-a-glance

The following information applies when providers correctly bill using the guidance on the previous pages.

- Customers can receive in-network COVID-19 screening (office visit or virtual), testing (i.e., specimen collection by clinician), and laboratory testing (i.e., performed by state, hospital, or commercial laboratory) at no cost-share through May 31, 2020.

- Customers can receive COVID-19 related virtual care at no cost-share through May 31, 2020 (e.g., telephonic screening) when seeing their usual provider through our own contracted provider network or through our vendor network (e.g., Amwell or MDLive).

- Customers can receive non-COVID-19 related virtual care from their provider through May 31, 2020 (e.g., oncology follow-up visit), covered and reimbursed at standard office visit rates and customer cost-share.

- Non COVID-19 related in-office and virtual care remains at standard cost share, billing, and reimbursement requirements.

Questions and Answers

COVID-19 LABORATORY TESTING

Q. Will Cigna cover the laboratory test for COVID-19?

Yes. To help remove any barriers to receive testing, Cigna is committed to covering the laboratory test for COVID-19 similar to a preventive benefit for fully-insured plans – thereby waiving co-pays, coinsurance, or deductibles for customers.

This includes customers enrolled in Cigna's employer-sponsored plans in the United States, Medicare Advantage, Medicaid, and the Individual & Family plans available through the Affordable Care Act. Organizations that offer Administrative Services Only (ASO) plans will also have the option to cover coronavirus testing as a preventive benefit.

Q: What is a typical process for a patient to get screened and tested for COVID-19?

Per the CDC, as well as state and local public health departments, it is recommended that patients first be screened virtually (i.e., by phone or video) by a clinician for potential COVID-19 symptoms.

Typical COVID-19 testing decision factors include:

- Local epidemiology of COVID-19
- The clinical course of illness
- Fever (subjective or confirmed)
- Symptoms of acute respiratory illness (e.g., cough, difficulty breathing) and risk factors (e.g., travel history, exposure to a COVID-10 patient)
- Any close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
- History of travel from affected geographic areas within 14 days of symptom onset

Getting tested after screening:

- After a positive screen, the clinician will refer a patient to a physician's office, urgent care center, hospital, "drive thru" specimen collection center, or other facility that is equipped to collect specimens in order to test for COVID-19
- Any physician, nurse practitioner, or physician assistant who has an approved testing kit may properly administer the test (i.e., specimen collection)
- The test is sent by the provider to an approved laboratory, where the specimen is tested for COVID-19
- The laboratory communicates the results to the provider within a few days, who communicates the results to the patient

Providers are also encouraged to test for other causes of respiratory illness, including infections such as influenza.

Q: What is a specimen collection center? What is the benefit of referring patients to one instead of a physician's office?

A specimen collection center is found at or adjacent to a hospital or other health care facility, and typically includes a specially designated area to collect specimens from potentially infected patients. These centers continue to be set up throughout the country by local health systems as a safer, quicker, and more efficient way of screening and testing patients.

Specimen collection centers set up to screen and test patients for COVID-19 typically employ health care personnel who adhere to CDC recommendations for infection prevention and control (IPC). This includes specialized equipment to prevent the spread of the virus.

Q: How does a provider properly collect the specimen for commercial laboratory testing?

Commercial laboratories have reported that many tests have not been able to be performed by the laboratory due to improper specimen collection.

Providers should follow the guidance below from a commercial laboratory to ensure that they properly collect and ship the COVID-19 specimens:

- LabCorp Specimen Collection and Shipping Instructions for COVID-19 Testing
- LabCorp Specimen Collection Visual Demonstration for COVID-19 Testing

For more information, please visit LabCorp's website.

Q: If a patient screens positive for risk of COVID-19, but their local provider cannot perform the test – and do not know where else to refer the patient – what should the provider do?

If a provider determines their patient needs a COVID-19 test, but is not able to conduct the test themselves, providers should work with their local health department or an affiliated hospital to determine where their patients can go in their community to get tested. Providers are encouraged to call ahead and work with their patient to take proper isolation precautions when referring them for testing.

We recognize that the availability of COVID-19 testing kits varies based on location and may not currently meet the demand. National commercial labs with testing capabilities (e.g., LabCorp and Quest) are currently reaching out to local offices for more information on education and workflows. We are closely monitoring the availability of test kits, and will share more information as it becomes available.

Additionally, commercial laboratories like LabCorp have noted that they can supply physicians with test kits and will pick up the specimen. For more information, please visit LabCorp's website.

Q. When will a commercial laboratory test kit be available and who has it?

A commercial laboratory test for COVID-19 is now available. A health care provider must order the test for COVID-19.

As of March 11, in addition to the CDC and state health agencies, commercial laboratories LabCorp and Quest are offering testing for COVID-19. Additional laboratories – including local hospital systems – are also beginning to test. Providers should contact LabCorp or Quest – or their local hospital system – to confirm specific testing information and locations.

Q: Can the specimen collection be done at a patient service center, such as a local LabCorp or Quest location?

No. LabCorp and Quest will not collect specimens directly from patients. Collecting the specimen can only be done by a physician, physician assistant, or nurse practitioner in a physician's office, specimen collection center, urgent care center, hospital, or other facility that is equipped to collect specimens. Laboratory patient service centers are not equipped to collect specimens.

Q: When does a public health facility run a test versus that same test being sent to a commercial laboratory like LabCorp or Quest?

There are currently three ways to get COVID-19 tests: through a public health facility, commercial laboratory (e.g., LabCorp and Quest), or hospital. Public health departments are primarily focused on large epicenter outbreaks and public health emergency situations, while providers, virtual care providers, and health systems are typically more focused on individual patients with risk concerns or symptoms.

Depending on the person's identification, acuity, and location, they may get any one of these tests. All approved tests that are sent to an approved laboratory can properly be tested for the presence of COVID-19.

Q: Are there any prior authorizations required for COVID-19 testing?

No. Prior authorization is not required for COVID-19 testing.

COVID-19 MEDICAL TREATMENT

Q: Will Cigna waive customer co-pay and cost-sharing requirements for in-network services related to COVID-19 screening and treatment?

Yes. All customer co-pay and cost-share for any in-network screening, diagnosis, and treatment related to COVID-19 will be waived. This includes:

- The initial COVID-19 screening (virtually, in an office, or at an emergency room, urgent care center, “drive thru” specimen collection center, or other facility)
- Testing (i.e., specimen collection by clinician)
- Laboratory test (i.e., performed by state, hospital, or commercial laboratory)

Even if the test results come back negative for COVID-19, or the provider does not believe the patient needs to be tested for COVID-19, the visit will still be covered without customer cost-share if the patient initially displays COVID-19 related symptoms (e.g., fever, cough, and difficulty breathing) or there is a concern of exposure. The provider will need to code appropriately to indicate COVID-19 related screening.

Q: Are there any prior authorizations required for COVID-19 treatment?

No. Prior authorization (i.e., precertification) is not required for evaluation, testing, or treatment for services related to COVID-19. Treatment is supportive only and focused on symptom relief.

Prior authorization for treatment follows the same protocol as any other illness based on place of service and according to plan coverage. Generally, this means routine office, urgent care, and emergency visits do not require prior authorization.

Q: Are referral requirements to see other physicians, specialists, or facilities being waived?

Referral requirements will remain the same as for any other illness according to plan coverage.

Q: What behavioral health resources does Cigna offer customers who may experience anxiety or other behavioral health-related issues as a result of COVID-19?

Cigna recommends using our Employee Assistant Program (EAP) or other behavioral health services, when available. EAP clinicians are available 24-hours a day, seven days a week.

In addition, many Cigna behavioral health providers offer telehealth services. Patients can visit myCigna.com to search for behavioral health providers who offers these services. Patients are also encouraged to ask their current behavioral health provider if they will begin extending virtual and telehealth services to their patients. We also provide behavioral health telehealth services through Amwell or MDLive.

For individuals who do not have health benefits or employee assistance program benefits through Cigna but could benefit from talking with a qualified representative, the toll-free number***,*** *866.912.1687,* will be open 24 hours a day, seven days a week, for as long as necessary. The service is open to anyone, free of charge, to help people manage their stress and anxiety so they can continue to address their everyday needs. Callers may also receive referrals to community resources to help them with specific concerns, including financial and legal matters.

Q: Is Cigna making a recommendation on where customers with COVID-19 symptoms should be steered (e.g. an urgent care center or emergency room for screening and testing instead of an office visit)?

Per the CDC, we recommend customers call ahead to their primary care provider or use telehealth if they develop a fever or symptoms of a respiratory illness, such as coughing or difficulty breathing, or have been in close contact with a person known to have coronavirus, or if they live in, or have recently visited, an area with ongoing spread.

Both primary care physicians and telehealth providers will work with the state's public health department and the CDC to determine if they need to be tested for coronavirus.

Q: Will providers who can't submit claims or request authorizations or file claims on time because of staffing shortages be penalized?

Cigna will make every effort to accommodate facilities and provider groups who are adversely affected by COVID-19, as appropriate.

We may request to review the care that was provided for medical necessity post-service.

Prior authorization is not required for evaluation, testing, or medically necessary treatment of Cigna customers related to COVID-19. For other services that do require authorization, we will not deny administratively for failure to secure authorization (FTSA) if the care was emergent, urgent, or if extenuating circumstances applied. Delays in timely filing of claims or the ability to request an authorization due to COVID-19 would be considered an extenuating circumstance in the same way we view care in middle of a natural catastrophe (e.g., hurricane, tornado, fires, etc.).

COVID-19 VIRTUAL CARE

Q: Will Cigna allow in-network providers to provide virtual care?

Yes. We are making it easier for customers to be treated virtually by their physicians who have the ability to offer virtual care. All providers can deliver virtual care to Cigna customers when the services are billed consistently with the guidance on pages 3-5. We are implementing this enhanced measure through May 31, 2020 to protect our customers by mitigating exposure risks and alleviating transportation barriers.

We are also working on a permanent Virtual Care Reimbursement Policy that will continue to allow providers in our network to offer virtual care after June 1, 2020. More information about this policy will be shared with providers in the coming months. In the meantime, our COVID-19 virtual care guidance will remain in effect until at least May 31, 2020.

Q: How will Cigna cover virtual care for COVID-19 related services?

When providers follow the billing guidance on pages 3-5, we will cover virtual care as follows:

- For COVID-19 related screening (i.e., quick phone or video consult):
  - By contracted physician in Cigna's network: No cost-share for customer
  - By virtual vendor (e.g., Amwell or MDLive): No cost-share for customer
- For non-COVID-19 related services (e.g., oncology visit, routine follow-up care)
  - By contracted physician in Cigna's network: Reimbursable at standard office visit rates.
  - By virtual vendor (e.g., Amwell or MDLive): Reimbursable at standard rates currently in place today.

STATE MANDATES

Q: How is Cigna complying with state mandates related to COVID-19, such as customer cost share, virtual care policies, testing covered at 100%?

Cigna health plans comply with all state mandates as applicable. We are actively reviewing all COVID-19 state mandates and will continue to share more details around coverage, reimbursement, and cost-share as it is available.

CIGNA BUSINESS CONTINUITY

Q: What are Cigna's contingency plans to ensure appropriate staffing for customer service, claim review, authorization requests, etc.?

Cigna has been actively engaged in business continuity planning to better protect our employees and serve our customers and plan participants during an emergency situation.

Maintaining business operations is a core area of planning:

- Cigna has a matrix of call and claim and health care facilitation centers in multiple locations around the United States and abroad. The systems capability in place gives the company the flexibility to re-route calls to other facilities as necessary in order to help ensure business continuity. We have employed this system for natural disasters such as hurricane season or during other weather-related facilities closures.
- Cigna has systems capability and flexibility, with the option to further expand these capabilities as warranted, to allow many of our employees to work from home in the event of an outbreak. Depending on the circumstances, we may encourage that practice in the event of any widespread disease.
- Cigna travel guidelines and restrictions have been developed and implemented to minimize the spread of the virus within the Cigna employee population and to generally minimize the spread of the virus from region to region, or country to country.

Q: What are Cigna/Express Scripts plans to sustain pharmacy inventories in the event of a drug shortage?

Cigna recently announced that we would provide free home delivery of up to 90-day supplies for Rx maintenance medications available through the Express Scripts Pharmacy and 24/7 access to pharmacists.

Additionally, we are well prepared to ensure we can meet the medication needs of our members so they can stay healthy. Our drug sourcing teams have a long-established risk monitoring tool that maps the origins of drug products around the globe and allows us to monitor supplies and adjust our inventory procurement to mitigate shortages. We have been monitoring this situation for several weeks, and have made adjustments to our procurement to ensure we have adequate inventories to meet demands.

Our business continuity team has been monitoring the COVID-19 situation for several weeks, and has been planning for potential scenarios. Our Chief Clinical Officer, Dr. Steve Miller, is leading a COVID-19 readiness center that will continue to monitor all aspects of this situation and ensure we can help our employees, clients, and customers be prepared.

Ensuring the health and safety of our employees, clients, and members is our top priority, and we are committed to communicating more information as it is available.

Q: Who do I contact if I have more information?

If you have additional questions about how Cigna is responding to COVID-19, please call Cigna Customer Service at 1.800.88Cigna (882.4462) or contact your local provider services representative or contractor, if applicable.

View in browser

COVID-19 TELEHEALTH GUIDANCE

Thank you for your continued partnership with Health Net Health Plan of Oregon (Health Net). In order to ensure that all Health Net members have needed access to care, we are increasing the scope and scale of our use of telehealth services for all products for the duration of the COVID-19 emergency. These coverage expansions will benefit not only members who have contracted or been exposed to the novel coronavirus, but also those members who need to seek care unrelated to COVID-19 and wish to avoid clinical settings and other public spaces.

Effective immediately, the policies we are implementing include:

- Continuation of zero member liability (copays, cost sharing, etc.) for care delivered via telehealth*
- Any services that can be delivered virtually will be eligible for telehealth coverage
- All prior authorization requirements for telehealth services will be lifted for dates of service from March 17, 2020 through June 30, 2020
- Telehealth services may be delivered by providers with any connection technology to ensure patient access to care**

**Please note: For Health Savings Account (HSA)-Qualified plans, IRS guidance is pending as to deductible application requirements for telehealth/telemedicine related services.*
***Providers should follow state and federal guidelines regarding performance of telehealth services including permitted modalities.*

Providers who have delivered care via telehealth should reflect it on their claim form by following standard telehealth billing protocols in their state.

We believe that these measures will help our members maintain access to quality, affordable healthcare while maintaining the CDC's recommended distance from public spaces and groups of people.

Again, we thank you for your commitment to the care and wellbeing of our members, as well as to the communities we share. Please don't hesitate to reach out to Provider Services at the numbers below with any questions you may have.

Commercial: 1.888.802.7001 Medicare Advantage: 1.888.445.8913 HealthNetOregon.com

---

Oregon Health Plan coverage of telephone/telemedicine/telehealth services

Information for Oregon Health Plan physical and behavioral health providers

What's new?

OHA is expanding coverage of telehealth and telephone services in light of the COVID-19 outbreak. This document summarizes existing and new coverage. New coverage includes:

- A new Health Evidence Review Commission (HERC) guideline clarifying expanded coverage of synchronous audio and video, telephone, online (e.g., patient portal) services and provider-to-provider consultations for physical and behavioral health (Guideline Note A5).
- Fee-for-service Medicaid is opening additional codes to payments:
  - telephone service evaluation/assessment and management codes for behavioral health providers (retroactive to January 1, 2020)
  - synchronous audio/video visits, online (e.g. patient portal) services and provider-to-provider consultations for physical health providers
- CCOs shall cover telemedicine services identified in HERC guideline note A5 effective March 13, 2020, but OHA encourages CCOs to make this coverage retroactive to January 1, 2020.
- OAR 410-130-0610 rule language is being revised and vetted through OHA to remove barriers to telemedicine services. A link to the new rule will be provided when published.
- OAR 410-146-0085 and 410-147-0120 rule language is being revised to clarify telemedicine encounters for FQHCs and RHCs. A link to the new rule will be provided when published.
- Fee-for-service Medicaid changes are pending claims system configuration. Please allow up to one week to MMIS changes to take effect.
- OHA is actively looking into ways to allow additional services to be provided so that members can access important services for physical and behavioral health.

Telemedicine/telehealth (e.g., video and patient portal)

What is telemedicine/telehealth?

Telemedicine or telehealth services are health care services rendered to patients using electronic communications such as secure email, patient portals and online audio/video conferencing.

Does the Oregon Health Plan cover telemedicine services?

To be eligible for coverage, telemedicine services must comply with:

- Oregon Administrative Rules (OAR) 410-120-1200 (excluded services and limitations),
- OAR 410-130-0610 (Telemedicine). *This rule is being updated and will be linked to this communication when published with the Secretary of State.*
- OAR 410-172-0850 (Telemedicine for behavioral health) and
- Guideline Note A5 (Teleconsultations and non-face-to-face telehealth services) from the Prioritized List of Health Services. *This guideline note was updated March 13, 2020.*

Does the Oregon Health Plan cover telephone services?

Yes. Telephone calls can be billed for the following services:

- 99441-99443 for providers who can provide evaluation and management services;
- 98966-98968 for other types of providers, including nonphysician behavioral health providers

What about CCOs? Does OHA allow CCOs to cover telehealth and telemedicine services?

Yes, subject to Guideline Note A5 for services that are already covered for in-person visits, such as:

- Evaluation and management services (for providers who can perform these services, such as physicians, physician assistants or nurse practitioners), or
- Assessment and management services (for other types of providers including behavioral health providers and dietitians).
- Consultations between providers in a variety of settings (by telephone or other electronic forms of communication)

This is true for both physical health and behavioral health services. CCO contracts require CCOs to ensure that telemedicine credentialing requirements are consistent with OAR 410-130-0610(5).

Can I provide telephone/telemedicine services to a CCO member?

Yes. If the service falls under those described in Guideline Note A5 in the HERC guidelines. CCOs may cover additional telephone/telemedicine services. Contact the patient's CCO for specific guidance on their telephone/telemedicine/telehealth services and policies.

What telephone/telemedicine codes are covered for physical health services?

- Audio/video telemedicine services with synchronous audio and video, regardless of the location of the patient (inpatient, outpatient or community) using ordinary evaluation and management codes. For instance, 99201-99215 are covered. See HERC Guideline Note Guideline Note A5 (Teleconsultations and non-face-to-face telehealth services) for a list of services that can be covered
- Online services (e.g. electronic patient portals). CPT codes include 99421-99423 for physicians, 98970-98972 for non-physicians who can bill evaluation and management services, and G2061-G2063 for assessment and management services by other provider types.
- CPT 99451-99452 and 99446-99449 are available for provider-to-provider consultations.
- Telephone services (CPT codes include 99441-99443 for providers who can provide evaluation and management services; 98966-98968 for other types of providers, including nonphysician behavioral health providers)

Some of these codes have other limitations, such as being only for established patients and not being related to an in-person visit. See industry coding resources for details. Online communications must by encrypted (HIPAA-compliant).

What codes are covered for behavioral health providers?

Telemedicine services (synchronous audio and video)

The fee-for service behavioral health fee schedule lists all codes that include telemedicine reimbursement when billed with modifier GT. These services have been covered for several years. These codes include:

- Psychotherapy,

- Team conferences,
- Crisis psychotherapy,
- Team psychotherapy,
- Mental health assessments and
- Service plan development.

To be eligible for telemedicine reimbursement, the services must be provided using a synchronous audio-video platform compliant with HIPAA and 42 CFR part 2. Reimbursement will be the same as for services provided in-person.

Telephone services (99441-99433, 98966-98968) are new codes for behavioral health providers during the COVID-19 crisis and will be configured in MMIS by Tuesday, March 17, 2020.

These codes are newly eligible for payment (retroactive to January 1, 2020) when the service is:

- Provided by a qualified nonphysician health care professional to an established patient, parent, or guardian,
- Not related to an assessment and management service provided within the previous 7 days,
- Not related to an assessment and management service or procedure scheduled to occur within the next 24 hours or soonest available appointment.

If there is a related visit, billing for that visit should suffice.

As part of the COVID-19 crisis, OHA is investigating ways to allow behavioral health providers to provide services via telephone. Additional guidance will be forthcoming as we receive approval from the Centers for Medicare & Medicaid Services (CMS).

I have more questions about telemedicine/telehealth. Who do I call?

If you have questions about OHA's fee-for-service coverage of telephone/telemedicine services, contact Provider Services at 800-336-6016 or dmap.providerservices@dhsoha.state.or.us.

If you have questions about CCO coverage of telephone/telemedicine services, contact the CCO.

Claims Payment Policy

Subject: Telehealth Services

Application: Medicare Advantage, Commercial and Medicaid Products
Policy number: CP2008102
Related policies: N/A

Effective date: Commercial: 07/2008
Medicare Advantage: 02/2009
Revision date: 12/2019

Overview

Telehealth is a method of delivering health care services via *electronic information and telecommunications technologies*. The following policy outlines how Humana plans reimburse *telehealth* services.

Medicare Advantage Payment Policy

In addition to the policy, claims payments are subject to other plan requirements for the processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements.

Original Medicare Telehealth Services

For dates of service beginning January 1, 2017, the Centers for Medicare & Medicaid Services (CMS) requires the use of *place of service (POS) code 02* on professional claims for *Original Medicare telehealth services*.

For dates of service before October 1, 2018, CMS required *Original Medicare telehealth services* to be identified with *modifier GT*.

Humana requires a provider to submit a charge for an *Original Medicare telehealth service* according to the applicable CMS guidance for the date of service. Humana Medicare Advantage (MA) plans allow *Original Medicare telehealth services* and *interprofessional telephone or internet assessment and management services* consistent with the applicable CMS guidance for the date of service.

Additional Telehealth Services

For dates of service beginning January 1, 2020, Humana MA plans also allow certain *additional telehealth services* that are not *Original Medicare telehealth services*. *Additional telehealth services* must meet the following criteria:

- The services must be primary care, urgent care, mental health or substance abuse services, as defined by Humana. The services must be provided by a physician or other qualified health care practitioner that has satisfied Humana's telehealth credentialing and recredentialing standards and has a valid and effective contract with Humana.
- The services must be provided by a physician or other qualified health care practitioner that satisfies the following requirements:
  - Meets all applicable licensure, certification and registration requirements, including Drug Enforcement Administration (DEA) registration, if applicable, in the state(s) in which they practice and the state in which the patient is located at the time of the encounter;
  - Is operating within the scope of their license; and
  - Meets professional practice standards in the state(s) in which they practice and the state in which the patient is located at the time of the encounter.
- The services must be provided through real-time interactive audio or visual methods.
- The physician or other qualified health care practitioner must verify the member's identity before providing services.
- The Humana member must provide verbal or written consent to receive the services, in accordance with state law.
- The Humana member must be present for the full duration of the service.

Services not meeting the criteria outlined above will not be allowed by Humana as *additional telehealth services*.

Physicians are responsible for supervising any *additional telehealth services* provided to Humana MA members by non-physician practitioners within their practices to ensure that such services conform in all respects to the requirements set forth herein.

Humana requires a provider to submit a charge for an *additional telehealth service* with *POS code 02*.

Note: For further information on the service codes that may be reported as *additional telehealth services*, see the Medicare Advantage Additional Telehealth Benefit Code List section of this policy.

Supplemental Telehealth Services

For dates of service before January 1, 2020, a Humana MA plan may also have had a *supplemental benefit* that allowed specific *supplemental telehealth services* in addition to the *Original Medicare telehealth services.* For additional details, providers and members are advised to contact Humana to verify whether a Humana MA plan had the *supplemental benefit.*

Commercial Payment Policy

In addition to the policy, claims payments are subject to other plan requirements for the processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements.

Humana requires a provider to submit a charge for a *telehealth* service with *modifier GT, modifier 95* or *POS code 02*.

Humana commercial plans allow *telehealth* and *interprofessional telephone or internet assessment and management services* with the following exception:

- Internet-only telehealth services, Current Procedural Terminology (CPT®) codes 99421-99423, 99444 and 98969-98972, are not allowed unless provided pursuant to a Humana telehealth vendor partnership or when required by an applicable state mandate.

Medicaid Payment Policy

In addition to the policy, claims payments are subject to other plan requirements for the processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements.

Humana Medicaid plans allow *telehealth* services consistent with federal law and state Medicaid agency requirements.

Definitions of *Italicized* Terms

- ***Additional telehealth services:*** Telehealth services provided by an MA plan, beginning in plan year 2020, under Section 1852(m) of the Social Security Act and which are treated as a basic benefit rather than a supplemental benefit.
- ***Electronic information and telecommunication technology:*** Technologies and devices which enable secure electronic communications and information exchange and typically involve the application of secure real-time audio/video conferencing or similar services, remote monitoring, or store and forward medical data technology to provide or support health care services.
- ***Interprofessional telephone or internet assessment and management service*:** A telephone or internet consultation in which a patient's treating physician or other qualified health care professional requests the opinion and or treatment advice of a physician with specific specialty expertise to assist the treating physician or other qualified health care professional in the diagnosis and or management of the patient's problem without the need for the patient's face-to-face contact with the consultant. (CPT codes 99446 through 99449)
- ***Modifier 95:*** Services delivered via telemedicine.
- ***Modifier GT:*** Services delivered via interactive video and video telecommunication systems. (For Medicare, effective January 1, 2018, modifier GT is only appropriate for use by critical access hospitals.)
- ***Original Medicare telehealth services:*** Telehealth services covered by Original Medicare under Section 1834(m) of the Social Security Act.
- ***Place of service code 02:*** The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)
- ***Supplemental benefit:*** A primarily health-related item or service, covered as a benefit by a specific MA plan, that Medicare part A, B and D would not cover as a benefit. A supplemental benefit is distinguished from such extended offerings as riders.
- ***Supplemental telehealth services:*** Telehealth services provided by an MA plan as a supplemental benefit before plan year 2020.
- ***Telehealth:*** A means to deliver health care services to a patient at a different physical location than the health professional using electronic information or telecommunications technologies consistent with applicable state and federal law. Telehealth services include telemedicine services and are also known as virtual visits.

References

- Social Security Administration website. Social Security Act. Title 18, Section 1834. https://www.ssa.gov.
- Social Security Administration website. Social Security Act. Title 18, Section 1852. https://www.ssa.gov.
- U.S. Government Publishing Office website. Code of Federal Regulations. Title 42, Section 410.78. Telehealth Services. https://www.govinfo.gov.

- U.S. Government Publishing Office website. Code of Federal Regulations. Title 42, Section 414.65. Payment for Telehealth Services. https://www.govinfo.gov.
- U.S. Government Publishing Office website. Federal Register, Vol. 84, No. 73. Department of Health and Human Services. Final Rule CMS-4185-F. https://www.govinfo.gov.
- Centers for Medicare & Medicaid Services website. Medicare Claims Processing Manual. Chapter 12, Section 190. http://www.cms.gov.
- Centers for Medicare & Medicaid Services website. Medicare Learning Network. Telehealth Services. http://www.cms.gov.
- Centers for Medicare & Medicaid Services website. Place of Service Code Set. Place of Service Codes for Professional Claims. http://www.cms.gov.
- Centers for Medicare & Medicaid Services HCPCS Level II and associated publications and services.
- American Medical Association's CPT and associated publications and services.

Note: Links to sources outside of Humana's control are verified at the time of publication. Please report broken links.

General Humana Resources

- Availity – Providers can register for access to information on a variety of topics such as eligibility, benefits, referrals, authorizations, claims and electronic remittances.
- Claims processing edit notifications – Alerts of upcoming claims payment changes are posted on the first Friday of each month.
- Claims resources – Providers can find information on referrals, authorizations, electronic claim submissions and more.
- Education and news – This page can help you find clinical guidelines, educational tools, Medicare and Medicaid resources, our provider magazine and other resources to help you do business with us.
- Making it easier – This page contains an educational series for providers and healthcare professionals.
- Medical and pharmacy coverage policies – Humana publishes determinations of coverage of medical procedures, devices and medications for the treatment of various conditions. There may be variances in coverage among plans.

Medicare Advantage Additional Telehealth Benefit Code List

The following list of procedure codes serves as a guide to assist providers in determining which services may be reimbursable under Humana's Medicare Advantage additional telehealth benefit for 2020. This list is subject to termination or modification by Humana at any time, without notice. Printed versions of this document may be out of date and do not control. For the most current and only controlling version of this guide, refer to the most current version of this policy published at the following website: Humana.com/ClaimPaymentPolicies.

This list does not constitute medical advice, guarantee of payment, plan pre-authorization, an explanation of benefits, or a contract. It does not govern whether a procedure is covered under a specific member plan or policy, nor is it intended to address every claim situation. Claims payment and coverage may be affected by other factors, including but not limited to federal laws and regulations, the member's Evidence of Coverage, provider contract terms, coverage policies, medical necessity, and Humana's professional judgment. Humana has full and final discretionary authority for its interpretation and application. No part of this may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, electronic, mechanical, photocopying or otherwise without express written permission from Humana.

A charge for any code in this list will not be reimbursed under Humana's Medicare Advantage additional telehealth benefit if any applicable additional telehealth benefit criterion is not satisfied. Likewise, a charge for any code in this list will not be reimbursed under Humana's Medicare Advantage additional telehealth benefit if any applicable criterion of that code is not satisfied.

Code Type	Code	Description	Primary Care	Urgent Care	Mental Health/ Substance Abuse
CPT	90785	Interactive complexity	X	X	
CPT	90791	Psychiatric diagnostic evaluation			X

Code Type	Code	Description	Primary Care	Urgent Care	Mental Health/ Substance Abuse
CPT	90792	Psychiatric diagnostic evaluation with medical services			X
CPT	90832	Psychotherapy, 30 minutes with patient			X
CPT	90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service			X
CPT	90834	Psychotherapy, 45 minutes with patient			X
CPT	90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service			X
CPT	90837	Psychotherapy, 60 minutes with patient			X
CPT	90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service			X
CPT	90839	Psychotherapy for crisis; first 60 minutes			X
CPT	90840	Psychotherapy for crisis; each additional 30 minutes			X
CPT	90845	Psychoanalysis			X
CPT	90846	Family psychotherapy (without the patient present), 50 minutes			X
CPT	90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes			X
CPT	92227	Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral	X		
CPT	92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral	X		
CPT	93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	X		
CPT	93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	X		
CPT	93268	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional	X		

Code Type	Code	Description	Primary Care	Urgent Care	Mental Health/ Substance Abuse
CPT	93270	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection)	X		
CPT	93271	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis	X		
CPT	93272	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional	X		
CPT	96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	X		X
CPT	96127	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	X		X
CPT	96156	Health behavior assessment or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)	X		X
CPT	96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	X	X	X
CPT	96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes	X	X	X
CPT	96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	X		X
CPT	96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument	X		X
CPT	96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	X		X
CPT	96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes	X		X
CPT	96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	X		X
CPT	96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes	X		X
CPT	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	X		
CPT	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	X		

Code Type	Code	Description	Primary Care	Urgent Care	Mental Health/ Substance Abuse
CPT	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes	X		
CPT	99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making.	X	X	X
CPT	99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making.	X	X	X
CPT	99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity.	X	X	X
CPT	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity.	X	X	X
CPT	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity.	X	X	X
CPT	99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.	X		X
CPT	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making.	X		X
CPT	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity.	X		X
CPT	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity.	X		X
CPT	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity.	X		X
CPT	99217	Observation care discharge day management	X		X
CPT	99238	Hospital discharge day management; 30 minutes or less	X		X
CPT	99239	Hospital discharge day management; more than 30 minutes	X		X

Code Type	Code	Description	Primary Care	Urgent Care	Mental Health/ Substance Abuse
CPT	99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity.	X		
CPT	99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.	X		
CPT	99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.	X		
CPT	99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making.	X		
CPT	99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity.	X		
CPT	99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity.	X		
CPT	99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity.	X		
CPT	99315	Nursing facility discharge day management; 30 minutes or less	X		
CPT	99316	Nursing facility discharge day management; more than 30 minutes	X		
CPT	99318	Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity.	X		
CPT	99324	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making.	X		
CPT	99325	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity.	X		
CPT	99326	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity.	X		

Code Type	Code	Description	Primary Care	Urgent Care	Mental Health/ Substance Abuse
CPT	99327	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.	X		
CPT	99328	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.	X		
CPT	99334	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making.	X		
CPT	99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity.	X		
CPT	99336	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity.	X		
CPT	99337	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity.	X		
CPT	99341	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making.	X		
CPT	99342	Home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity.	X		
CPT	99343	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity.	X		
CPT	99344	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.	X		
CPT	99345	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.	X		

Code Type	Code	Description	Primary Care	Urgent Care	Mental Health/ Substance Abuse
CPT	99347	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making.	X		
CPT	99348	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity.	X		
CPT	99349	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity.	X		
CPT	99350	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity.	X		
CPT	99354	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour			X
CPT	99355	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes			X
CPT	99358	Prolonged evaluation and management service before and/or after direct patient care; first hour	X		
CPT	99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes	X		
CPT	99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older	X		
CPT	99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older	X		
CPT	99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	X	X	
CPT	99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	X		
CPT	99415	Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour	X		

Code Type	Code	Description	Primary Care	Urgent Care	Mental Health/ Substance Abuse
CPT	99416	Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes	X		
CPT	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	X		
CPT	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	X		
CPT	99423	Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 21 or more minutes	X		
CPT	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	X		
CPT	99442	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; 11-20 minutes of medical discussion	X		
CPT	99443	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; 21-30 minutes of medical discussion	X		
CPT	99446	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	X	X	
CPT	99447	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; 11-20 minutes of medical consultative discussion and review	X	X	

Code Type	Code	Description	Primary Care	Urgent Care	Mental Health/ Substance Abuse
CPT	99448	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; 21-30 minutes of medical consultative discussion and review	X	X	
CPT	99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	X	X	
CPT	99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision making of at least moderate complexity during the service period; Face-to-face visit, within 14 calendar days of discharge	X		
CPT	99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision making of high complexity during the service period; Face-to-face visit, within 7 calendar days of discharge	X		
CPT	99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	X		
CPT	99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes	X		
HCPCS Level II	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	X		
HCPCS Level II	G0109	Diabetes outpatient self-management training services, group session (two or more), per 30 minutes	X		
HCPCS Level II	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes	X		
HCPCS Level II	G0296	Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making)	X		
HCPCS Level II	G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes	X		

Code Type	Code	Description	Primary Care	Urgent Care	Mental Health/ Substance Abuse
HCPCS Level II	G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes	X		
HCPCS Level II	G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth	X		
HCPCS Level II	G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth	X		
HCPCS Level II	G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth	X		
HCPCS Level II	G0420	Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per 1 hour	X		
HCPCS Level II	G0421	Face-to-face educational services related to the care of chronic kidney disease; group, per session, per 1 hour	X		
HCPCS Level II	G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth	X		
HCPCS Level II	G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth	X		
HCPCS Level II	G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth	X	X	
HCPCS Level II	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	X	X	
HCPCS Level II	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	X	X	
HCPCS Level II	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit	X		
HCPCS Level II	G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit	X		
HCPCS Level II	G0442	Annual alcohol misuse screening, 15 minutes	X		
HCPCS Level II	G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	X	X	
HCPCS Level II	G0444	Annual depression screening, 15 minutes	X		
HCPCS Level II	G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	X		
HCPCS Level II	G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services	X		
HCPCS Level II	G2011	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, DAST), and brief intervention, 5-14 minutes	X	X	
HCPCS Level II	G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month	X		X
HCPCS Level II	G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month	X		X

Code Type	Code	Description	Primary Care	Urgent Care	Mental Health/ Substance Abuse
HCPCS Level II	G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes	X		X

Manual: Reimbursement Policy

Policy Title: **Telehealth And Telemedicine**

Section: Medicine

Subsection: None

Date of Origin: 1/1/2010 **Policy Number:** RPM052

Last Updated: 2/12/2020 **Last Reviewed:** 2/12/2020

Scope

This policy applies to Oregon insured Commercial medical benefit plans, any ASO plans which adopt the Oregon telehealth mandate, Alaska group and individual medical plans issued or renewing 10/1/2016 and after, any Alaska ASO plans which adopt the Alaska telehealth mandate, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

The policy applies to professional and other qualified healthcare professionals and facilities providing telemedicine services to a member on one of our plans.

This policy does not apply to:

- Dental-only plans.
- Vision-only plans.
- Medicare supplemental benefit plans.

This policy is intended to define telehealth and telemedicine terminology for our company, plans, and claims, provide clarification of which services are and are not eligible for reimbursement, and specify the criteria and requirements which must be met.

Reimbursement Guidelines

A. Commercial Oregon plans

Moda Health Oregon Commercial plans comply with OR SB 144 / ORS 743A.058 and ORS 743A.185.

1. Telemedicine services are eligible for reimbursement when:
    - The billed services must be within the provider's scope of license.
    - The billed services are a covered benefit under the member's plan.
    - The services can be safely and effectively performed as a telemedicine service.
    - Any applicable Medical Necessity Criteria are met.

- Oregon licensed providers can provide telemedicine services to Oregon residents while the provider is out-of-state.
- The billing and coding guidelines in this policy are met.

  Note: CMS originating site (patient location) restrictions and geographic restrictions do not apply to Oregon Commercial plans.

2. Telemedicine services are not eligible for reimbursement when:
   - Email/online written communication only is used.
     - These are not considered "telemedicine services" and are not a covered benefit on our standard plans.
     - Exception: If the member's plan has a specific benefit addressing coverage for email or online communication.
   - The service is not covered under the member's plan.
   - Other criteria in # 1 are not met.

3. Telemedicine services performed by non-contracted providers will be eligible for available benefits at the member's out-of-network benefit level.

4. Billing and Coding Guidelines:
   a. Report the primary service(s) using the appropriate CPT or HCPCS code(s) for the professional service(s) performed.
      1) Report with place of service (POS) 02. (MLN[12], CMS[13])
      2) Append modifier GQ, modifier 95, or modifier GT to the procedure code to indicate the type of transmission technology used.
      3) Use modifier G0 (G Zero) for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (MLN[17])
      4) Do not submit a telemedicine service or evaluation with CPT code 99499 (Unlisted evaluation and management service).
   b. Online evaluation and management service procedure codes include description wording of "… provided to an *established patient…"* or *"…for an established patient…"*
      1) Procedure codes 99444 *(DOS 2019 & prior)* or 99421-99423 *(DOS 1/1/2020 & following)* are used by providers in two distinct ways; to report:
         i. An audio/video real-time interactive telemedicine visit handled via a secure internet connection or app.
            a) This would be a telemedicine visit eligible for coverage if all criteria is met.
            b) Moda's guidelines instruct to report this service with the appropriate E/M procedure code and POS 02. However, some clinics are reporting with 99444 or 99421-99423 and cite their own internal policies.
         ii. A provider-patient exchange by written communication only online (e.g. email or private messaging), which is only a covered benefit for a few non-standard plans.

2) No matter if 99444 or 99421-99423 represent an email/written exchange or a real-time audio/visual internet visit, the code definitions for CPT codes 99444 or 99421-99423 require that the patient be an established patient.
    i. Codes 99444 or 99421-99423 may not be used to report a telemedicine visit to a new patient. Use the appropriate new patient E/M code with POS 02.
    ii. If 99444 or 99421-99423 are reported for a new patient member (with no previous billed services within the past 3 years), a clinical edit denial will be generated.
        a) A corrected claim will be needed.
        b) If the member is an established patient but previous services occurred before the member became effective on the Moda plan, submit a brief cover letter with explanation and attached medical record documentation and request a reconsideration using the provider inquiry/appeal process.

c. Originating site fee –
    1) An originating site fee may not be billed when the patient is located at home or at a self-service kiosk.
    2) The originating site (office or facility where the patient was located at the time of the telemedicine professional service) may submit an originating site facility fee for telemedicine services with HCPCS code Q3014 and one unit per provider of telemedicine services.
        a) Per Medically Unlikely Edits (MUE) unit limits for Q3014, Moda Health will reimburse a maximum of one unit per date of service to a professional provider or clinic, and a maximum of two units per date of service for facilities.
        b) The originating site fee (Q3014) may not be billed by the same provider or on the same claim as the telemedicine visit services performed by the provider at the distant site (where the patient is not located). Even if both office locations are within a large system of multi-location clinics or facilities and even if they share the same TIN, services where the patient is located (Q3014) and services where the patient is not located (e.g. 99213-GT/POS 02 or 99213-95/POS 02) need to be submitted under separate claims with separate NPIs and separate service addresses.
        c) A provider may do a face-to-face E/M, and then also be the originating site (space and equipment) for the patient to have a telemedicine visit with a second provider at another location, when a different specialty or more advanced care is needed. Both the face-to-face E/M visit and the Q3014 will be eligible for reimbursement.
        d) Moda Health does not reimburse for Q3014 for audio + visual telemedicine services utilizing ordinary non-secure smart phone or internet video phone call technology (e.g. Skype, FaceTime, etc.), applications, etcetera. These services are not HIPAA-compliant for a telemedicine service/PHI.

e) The originating site should keep a written record of the telemedicine session in the member's medical record, just as for any other patient service. The documentation should include the date, time, and duration of session; technology and equipment used; staff members present (name and licensure) at originating site; name, licensure, specialty, and location of the telemedicine provider at distant site; and reason for the telemedicine service.
f) The telemedicine session record must be provided for review upon request to substantiate the originating site facility fee.
g) Moda Health does not reimburse for T1014 (Telehealth transmission, per minute, professional services bill separately). T1014 is a HCPCS code specific to Medicaid services.

d. Telemedicine services are not reimbursed for the following:

1) Telemedicine that occurs the same day as an in-person visit, when performed by the same provider.
2) Online medical evaluations for evaluation and management services.
3) Patient communications incidental to E/M, counseling, or other covered medical services, including, but not limited to:
    a) Reporting of test results.
    b) Further discussion of symptoms or care.
    c) Provision of educational materials.

e. Some services (such as home cardiac event monitoring) are routinely performed using asynchronous telecommunications technology, and do not normally involve face-to-face provider contact. These services do not need to be submitted with modifier GQ. See # 8 below for more information.

5. Telemedicine services include the following items which are not eligible to be separately billed or reimbursed:

a. Pre-service activities include, but are not be limited to:
    1) Reviewing patient data (for example, diagnostic and/or imaging studies, interim lab work).
    2) Communicating with other professionals.
    3) Communicating with the family and/or further with the patient as needed.

b. Intra-service activities include, but are not be limited to, the key elements for each procedure code.

c. Post-service activities include, but are not limited to:
    1) Completing medical records or other documentation.
    2) Communicating results of the service and further care plans to other health care professionals.

6. Specific types of providers who are eligible to perform telemedicine services include but are not limited to the following:
    - Physician (MD, DO)
    - Naturopathic physicians (ND)
    - Nurse practitioner (NP)
    - Physician assistant (PA)
    - Certified Nurse-midwife (CNM)
    - Nurse Practitioner Midwife (NPM)
    - Clinical nurse specialist (CNS), Registered Nurse Clinical Specialist (RNCS)
    - Certified registered nurse anesthetist (CRNA), for pain management services only.
    - Clinical psychologists (CP, LCP, PhD.) *(See Coding Guidelines and MLN[5] for code restrictions.)*
    - Clinical social worker (LCSW, CSW) *(See Coding Guidelines and MLN[5] for code restrictions.)*
    - Board Certified Behavior Analyst (BCBA)
    - Other contracted mental health or chemical dependency providers
    - Registered dietitian (RD)
    - Speech Therapists, Speech-Language Pathologists (SLP).
    - Optometrists. (ORS[16])
    - Other provider types who meet the requirements in section A.1.

7. Providers are expected to:
    - Verify the member's identity and eligibility.
    - Ensure that all data transmission and recording is secure and HIPAA-compliant.
    - Comply with all state and federal laws governing privacy and security of protected health information (PHI), including laws in the state where the patient is located.
    - Utilize and follow community standards, best practices, prevailing technology, etc. for recording consent, security, encryption, transmission, storage, and storage disclosure.
    - Document the service in the patient's record in the same manner as if it were performed in-person. The written record is in addition to any stored recording of the data transmission of the service.
        - Include additional notations indicating the service was performed as a telemedicine service, and document any relevant impacts this had on the encounter or service.
        - Specify the type of transmission utilized (e.g. real-time or delayed, telephonic, audio + video, encrypted transmission of diagnostic test data, etc.).
        - Identify and note participation of any additional staff present at the member's location to assist with the telemedicine service.
        - The medical record must be available and provided to the health plan upon request for review at any time (pre-payment or post-payment).

- Care provided via telemedicine will be evaluated according to the clinical standard of care applicable to the relevant area of specialty for more traditional in-person medical care (e.g. pertinent physical exam findings, etc.). Additionally, telemedicine providers are expected to adhere to current standards for practice improvement and monitoring of outcomes.
- For ESRD-related services, a physician, NP, PA, or CNS must furnish at least one "hands on" in-person visit (not telehealth) each month to examine the vascular access site.

8. Services are eligible to be covered as telemedicine services if they are a covered benefit when performed in-person, and can be safely and effectively performed as a telemedicine service. Examples include but are not limited to:
   - Treatment of diabetes and/or Diabetes Self-Management Training (DSMT) (individual, or group).
   - Most evaluation and management (E/M) services are eligible to be performed as telemedicine services.
   - Most behavioral health services are eligible to be performed as telemedicine services.
   - Medical nutrition therapy assessment, individual, or group.
   - Other covered condition-specific assessments or patient education (mandated benefits or verify each member's plan benefits).

9. Services not eligible to be performed as telemedicine services (common examples, list not all-inclusive):

Service	**Why not eligible for telemedicine**
Anesthesia services	Requires member and provider to be in the same physical location to be performed safely and effectively.
Consultation between two physicians or providers	Does not require the presence of the patient for an in-person service.
Laboratory tests	Not performed as an in-person service.
Radiology interpretation and report services	Not performed as an in-person service.
Surgery	Requires member and provider to be in the same physical location to be performed safely and effectively.
Telephone calls with member(s).	When/if covered, a telephone call is not considered a telemedicine service, as telephone calls have always supplemented face-to-face services, and do not include video interaction.

10. Services not considered covered telemedicine services, but which may be otherwise covered as non-telemedicine services.

    Some professional services do not require the patient to be present in-person with the practitioner when they are furnished, and are commonly furnished using some form of telecommunications technology. These services are part of the broader scope of telehealth, but are not considered *telemedicine* service(s), and do not need to be reported with modifier GQ to signify asynchronous technology was used. They are processed as usual under the member's benefits, and reimbursed under the usual fee schedule.

    Examples of such services include:

    - Real-time remote intraoperative neurophysiologic monitoring.
    - Radiology interpretations. Claims should be billed with modifier 26.
    - Home cardiac event monitoring.
        - May utilize real-time or asynchronous transmission technology.
        - Duration of monitoring and monitor technology utilized must be documented, as proper code selection relies on a combination of both factors.

    Beginning in 2017, the current CPT book Appendix P includes some procedure codes of this nature. Modifier 95 will be considered valid for these codes (based upon the CPT book information only), but modifier GT and GQ will not be considered valid for these procedure codes.

Code	Code Definition
92227	Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional
93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional

Code	Code Definition
93268	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional
93270	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection)
93271	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis
93272	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional
93298	Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results

11. Services and activities not considered telemedicine services which are not eligible to be separately reported:
    - Sending e-mail, facsimile transmission, secure messaging, etc. to another provider, office, or facility containing clinical information.
    - Installation or maintenance of any telecommunication devices or systems to support telemedicine services.
    - Home health or safety monitoring (e.g. Medical Guardian Alert, VueZone, QuietCare Plus, LifeFone).
    - Advice-nurse lines, poison center, or other "health line" type services provided by nurses and other non-physician, non-nurse practitioner providers.
    - Triage to assess the appropriate place of service and/or appropriate provider type to render needed care.
    - Administrative services, including but not limited to: scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.

B. Moda Health Alaska Commercial plans

Moda Health Alaska Commercial plans comply with Alaska Statute 21.42.422.

1. Telemedicine services are eligible for reimbursement when:
   - The billing provider is licensed in the state of Alaska. Billing providers outside the state of Alaska need to be registered with the Alaska telemedicine business registry.
   - The billed services are a covered benefit under the member's plan.
   - The services can be safely and effectively performed as a telemedicine service.
   - Any applicable Medical Necessity Criteria are met.
   - The billing and coding guidelines in this policy are met.
   - Synchronous two-way interactive audio + video (A/V) conferencing is used.
     - The A/V conferencing the application and technology used meet all state and federal standards for privacy and security of protected health information (HIPAA).
     - The billing provider is responsible to ensure these HIPAA privacy protection standards are met.
   - The same benefit cost-sharing (deductible, copayment, co-insurance) applies to the telemedicine service as would apply if the service were performed in person.

     Note: CMS originating site (patient location) restrictions and geographic restrictions do not apply to Alaska Commercial plans.

2. Telemedicine services are not eligible for reimbursement when:
   - The provider is not either licensed in the state of Alaska or registered with the Alaska telemedicine business registry.
   - Asynchronous transmission is used (time-delay).
   - Audio-only conferencing or audio-web conferencing without person-to-person video abilities is used.
   - Other criteria in # 1 are not met.

3. Billing and Coding Guidelines:

   a. Report the primary service(s) using the appropriate CPT or HCPCS code(s) for the professional service(s) performed.
      1) Report with place of service 02. (MLN[12], CMS[13]) Do not report with POS 99 (Other place of service not identified above).
      2) Append modifier GQ, modifier 95, or modifier GT to the procedure code to indicate the type of transmission technology used.
      3) Use modifier G0 (G Zero) for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (MLN[17])
      4) Do not submit a telemedicine service or evaluation with CPT code 99499 (Unlisted evaluation and management service).

5) CPT codes 99444 and 99421-99423 all have descriptions which require that the patient be an established patient. Codes 99444 and/or 99421-99423 may not be used to report a telemedicine visit to a new patient. Use the appropriate new patient E/M code with POS 02.

b. Originating site fee –
   1) An originating site fee may not be billed when the patient is located at home or at a self-service kiosk.
   2) The originating site (office or facility where the patient was located at the time of the telemedicine professional service) may submit an originating site facility fee for telemedicine services with HCPCS code Q3014 and one unit per provider of telemedicine services.
      a) Per Medically Unlikely Edits (MUE) unit limits for Q3014, Moda Health will reimburse a maximum of one unit per date of service to a professional provider or clinic, and a maximum of two units per date of service for facilities.
      b) The originating site fee (Q3014) may not be billed by the same provider or on the same claim as the telemedicine visit services performed by the provider at the distant site (where the patient is not located). Even if both office locations are within a large system of multi-location clinics or facilities and even if they share the same TIN, services where the patient is located (Q3014) and services where the patient is not located (e.g. 99213-95/POS 02 or 99213-GT/POS 02) need to be submitted under separate claims with separate NPIs and separate service addresses.
      c) A provider may do a face-to-face E/M, and then also be the originating site (space and equipment) for the patient to have a telemedicine visit with a second provider at another location, when a different specialty or more advanced care is needed. Both the face-to-face E/M visit and the Q3014 will be eligible for reimbursement.
      d) Moda Health does not reimburse for Q3014 for audio + visual telemedicine services utilizing ordinary non-secure smart phone or internet video phone call technology (e.g. Skype, FaceTime, etc.), applications, etcetera. These services are not HIPAA-compliant for a telemedicine service/PHI.
      e) The originating site should keep a written record of the telemedicine session in the member's medical record, just as for any other patient service. The documentation should include the date, time, and duration of session; technology and equipment used; staff members present (name and licensure) at originating site; name, licensure, specialty, and location of the telemedicine provider at distant site; and reason for the telemedicine service.
      f) The telemedicine session record must be provided for review upon request to substantiate the originating site facility fee.
      g) Moda Health does not reimburse for T1014 (Telehealth transmission, per minute, professional services bill separately). T1014 is a HCPCS code specific to Medicaid services.

c. Telemedicine services are not reimbursed for the following:
    1) Telemedicine that occurs the same day as an in-person visit, when performed by the same provider.
    2) Online medical evaluations for evaluation and management services.
    3) Patient communications incidental to E/M, counseling, or other covered medical services, including, but not limited to:
        a) Reporting of test results.
        b) Further discussion of symptoms or care.
        c) Provision of educational materials.

d. Some services (such as home cardiac event monitoring) are routinely performed using asynchronous telecommunications technology, and do not normally involve face-to-face provider contact. These services do not need to be submitted with modifier GQ. See # 8 below for more information.

4. Telemedicine services include the following items which are not eligible to be separately billed or reimbursed:

    a. Pre-service activities include, but are not be limited to:
        1) Reviewing patient data (for example, diagnostic and/or imaging studies, interim lab work).
        2) Communicating with other professionals.
        3) Communicating with the family and/or further with the patient as needed.

    b. Intra-service activities include, but are not be limited to, the key elements for each procedure code.

    c. Post-service activities include, but are not be limited to:
        1) Completing medical records or other documentation.
        2) Communicating results of the service and further care plans to other health care professionals.

5. Providers are expected to:
    - Verify the member's identity and eligibility.
    - Ensure that all data transmission and recording is secure and HIPAA-compliant.
    - Comply with all state and federal laws governing privacy and security of protected health information (PHI), including laws in the state where the patient is located.
    - Utilize and follow community standards, best practices, prevailing technology, etc. for recording consent, security, encryption, transmission, storage, and storage disclosure.
    - Document the service in the patient's record in the same manner as if it were performed in-person. The written record is in addition to any stored recording of the data transmission of the service.
        - Include additional notations indicating the service was performed as a telemedicine service, and document any relevant impacts this had on the encounter or service.

- Specify the type of transmission utilized (e.g. real-time or delayed, telephonic, audio + video, encrypted transmission of diagnostic test data, etc.).
- Identify and note participation of any additional staff present at the member's location to assist with the telemedicine service.
- The medical record must be available and provided to the health plan upon request for review at any time (pre-payment or post-payment).

- Care provided via telemedicine will be evaluated according to the standard of care applicable to the relevant area of specialty for more traditional in-person medical care. Additionally, telemedicine providers are expected to adhere to current standards for practice improvement and monitoring of outcomes.

6. Services and activities not considered telemedicine services which are not eligible to be separately reported:
   - Sending e-mail, facsimile transmission, secure messaging, etc. containing clinical information.
   - Installation or maintenance of any telecommunication devices or systems to support telemedicine services.
   - Home health or safety monitoring (e.g. Medical Guardian Alert, VueZone, QuietCare Plus, LifeFone).
   - Advice-nurse lines, poison center, or other "health line" type services provided by nurses and other non-physician, non-nurse practitioner providers.
   - Triage to assess the appropriate place of service and/or appropriate provider type to render needed care.
   - Administrative services, including but not limited to: scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.

C. Moda Health Medicare Advantage plans

CMS covers a limited number of Part B telemedicine services furnished by a physician or practitioner to an eligible beneficiary when specific criteria are met.

Moda Health Medicare Advantage plans follow CMS telemedicine guidelines and requirements.

1. Services must be provided using real-time, interactive audio and video telecommunications system.

   The physician/provider and the beneficiary/member are in different locations. They must be able to both see and hear each other, and talk to each other without any time-delay or lag.

2. Moda Health Medicare Advantage plans do not participate in the Federal telemedicine demonstration programs in Alaska or Hawaii for the use of asynchronous "store and forward" technology for telemedicine services. Services billed with modifier GQ are denied to provider write-off.

3. Specific locations must be used. The member must be located at one of the following Medicare-approved "originating sites" (MLN[5]):
    a. Physician or practitioner's office
    b. Hospital
    c. Critical Access Hospital (CAH)
    d. Rural Health Clinic (RHC)
    e. Federally Qualified Health Center (FQHC)
    f. Hospital-based or CAH-based Renal Dialysis Center (including satellites)
    g. Skilled Nursing Facility (SNF)
    h. Community Mental Health Center (CMHC)
    i. Renal Dialysis Facility
    j. Home of beneficiaries with End-Stage Renal Disease (ESRD) receiving home dialysis
    k. Mobile Stroke Units
    l. Beginning date of service July 1, 2019: Home of beneficiaries receiving treatment of a substance use disorder or a co-occurring mental health disorder.
4. The following types of providers are defined by CMS as eligible to perform and receive reimbursement for covered telemedicine services (subject to state law and scope of license restrictions) (MLN[5]):
    a. Physicians
    b. Nurse practitioners (NPs)
    c. Physician assistants (PAs)
    d. Nurse-midwives (CNMs)
    e. Clinical nurse specialists (CNSs)
    f. Certified registered nurse anesthetists
    g. Clinical psychologists (CPs) and clinical social workers (CSWs).
        Note: CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.
    h. Registered dietitians or nutrition professionals.
5. The services provided must otherwise be a benefit under the Medicare Advantage plan. Any benefit periods, limitations, or quantities exhausted will apply.
6. The services must be on the list of Medicare-approved telemedicine procedure codes applicable for the date of service year.
    a. Medicare publishes a list of procedure codes approved for telemedicine/telehealth services which is updated annually and effective for the calendar year.
        i. This list of codes is available for download on the CMS website and is published in the MedLearn Matters Telehealth Services Fact Sheet annual update.

ii. Covered telemedicine procedure codes must be submitted with place of service 02. The use telehealth POS 02 certifies that the service meets the telehealth requirements. (CMS[14])

iii. The rules for modifier GT have changed for Medicare Advantage claims.

1) For distant site services billed under Critical Access Hospital (CAH) method II on institutional claims, the GT modifier will still be required. (CMS[14])

2) For non-CAH facilities with dates of service January 1, 2017 through September 30, 2018, the optional use of modifier GT will not result in denial as an inappropriate modifier.

3) For non-CAH facilities with dates of service October 1, 2018 and following, claims billed with modifier GT will be denied to provider liability. (CMS[15]) Per CMS, for dates of service October 1, 2018 and following, modifier GT is only allowed on institutional claims billed under CAH Method II billing. (CMS[X])

4) For professional claims, POS 02 is sufficient; modifier GT is not required. There is currently no known CMS guidance to deny professional claims submitted with modifier GT, however Moda Health requests modifier GT no longer be used on Medicare Advantage non-CAH professional claims.

iv. The GQ modifier is still required when applicable.

v. Do not use modifier 95 for Medicare Advantage telemedicine services.

vi. Use modifier G0 (G Zero) for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (MLN[17])

b. Services not on the list of approved CMS telemedicine procedure codes will not be allowed as telemedicine services under Moda Health Medicare Advantage plans.

c. Non-covered telemedicine services (those which do not meet Medicare requirements for any reason) will be denied to provider liability. See RPM036 for pre-service requirements to seek any payment. (Moda [B])

D. Oregon Medicaid/EOCCO plans

Moda Health Medicaid/EOCCO plans cover telemedicine services to an eligible beneficiary when specific criteria are met. The CMS Medicare/Medicaid Telemedicine requirements are followed.

1. Services must be provided using real-time, interactive audio and video telecommunications system.

   The physician/provider and the beneficiary/member are in different locations. They must be able to both see and hear each other, and talk to each other without any time-delay or lag.

2. Moda Health Medicaid/EOCCO plans do not cover telemedicine services performed using asynchronous "store and forward" technology. Services billed with modifier GQ are denied to provider write-off.
3. Specific locations must be used. The member must be located at one of the following Medicare-approved "originating sites" (MLN[5]):
    a. Physician or practitioner's office
    b. Hospital
    c. Critical Access Hospital (CAH)
    d. Rural Health Clinic (RHC)
    e. Federally Qualified Health Center (FQHC)
    f. Hospital-based or CAH-based Renal Dialysis Center (including satellites)
    g. Skilled Nursing Facility (SNF)
    h. Community Mental Health Center (CMHC)
4. The following types of providers are defined by CMS as eligible to perform and receive reimbursement for covered telemedicine services (subject to state law and scope of license restrictions) (MLN[5]):
    a. Physicians
    b. Nurse practitioners (NPs)
    c. Physician assistants (PAs)
    d. Nurse-midwives (CNMs)
    e. Clinical nurse specialists (CNSs)
    f. Certified registered nurse anesthetists
    g. Clinical psychologists (CPs) and clinical social workers (CSWs).
        Note: CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.
    h. Registered dietitians or nutrition professionals.
5. The provider may be contracted with Moda Health Community Health, Inc. on behalf of EOCCO or out of network.
6. The provider may be located outside of the state of Oregon.
7. The services provided must otherwise be a benefit under the Medicaid/EOCCO plan. Any benefit periods, limitations, or quantities exhausted will apply.
8. The services must be on the list of Medicare-approved telemedicine procedure codes applicable for the date of service year.
    a. Medicare publishes a list of procedure codes approved for telemedicine/telehealth services which is updated annually and effective for the calendar year.
        i. This list of codes is available for download on the CMS website and is published in the MedLearn Matters Telehealth Services Fact Sheet annual update.

ii. Covered telemedicine procedure codes must be submitted with place of service 02. The use telehealth POS 02 certifies that the service meets the telehealth requirements. (CMS[14])
iii. The use of modifier GT is optional and no longer required for Moda Health Medicaid/EOCCO claims. POS 02 is sufficient.
iv. The GQ modifier is still required when applicable.
v. Do not use modifier 95 for Moda Health Medicaid/EOCCO telemedicine services.
vi. Use modifier G0 (G Zero) for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (MLN[17])

b. Services not on the list of approved CMS telemedicine procedure codes will not be allowed as telemedicine services under Moda Health Medicaid/EOCCO plans.

Codes, Terms, and Definitions

Acronyms Defined

Acronym		Definition
ASO	=	Administrative Services Only
ATA	=	American Telemedicine Association
CAH	=	Critical Access Hospital
CMHC	=	Community Mental Health Center
CMS	=	Centers for Medicare and Medicaid Services
DSMT	=	Diabetes self-management training
E/M	=	Evaluation and management (service)
ESRD	=	End-stage renal disease
FQHC	=	Federally Qualified Health Center
HealthIT.gov	=	A federal government resource website maintained by ONC.
HHS	=	U.S. Department of Health and Human Services
HIPAA	=	Health Insurance Portability and Accountability Act
HITECH	=	Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009
NPI	=	National Provider Identifier
NRTRC	=	Northwest Regional Telehealth Resource Center
ONC	=	Office of the National Coordinator for Health Information Technology (ONC)

Acronym		Definition
PHI	=	Protected Health Information
POS	=	Place of Service
RHC	=	Rural Health Clinic
RPM	=	Remote patient monitoring
RPM	=	Reimbursement Policy Manual (e.g. in context of “RPM052” policy number, etc.)
SBIRT	=	Screening, Brief Intervention and Referral to Treatment
SNF	=	Skilled Nursing Facility
TIN	=	Tax ID Number
VoIP	=	Voice over Internet Protocol

Definition of Terms

Sorting-out "Tele-" Terminology	
Term	**Definition**

Telehealth	Telehealth is the use of technology to deliver health care, health information or health education at a distance. Telehealth is a broad term that includes:
	• Telemedicine clinical services
	• Other clinical services. Examples include:
	  ○ Provider-to-provider consultations which are not face-to-face
	  ○ Remote patient monitoring
	  ○ Remote patient health education (e.g. webinars on specific health issues), prescribed or voluntary.
	• Non-clinical services. Examples include:
	  ○ Physician teleconference about new best practices in treating angina
	  ○ Provider training (medical students or licensed staff)
	  ○ Administrative meetings
	  ○ Continuing medical education
	• Technology –
	  ○ Audio plus video
	  ○ Audio-only (telephone)
	  ○ Data-only (remote intraoperative monitoring)
	  ○ Audio plus data or webinar, no person-to-person video
	  ○ Instant messaging
	  ○ Email contact
	• Timing –
	  ○ Immediate, real-time, interactive exchanges.
	  ○ Delayed data transmission and/or delayed interpretation and results.
	"Telehealth is different from telemedicine because it refers to a *broader scope of remote healthcare services* than telemedicine." (ONC/HealthIT.gov[1])

Sorting-out "Tele-" Terminology	
Term	**Definition**
Telemedicine	Remote clinical services which are typically or traditionally delivered in-person with the provider and patient in the same location. Telemedicine services are delivered via technology because the patient and the provider are in two different locations (remote services). **Note 1 (Commercial plans):** Services performed via synchronous two-way interactive audio + video secure conferencing by a contracted provider are considered ***covered*** telemedicine services eligible for reimbursement, when all other requirements are met. Services performed by a non-contracted provider or by contracted providers via asynchronous technology are ***not considered covered*** telemedicine services and are not eligible for reimbursement under a Moda Health Commercial plan. **Note 2 (Medicare Advantage plans):** Medicare and Medicaid (CMS) considers Telemedicine to **only** include: Remote, face-to-face clinical services with real-time, two-way, interactive communication using both audio and video transmission. (CMS[2, 3]) This CMS definition is very strict. Any communication or data exchange which is time-delayed or does not include video (visual) transmission of information and data is not considered a telemedicine service by CMS. For Moda Health Commercial plans, there are covered telemedicine services and non-covered telemedicine services; but for CMS and Medicare Advantage, if the service does not meet the coverage requirements, it may not be called a "telemedicine service."
Telemonitoring	The use of telecommunications and information technology to provide patient monitoring (real-time or delayed store and transmit) to a separate monitoring and interpretation site.
Telepresenter	An individual, at the same location as the member who provides support to the patient and the telemedicine consulting provider, in completing the physical examination and/or telemedicine activity. The telepresenter is trained to use specialized telemedicine technology, such as digital stethoscope, otoscope, ophthalmoscope and examination camera, to facilitate comprehensive exams under physician guidance. (ATA[7], NRTRC[8])

Telehealth-related Terms	
Term	**Definition**
Asynchronous (also called "Store and Forward")	Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image or information data that is sent (forwarded) via telecommunication to another site for consultation.
Distant site (also called "Hub site")	Site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.
E-visit	An exchange of emails between member and provider asking and addressing clinical concerns are sometimes referred to as an "e-visit." Most groups do not provide benefits for email exchanges between member and provider or "e-visits;" a few select plans may specifically have an additional benefit for this service.
Hub site (also called "Distant site")	Site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.
In-person	Face to face interaction when the member and provider are physically in the same location.
Originating site (or Spoke site)	Location of the patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.
Remote patient monitoring	Remote patient monitoring (RPM) is using technology to enable monitoring of patients outside of conventional clinical settings (e.g. monitoring the patient in the home instead of in the clinic or the hospital).
Remote services	Services which occur when the member and provider are not physically in the same location. The amount of distance between the member's location and the provider's location is not significant; the member and provider may be located in the same city but different buildings and communicating via technology. The member may be in a rural or urban location, and does not need to be in a Health Professional Shortage Area (HPSA).

Telehealth-related Terms	
Term	**Definition**
Secondary Provider Network AKA: "Rented Network" or "Travel Network."	A group of providers contracted directly with another company. Moda Health then contracts with that other company to use their network of providers for specific member plans under specific circumstances. The secondary network company has control over the list of participating providers, fee schedule, and other contract terms. Moda Health pays for the additional provider access and hold-harmless protection for our members. Claims are processed as in-network when criteria is met. Different plans/groups may use different secondary networks. Examples include: Private Healthcare Services (PHCS), First Choice Health Network, Idaho Physician's Network (IPN), and First Health Network. Sometimes also called "rented network" or "travel network."
Spoke site (or Originating site)	Location of the patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.
"Store and Forward" (also called Asynchronous)	Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation.
Virtual Care	A wide-ranging term that includes telemedicine, virtual visits, and other non-telemedicine benefits and/or services. May include a nurse-advice line, emailing a physician, etc. which are not considered telemedicine.
Virtual Visit	A telemedicine visit that uses real-time, audio-visual technology and special equipment to accomplish a visit that is virtual or "the same as being there in person." Qualifies for modifier GT or 95.

Procedure codes:

Online evaluation and management service procedure codes		
Code	**Code Description**	**Applicable DOS**
99444	Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network	Terminated 12/31/2019. **Do not use for 2020 dates of service.**
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	Effective 1/1/2020
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	Effective 1/1/2020
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Effective 1/1/2020

Note: These are originating site fees. They do not represent the primary service performed.	
Code	**Code Description**
Q3014	Telehealth originating site facility fee
T1014	Telehealth transmission, per minute, professional services bill separately

Modifier Definitions:

Modifier	**Modifier Definition**
G0	Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke
GQ	Via asynchronous telecommunications system
GT	Via interactive audio and video telecommunication systems

Modifier	Modifier Definition
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System: Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Modifier 95 may only be appended to the services listed in Appendix P. Appendix P is the list of CPT codes for services that are typically performed face-to-face, but may be rendered via a real-time (synchronous) interactive audio and video telecommunications system.

Place of Service code:

Note: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service. (CMS MM9726[12])

Code	Short Description	Place of Service Code Long Description
02	Telehealth	The location where health services and health related services are provided or received, through telecommunication technology. (Does not apply to originating site facilities billing a facility fee.) (Effective for claims submitted 1/1/2017 and following, regardless of date of service.)

National Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"Submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, "via interactive audio and video telecommunications systems" (for example,99201 GT). By coding and billing the GT modifier with a covered telehealth procedure code, you are certifying that the beneficiary was present at an eligible originating site when you furnished the telehealth service. By coding and billing the GT modifier with a covered ESRD-related service telehealth code, you are certifying that you furnished one "hands on" visit per month to examine the vascular access site." (MLN[5])

"Clinical psychologists (CPs) and clinical social workers (CSWs). CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838…" (MLN[5])

"The originating site facility fee is a separately billable Part B payment. The contractor pays it outside of other payment methodologies. This fee is subject to post payment verification." (CMS[10])

Cross References

A. "Medical Records Documentation Standards." Moda Health Reimbursement Policy Manual, RPM039.

B. "Modifiers GA, GX, GY, and GZ." Moda Health Reimbursement Policy Manual, RPM036.

References & Resources

1. ONC. "What is telehealth? How is telehealth different from telemedicine?" June 16, 2016. https://www.healthit.gov/providers-professionals/faqs/what-telehealth-how-telehealth-different-telemedicine

2. CMS. "Telehealth." June 16, 2016. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html .

3. CMS. "Telemedicine." June 16, 2016. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html .

4. CMS. "List of Telehealth Services." https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html

5. MLN. "Telehealth Services Fact Sheet." Medicare Learning Network (MLN) Publications. January 2019: August 27, 2019. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf .

6. American Telemedicine Association (ATA). "Telemedicine Frequently Asked Questions (FAQs)." June 21, 2016. http://www.americantelemed.org/about-telemedicine/faqs#.V2nMAv72b4Y .

7. American Telemedicine Association (ATA). "Expert Consensus Recommendations for Videoconferencing-Based Telepresenting." June 21, 2016. http://www.americantelemed.org/resources/telemedicine-practice-guidelines/telemedicine-practice-guidelines/recommendations-for-videoconferencing-based-telepresenting#.V2nOEP72b4Y .

8. "The Role of Telepresenter (Webinar Description)." Northwest Regional Telehealth Resource Center (NRTRC). June 21, 2016. https://www.nrtrc.org/education-article-19 .

9. CMS. “A/B MAC (B) Editing of Telehealth Claims.” *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 190.7.

10. CMS. “Facility Fee For Originating Site.” *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 190.5.2.

11. ONC. “About ONC.” June 16, 2016. https://www.healthit.gov/newsroom/about-onc

12. MLN. “New Place of Service (POS) Code for Telehealth and Distant Site Payment Policy.” Medicare Learning Network (MLN) Matters. MM9726. August 12, 2016: January 13, 2017. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9726.pdf .

13. MLN. “Telehealth Services Fact Sheet.” Medicare Learning Network (MLN) Publications. ICN 901705 January 2019. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf .

14. MLN. “Elimination of the GT Modifier for Telehealth Services.” Medicare Learning Network (MLN) Publications. MM10152. November 29, 2017: January 2, 2018. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10152.pdf .

15. CMS. “Revisions to the Telehealth Billing Requirements for Distant Site Services.” Transmittal # R2095OTN; CR10583. June 20, 2018: January 4, 2019. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2095OTN.pdf .

16. Oregon SB 129, ORS 683.010, ORS 683.180. https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB129/Enrolled .

17. MLN. “New Modifier for Expanding the Use of Telehealth for Individuals with Stroke.” Medicare Learning Network (MLN) Publications. MM10883. January 1, 2019.

Background Information

Telehealth and telemedicine are terms which are defined in multiple ways by multiple entities and organizations. The terms "telemedicine" and "telehealth" are often used interchangeably, although "telehealth" typically refers to a broader range of services, and “telemedicine” is generally a specific subset of “telehealth” services.

In general, the terms “telehealth” and “telemedicine” refer to the use of technology to deliver health care, health information or health education at a distance. Some of these applications

involve the patient directly, others are professional-to-professional consultations regarding patient care, and yet others are professional education which is not connected to the care of a patient. Some of these telehealth applications are covered and eligible for reimbursement and others are not. Telemedicine and telehealth comprise a significant and rapidly growing component of health care in the United States. (ATA[6]) The boundaries of telehealth are limited only by the technology available - new applications are being invented and tested every day. (ONC[1])

Telehealth is a potentially useful tool that, if employed appropriately, can provide important benefits to patients and improve healthcare. A wide variety of services may be performed as telemedicine services; some may meet the requirements for coverage, and others may not. The basic service is reported with the normal procedure code(s) for the service performed. The fact that the services were performed as a telemedicine service may be identified with a modifier.

The Centers for Medicare and Medicaid Services (CMS) promotes telemedicine as beneficial and useful to improve primary and preventative care to Medicare beneficiaries who live in underserved and rural areas. CMS states that telemedicine provides remote access for face to face services when beneficiaries and providers are geographically separated and offers great promise for reducing access barriers for chronically ill Medicare beneficiaries.

In addition, there are legislative mandates for coverage of some specific telehealth and telemedicine services. Oregon state law mandates certain specific telemedicine services. OR SB 144 modified an existing telemedicine mandate, ORS 743A.058. The modified mandate of OR SB 144 applies to Oregon commercial insured medical benefit plans which are issued or renewed on and after 1/1/2016. Alaska HB 234 incorporated telehealth coverage for mental health benefits in Alaska Statute 21.42.422 for new and renewing plans on and after 10/1/2016.

This policy is intended to define telehealth and telemedicine terminology for our company, plans, and claims, provide clarification of which services are and are not eligible for reimbursement, and specify the criteria and requirements which must be met.

IMPORTANT STATEMENT

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI/NCCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.

Telemedicine

State(s):	LOB(s):
☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*	☒ *Commercial* ☒ *Medicare* ☒ *Medicaid*

Enterprise Policy

BACKGROUND

Providers will be reimburse for specific telemedicine services (real-time two-way video communication, telephone consultation, and consultations provided over e-mail (e-visits) when the criteria associated with the telemedicine communication service are met.

DEFINITIONS

Telemedicine – refers to actual medical consultations provided in real-time over an electronic mechanism as allowed below. This includes, but is not limited to, the Teladoc-style web doctor services. Telemedicine visits typically result in normal claims specifically coded as telemedicine visits. Telemedicine visits involve a medical doctor or a nurse practitioner.

Telecare – distinct from telemedicine, telecare refers to health monitoring and other technology-enabled health support services. Not addressed in this policy.

Telehealth – distinct from telemedicine and telecare, telehealth refers to health and wellness programs, nurse lines, and other services supporting patient health. Not addressed in this policy.

E-visits – outdated term formerly used internally to refer to various technology-supported care, most typically email. Phasing out this term.

Email Consultations – refers to consultations over secure email systems, non-real-time. Generally not addressed in this policy, with specific exception noted below.

This policy focuses on medical telemedicine specifically, additional information regarding dental or other categories of care to be addressed in additional policies

CRITERIA- CONDITIONS UNDER WHICH WE COVER

Tele-Video and Telephonic

Providers will be reimbursed for services delivered by real-time, interactive, two-way video and phone communication when those services are medically necessary, evidence-based, and a covered benefit.

Originating Site: The originating site means the physical location of the patient (receiving telemedical health services), be that a healthcare facility, home, school or workplace, etc.

Criteria for Tele-Video Services and Telephonic Services

Preauthorization to use a telemedicine service is not required; however, if the service requires preauthorization when done in-person, then preauthorization is required when done as a telemedicine service. Services must meet ***all*** of the following in order to qualify for coverage under the health plan:

- Eligible telemedicine services are limited to two-way real time video and phone communication.
- Services must be medically necessary and eligible for coverage if the same service were provided in person.
- Providers must be eligible for reimbursement under the PacificSource health contracts.
- Telemedical video communication services are subject to all terms and conditions of the plan, including but not limited to deductible, copayment or coinsurance for which the member would be responsible for if the service had been provided in person.
- Modifier-GT must be appended to the CPT or HCPCS for telemedicine consultations.
- Facility fee charges from the originating site are ineligible for reimbursement.
- Some office visits and/or procedures will be subject to retrospective review.

State-specific Criteria

- Oregon – Allows telemedicine to be both video and phone visits
- Montana – Allows telemedicine to be both video and phone visits
- Idaho – requires telemedicine visits to be video specifically, voice-only not allowed
- Washington - requires telemedicine visits to be video specifically, voice-only not allowed

Email Visits

In limited cases, specific provider contracts allow patients to have email consultations with providers. Email visits are defined in the CPT manual, and their billing and coding requirements can be found immediately preceding CPT code 98969 for qualified non-physicians and immediately preceding CPT 99444 for physicians.

Communications Privacy Requirements for Email

The provider must use encrypted or authenticated email for online medical evaluation visits. Standard email is not acceptable, since it is not secure, has no "terms of use" or legal disclaimers in place to protect the patient or provider, and can easily expose patient PHI including email addresses and contents of consultation discussion to unintended third parties.

CRITERIA- BEHAVIORAL HEALTH CONDITIONS UNDER WHICH PACIFICSOURCE COVERS TELE-VIDEO

Tele-Video for Behavioral Health Providers

Eligible behavioral health providers will be reimbursed for services delivered by real-time, interactive, two-way video when those services are medically necessary, evidence-based, and a covered benefit.

Coding Information

0188T	Remote real-time interactive video-conferenced critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
0189T	Remote real-time interactive video-conferenced critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
98966	Telephone assessment and management services provided by a qualified non-physician health care professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management services or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion.
98967	11-20 minutes of medical discussion
98968	21-30 minutes of medical discussion
98969	Non-physician online assessment and management services provided by a qualified non-physician health care professional to an established patient, guardian, or health care provider not originating from a related assessment and management service provided within the previous 7 days, using the internet or similar electronic communications network.
99091	Collection & Interpretation Physiologic Data,(e.g. ECG, blood pressure, glucose monitoring) digitally stored &/OR Transmitted, requiring a minimum of 30 minute of time, each 30 days
99441	Telephone evaluation and management services provided by a physician 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.
99442	11-20 minutes of medical discussion
99443	21-30 minutes of medical discussion
99444	Physician online evaluation and management - physician non-face-to-face E&M service to patient/guardian or health care provider not originating from a related E&M service provided within the previous 7 days.
99451	Interprof telephone/Internet/EHR assessment and management service provided by consultative phys, incl written report to patient's treating physician, 5+ of med consultative time

99452 Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or QHC professional, 30 minutes

99453 Remote monitoring of physiologic parameter(s) (eg weight, blood pressure, pulse oximetry, respiratory flow rate) initial ; set-up and patient education on use of equipment

99454 Remote monitoring of physiologic parameter(s), initial device(s) supply with daily recordings(s) or programmed alert(s) transmission, each 30 days

99457 Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician time in a calendar month requires interactive communication with the patient/caregiver

99484 Behavioral health condition 20min clinical staff time per calendar month with required assessment/rating scales continuity of care with a designated member of the care team

99487 Complex Chronic Care Coordination Services; first hour with no face-to-face visit, per calendar month

99489 Complex Chronic Care Coordination Services; each additional 30 minutes, per calendar month

99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

99491 Chronic care management services, provided personally by a physician or other QHC professional, at least 30 minutes of physician or other QHC professional time

99492 Initial psychiatric collaborative care manager 70 min/1 month behavioral health care manager activities in consult with psychiatric consult & directed by treating physician other focused treatment strategies

99493 Subsequent psychiatric collaborative care 60 minutes subsequent month other treatment goals and are prepared for discharge from active treatment

99494 Int/subsequent psychiatric collaborative care manager, each additional 30 minutes/calendar month behavioral health care manager activities in consultation with a psychiatric consultant & directed by treating physician

99495 Transitional Care management Services, moderate complexity, within 14 calendar days of discharge

99496 Transitional Care management Services, moderate complexity, within 7 calendar days of discharge

G0406 Follow-up inpatient telehealth consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth (modifier GT--Via interactive audio and video telecommunications systems

G0407 Follow-up inpatient telehealth consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth

G0408 Follow-up inpatient telehealth consultation, complex, physicians typically spend 35 minutes or more communicating with the patient via telehealth

G0425 Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth

G0426 Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth

G0427 Telehealth consultation, emergency department or initial inpatient, typically 70 minutes communicating with the patient via telehealth

G0459 Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy

NOTE:

Teladoc is a specific branded service which provides telephone and video visits with Teladoc's own providers.

- Teladoc codes for general medicine tele visit will be 99441, 99442, and 99443 (all will include GT modifiers)
- Teladoc codes for behavioral health telemedicine visit will be listed in an additional policy doc

Coding Information – Ineligible code for commercial ONLY

Q3014 Telehealth originating site facility fee (ineligible code for commercial)

Coding Information – Other codes reimbursable for professional services
Codes reimbursable for professional services which are reimbursable (and other criteria are met) as Live Video and phone Telemedicine Encounters must have -GT modifier attached

PROVIDENCE HEALTH PLANS PAYMENT POLICY	
SUBJECT: Telehealth Services DURING COVID-19 CRISIS	**DEPARTMENT**: Coding Compliance
ORIGINAL EFFECTIVE DATE: 7/04	**DATE(S) REVIEWED / REVISED:** 1/05 – 01/13, 05/13, 01/14, 03/14, 01/15, 03/15, 08/15, 01/16, 02/16, 04/16, 01/17, 01/18, 06/18, 01/19, 01/20, 3/6/20
APPROVED BY: PPRC 3/2020	**NUMBER**: 67.0 **PAGE:** 1 of 7

POLICY:

NOTE: EFFECTIVE MARCH 6, 2020 THROUGH JUNE 30, 2020 OR UNTIL FURTHER NOTICE, SERVICES LISTED ON THIS POLICY WILL NOT REQUIRE AN ORIGINATING SITE. THIS IS AN EMERGENCY PROVISION SUBJECT TO CANCELLATION AT THE SOLE DISCRETION OF PROVIDENCE HEALTH PLANS.

For the duration of this emergency provision, codes listed on this policy may be paid for services performed by two-way video connections where the patient is calling from a personal device. No contract amendment or attestation is required.

Services covered by this policy are listed on pages 3 and 4 of this policy. Submit telehealth claims with the appropriate CPT code for the professional service provided and **location code 02. Do NOT append modifier GT or 95**. For services that have a site of service payment differential, PHP uses the facility payment rate when services are furnished via telehealth.

Services covered by this policy require that the patient be in an originating site as defined on this policy, except as noted above for services during Covid-19 crisis. See Payment Policy 93.0 (Web-Based Services) for services provided to patients who are not in an originating site (except for services during Covid-19 crisis).

Telehealth services are services delivered via an electronic two-way communication system. PHP provides coverage for telehealth services when the service is medically necessary and supported by evidence-based medical criteria. Coverage for telehealth services includes payment for consultations, office visits, individual psychotherapy, and pharmacologic management. Effective March 6, 2020, and until further notice, PHP will allow payment for medically appropriate services performed using HIPAA-compliant, encrypted two-way video connections where the patient is calling from a personal device.

Effective March 6, 2020, and until further notice, PHP will allow payment for medically appropriate services performed using two-way video connections where the patient is calling from a personal device.

The following conditions must be met for PHP to make payments for telehealth services listed on this policy:

- The service must be furnished via an interactive telecommunications system;
- The service must be furnished by a physician or authorized practitioner credentialed with PHP;
- The service must be furnished to an eligible telehealth individual;
- **The individual receiving the service must be located in a telehealth originating site. See page 2 for definition of originating site. NOTE: For services on or after March 6, 2020, and until further notice, services are expanded to allow two-way video conferencing when the patient is calling from a personal device.**

APPLIES TO:
Health Plan Providers
All Lines of Business

REFERENCE:
CMS Rules and Regulations
Current Procedural Terminology (CPT)
PHP Coding Edits

PROCEDURE:
Originating Site (May be either rural or urban)
PHP does not distinguish between originating sites that are rural or urban in providing coverage for telehealth services. Additional information about originating site may be found on page 5 of this policy. An originating site for telehealth services includes, but is not limited to:

1. Hospital;
2. Rural health clinic;
3. Federally qualified health center;
4. Physician's office;
5. Community mental health center;
6. Skilled nursing facility;
7. Renal dialysis center;
8. Site where public health services are provided;
9. Nurse call center employing independent practitioners.
10. Mobile stroke unit (modifier G0) for acute stroke only. (See page 3.)
11. Homes of beneficiaries with ESRD getting home dialysis

Coverage of Telehealth

The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy, medical nutrition therapy and pharmacologic management. These services and corresponding CPT/HCPCS codes are listed below.

- Initial consult codes for emergency telehealth services only (HCPCS codes G0425-G0427)**(See notes on Page 3)
- Follow-up inpatient consultations for telehealth services only (HCPCS codes G0406-G0408)**(See notes on Page 3)
- Critical care telehealth consultation (HCPCS codes G0508-G0509)
- Subsequent hospital care services (limited to one every three days) (CPT codes 99231-99233)
- Subsequent nursing facility care services (limited to one every 30 days) (CPT codes 99307-99310)
- Office or other outpatient visits (CPT codes 99201 - 99215)
- Advanced care planning (CPT codes 99497-99498)
- Psychotherapy (CPT codes 90832-90834, 90836-90838, 90845-90847)
- Medical nutrition therapy (HCPCS/CPT codes G0270, 97802, 97803, 97804)
- Inpatient pharmacologic management (HCPCS code G0459)
- Psychiatric diagnostic interview examination (CPT codes 90791-90792) Neurobehavioral status exam (CPT code 96116)
- End stage renal disease related services (CPT codes 90951-90952, 90954-90955, 90957-90958, 90960-90961, 90963-90970)
- Chronic kidney disease educational services (G0420-G0421)
- Diabetic self-management training services (G0108-G0109)
- Health and behavior assessments (CPT codes 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171)
- Alcohol and/or substance (other than tobacco) abuse assessment and brief intervention (HCPCS codes G0396 and G0397)
- Annual alcohol misuse screening (HCPCS code G0442)
- Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes (HCPCS code G0443)
- Smoking and tobacco use cessation counseling (CPT codes 99406-99407, HCPCS codes G0436-G0437)
- Annual depression screening, 15 minutes (HCPCS code G0444)
- High-intensity behavioral counseling to prevent STD (HCPCS code G0445)
- Annual face-to-face intensive behavioral therapy for cardiovascular disease (HCPCS code G0446)
- Face-to-face behavioral counseling for obesity (HCPCS code G0447)
- Transitional care management (CPT codes 99495-99496)
- Prolonged services codes, by review only (CPT codes 99354- 99355 and 99356-99357)
- Annual wellness visits (HCPCS codes G0438-G0439)

- Counseling visit to discuss need for lung cancer screening using low dose CT scan (G0296)
- Interactive complexity psychiatry services and procedures (90785)
- Health risk assessment (96160-96161)
- Comprehensive assessment of and care planning for patients requiring chronic care management (G0506)
- Psychotherapy for crisis (90839-90840)

FOR DATES OF SERVICE MARCH 6, 2020, AND UNTIL FURTHER NOTICE, THESE ADDITIONAL CODES FOR PHYSICAL THERAPY, SPEECH THERAPY, OCCUPATIONAL THERAPY WILL BE COVERED AS TELEHEALTH SERVICES:

- 92507, 92526, 92609, 97110, 97112, 97129, 97130, 97161, 97162, 97163, 97530, 97535 may be used to report two-way video services performed by physical therapists, occupational therapists, or speech and language pathologists for services within that practitioner's scope of license.

** Inpatient telehealth consultations are furnished to PHP members in hospitals or skilled nursing facilities via telehealth at the request of the physician of record, the attending physician, or other appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner.

Submit telehealth claims with the appropriate CPT code for the professional service provided and location code 02. **Do not append modifier GT or 95.** When store and forward technologies are used, submit the appropriate CPT code with location code 02 and telehealth **modifier GQ**, "via asynchronous telecommunications system." (See "Alaska/Hawaii Demonstration Program" section.)

Effective January 1, 2019, modifier G0 (G-zero) may be used to identify telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of acute stroke. PHP does not distinguish between originating sites that are rural or urban in providing coverage for telehealth services, so modifier is G0 is not required for these services, but it is accepted. In addition to other qualifying originating sites listed on this policy, acute stroke telehealth services may be furnished in a mobile stroke unit.

Alaska/Hawaii Demonstration Program

In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, PHP payment is permitted for telemedicine when asynchronous 'store and forward technology' in single or multimedia formats is used as a substitute for an interactive telecommunications system. The originating site and distant site practitioner must be included within the definition of the demonstration program. Store and forward technologies may be used as a substitute for

an interactive telecommunications system. (See "Definition of Store and Forward" under "Conditions of Payment.")

By using the GQ modifier, the distant site practitioner verifies that the asynchronous medical file was collected and transmitted to the physician or practitioner at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii. (See "Conditions of Payment" section.)

Conditions of Payment

For PHP payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the PHP member. As a condition of payment, the patient must be present and participating in the telehealth visit.

Definition of "store and forward": For purposes of this instruction, "store and forward" means the asynchronous transmission of medical information to be reviewed at a later time by physician or practitioner at the distant site. A patient's medical information may include, but is not limited to, video clips, still images, x-rays, MRIs, EKGs and EEGs, laboratory results, audio clips, and text. The physician or practitioner at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time. Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patient's condition and adequate for rendering or

confirming a diagnosis and/or treatment plan. Dermatological photographs, e.g., a photograph of a skin lesion, may be considered to meet the requirement of a single media format under this instruction.

Professional Charges

PHP practitioners may receive payment at the distant site, i.e., at a site other than where beneficiary is. As a condition of PHP payment for telehealth services, the physician or practitioner at the distant site must be licensed to provide the service under State law. When the physician or practitioner at the distant site is licensed under State law to provide a covered telehealth service (i.e., professional consultation, office and other outpatient visits, individual psychotherapy, or pharmacologic management), then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

Effective 1/1/17, the physician or practitioner furnishing telehealth services from a distant site should use location code (or place of service code) "02." Location code "02" does not apply to the originating site. (See Page 5 for information on location code for originating site.) Only the CPT codes listed on this policy (Pages 2-3) billed location code 02 are allowed for telehealth services. Physicians will be paid at the facility rate for services billed with location code 02.

PHP practitioners who may bill for covered telehealth services subject to State law are:

- Physician
- Nurse practitioner
- Physician assistant
- Nurse midwife
- Clinical nurse specialist
- Registered dieticians
- Certified Nutrition Specialists
- Clinical psychologist*
- Clinical social worker*

For Commercial lines of business only, additional practitioners who may bill for covered telehealth services subject to State law are:

- Licensed Professional Clinical Counselor*
- Licensed Mental Health Counselor*
- Licensed Marriage and Family Therapist*

*Clinical psychologists, counselors, therapists, and clinical social workers may not bill Evaluation and Management services.

Originating Site Facility Fee Payment Methodology

The term originating site means the location of an eligible PHP member at the time the service being furnished via a telecommunications system occurs. For asynchronous, store and forward telecommunications technologies, an originating site is only a Federal telemedicine demonstration program conducted in Alaska or Hawaii.

Originating Site Facility Fee

To receive the originating facility site payment, submit claims with HCPCS code Q3014, “telehealth originating site facility fee" (short description "telehealth facility fee"). The type of service for telehealth originating site facility fee is “9, other items and services.”

The benefit may be billed on bill types 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, and 85X. Unless otherwise applicable, report the originating site facility fee under revenue code 078X and include HCPCS code Q3014.

If the originating site is a physician’s office, the office location code (or place of service code) “11” is the only payable setting for code Q3014. The provider who bills the originating site facility fee may not be the same provider (or the same provider group or the same tax identification number) as the provider who is billing for services performed.

Modifier G0 (Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke) may be added to Q3014 to identify services furnished for treatment of acute stroke. This modifier is not required by PHP but is accepted.

PROVIDENCE HEALTH PLANS PAYMENT POLICY	
SUBJECT: Online Digital Evaluation and Management Services (Formerly E-Visits)	**DEPARTMENT**: Coding Compliance
ORIGINAL EFFECTIVE DATE: 01/04	**DATE(S) REVIEWED / REVISED:** 10/04 - 01/09, 03/09, 01/10, 01/11, 01/12, 01/13, 07/13, 11/13, 01/14, 01/15, 01/16, 04/16, 05/16, 01/17, 01/18, 01/19, 01/20
APPROVED BY: PPRC: 12/19	**NUMBER:** 53.0 **PAGE:** 1 of 4

POLICY:
Online digital evaluation and management (E/M) services are patient-initiated services with physicians or non-physician practitioners (NPP). PHP recognizes only Physician's Assistants (PA) or Nurse Practitioners (NP) as non-physician practitioners (see Payment Policy 40.0). Patients initiate these services through Health Insurance Portability and Accountability Act (HIPAA)-compliant secure platforms, such as electronic health record (EHR) portals, secure email, or other digital applications which allow digital communication with the physician or NPP. PHP allows these services to be paid for new or established patients, as long as all other criteria listed on the policy are met.

APPLIES TO:
All lines of business
Participating providers only

REFERENCE:
PHP Payment Policies
Current Procedural Terminology (CPT)
HIPAA Rules and Regulations

PROCEDURE:
Online digital E/M services require physician or NPP evaluation, assessment, and management of the patient. These codes may NOT be used to report non-evaluative electronic services such as communication of test results, scheduling of appointments, or other communication that does not include E/M. Online digital E/M services are not covered for patients who are hospitalized, including inpatient, outpatient, or observation status.

Criteria for Payment:
1. Service must be provided in response to the patient's online inquiry.
2. Online digital E/M services must be provided by a physician or licensed independent practitioner within their scope of practice. MD, DO, NP, and PA are the only practitioners approved for online digital E/M services.

3. Documentation should model SOAP charting; must include patient history, provider assessment, treatment plan, and follow-up instructions; must be adequate so the information provided supports the assessment and plan; must be retained in the patient's medical record and be retrievable.
4. Physician or NPP response must be by end of next business day following the patient's inquiry.
5. Clinical responses must be clearly identified as MD, DO, NP or PA.
6. Physician or NPP must confirm member eligibility.
7. Online digital E/M service must involve permanent storage (electronic or hard copy) of the encounter.

Billing Guidelines:

Only providers who may report E/M services may bill online digital E/M services to PHP; therefore, CPT codes 99421, 99422, and 99423 are the only codes that are reimbursed for online digital E/M services. CPT codes 98970, 98971, and 98972 (Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days) are considered bundled services and are listed on Payment Policy 13.0 (Bundled or Adjunct Services).

CPT code 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

CPT code 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

CPT code 99423: Online digital evaluation and management service, for an established** patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

** NOTE: PHP allows these visits for both new and established patients, despite the code description.

PHP follows CPT guidelines for use of CPT codes 99421, 99422, and 99423, including the following:

1. Online digital E/M services are reported once for the physician's or NPP's cumulative time devoted to the service during a seven-day period. The seven-day period begins with the provider's personal review of the patient-generated inquiry. All professional decision making, assessment, and subsequent management by other providers in the same group practice contribute to the cumulative service time of the patient's online digital E/M service.
2. If a separately reported E/M visit occurs within the seven days of initiation of an online digital E/M service, the physician or NPP work devoted to the online digital E/M service is incorporated into the separately reported E/M visit. The online digital E/M visit may not be reported separately with the face-to-face E/M visit.
3. If the patient initiates an online digital inquiry for the same or related problem within seven days of a previous E/M service, the online digital visit is not reported.
4. If the online digital inquiry is related to a surgical procedure and occurs during the postoperative period of a previously completed procedure, the online digital E/M service is not reported separately.
5. If the patient presents a new, unrelated problem during the seven-day period of an online digital E/M service, then the provider's time spent on evaluation, assessment, and management of the additional problem is added to the cumulative service time of the original online digital E/M service for that seven-day period.

Use **location code "99"** for reporting online digital E/M services. **Do not append modifier GT or modifier 95**. Modifier 95 is not accepted by PHP. Modifier GT is not accepted with this code.

Medicolegal and Administrative Guidelines:

1. To ensure information security procedures are followed, PHP requires use of a Secure Messaging System, either through a vendor-supported system or an EMR-embedded system.
2. Online digital E/M services must meet HIPAA standards for privacy.
3. Online digital E/M services must require member-specific login.
4. The patient and provider must use the secure messaging portal to communicate, as this ensures that safety and security procedures are followed.
5. Online digital E/M services require patient-clinician agreement of informed consent for online digital E/M services. The agreement must be signed by the patient and documented in the medical record.
6. Privacy statements must be visible or accessible to the member.
7. Directions must be user-friendly and easy to follow.
8. Access for online digital E/M service must be member-specific, i.e., health information available to the member only, with exceptions for children.

9. Provider of service must be clearly identified so that the member knows who they are contacting with health information.
10. Expected provider response time must be stated prior to member obtaining access to online digital E/M service.
11. Directions for emergency care must be stated prior to member obtaining access to online digital E/M service.
12. Provider must confirm member information prior to responding to patient inquiry.
13. The administration of online digital E/M services must meet the criteria contained in this payment policy. PHP may perform an audit of online digital E/M services to ensure the service meets the intent of this policy. Providers will receive advance notice of any such audit.

PROVIDENCE HEALTH PLANS PAYMENT POLICY	
SUBJECT: TELEPHONE SERVICES	**DEPARTMENT**: Coding Compliance
ORIGINAL EFFECTIVE DATE: 01/01/2015	**DATE(S) REVIEWED / REVISED:** 01/15, 01/16, 01/17, 01/18, 01/19, 01/20
APPROVED BY: PPRC: 11/19	**NUMBER**: 92.0 **PAGE:** 1 of 2

POLICY:
Telephone services are non-face-to-face evaluation and management (E/M) services provided by a physician or other qualified health care professional to a patient using the telephone. These codes are used to report episodes of care by the physician or other qualified health care professional initiated by an established patient or guardian of an established patient. If the service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the pre-service work of the subsequent E/M service and/or procedure. Likewise, if the telephone service is related to an E/M service performed and reported by the physician or other qualified health care professional within the previous seven days (either provider-requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure. All CPT guidelines for use of these codes must be followed.

The only non-physician providers who may report telephone services are health care professionals who may report E/M services.

APPLIES TO:
All lines of business
Participating providers only

REFERENCE:
Current Procedural Terminology (CPT)
CMS/Medicare Rules and Regulations
PHP Coding Edits

PROCEDURE:
The physician or other qualified health care professional may report the appropriate code based on the amount of time spent on the visit. All CPT guidelines for use of these codes must be followed:

- **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**

- **99442:** Telephone evaluation and management service (same as above), **11-20 minutes of medical discussion**

- **99443:** Telephone evaluation and management service (same as above), **21-30 minutes of medical discussion**

Note: **Code 99443 is used for visits of 21 minutes or longer. No additional payment is made for visits longer than 30 minutes**.