Local and National Telehealth Guidelines

Pertaining to Governor Gina Raimondo's Executive Orders in Response to the COVID 19 Crisis

Updated 3/25/2020

Local Telehealth Updates					
Insurer	**Billing Codes**	**Modifiers & POS *****	**Co-Pay/Co-insurance**	**Reimbursement**	**Notes**
BCBS of RI	CPT: 97000 codes: 97110,97535, 97530,97112, 97161, 97162, 97163	Mod: CR POS: "02"	Waiving all cost-sharing: Co pay, co-insurance, deductibles.	Payment parity at contracted rates	**This policy is effective for dates of service on or after March 18, 2020. For dates of service prior to March 18, 2020, please refer to the BCBSRI policies that were in effect for prior dates of service.** This policy applies to BCBSRI participating providers only. **Notice of the implementation, update or withdrawal of this policy will be communicated to BCBSRI providers via a notice on BCBSRI's provider website/portal under Alerts and Updates.** It is expected this policy will be in effect until Monday, April 17, 2020 as outlined in OHIC's Bulletin, unless Executive Order 20-06 is renewed, modified or terminated by a subsequent Executive Order resulting in a longer or shorter full force and effective period. **PUBLISHED** BCBSRI's website under Alerts and Update An FAQ document is available on BCBSRI.com
NHP					Click here for policy
Tufts RI Source: Tufts website Updated 3/24	97000 Codes	Mod: GT POS: "02"	Collect co-pay/co-insurance/ deductibles that are applicable	Contracted rates	**Effective for dates of services on or after March 6, 2020 until April 15, 2020,** coverage for Tufts Health Commercial (including Tufts Health Freedom Plan), Tufts Health Medicare Preferred HMO, Tufts Health Plan Senior Care Options (SCO), Tufts Health Public Plans (Tufts Health Direct, Tufts Health RI Together, Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans [ACPPs], and Tufts Health Unify) members is as follows: Telehealth/telemedicine • Tufts Health Plan will compensate providers at 100% of the in-office rate as specified in their provider agreements or fee schedules for telehealth • All Tufts Health Plan contracting providers can provide telemedicine services to our members (medical, behavioral health and ancillary health visits) • This will also include telephone consultation

					• Tufts Health Plan will waive member cost share for any primary care and behavioral health service
					• Documentation requirements for a telehealth service are the same as those required for any face-to-face encounter, with the addition of the following:
					  • A statement that the service was provided using telemedicine or telephone consult;
					  • The location of the patient;
					  • The location of the provider; and
					  • The names of all persons participating in the telemedicine service or telephone consultation service and their role in the encounter.
					  ▪ This applies for all diagnoses and is not specific to a COVID-19 diagnosis
					  ▪ This is intended to prevent people from having to leave their house to receive care

Harvard Pilgrim HC	97000 Codes	Mod: GT POS: "02"	Waiving cost-sharing on at this time		
GIC Indemnity	97000 Codes	Mod: GT POS: "02"	Deductibles/Co-pays /Co-pays apply	Contracted rates	
RI WC: Beacon-Mitchell					
RI WC: Claims Strategies					
RI WC: State of RI					
MA WC					
National Telehealth updates					
Medicare	e visits G2061 G2062 G2063	Mod: CR POS: "11 or 12"	Deductible/Co-ins apply	G2061: need RI/NGS rates? G2062: G2063:	• No new evals but can do follow ups and new injury to different body part • These services can only be reported when the billing practice has an established relationship with the patient. For these E-Visits, the patient must generate the initial inquiry and communications can occur over a 7-day period." Per CMS, "E-Visits" differ from "Telehealth Visits," which encompass any "office, hospital visits and other services that generally occur in-person." PTs, OTs, and SLPs still are not included in the list of providers who are eligible to conduct Telehealth Visits under Medicare.

					• https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
Aetna	e-visits G2061 G2062 G2063	Mod:CR? POS:	Waiving all cost sharing		http://www.apta.org/PTinMotion/News/2020/03/18/CoronavirusUpdateMarch19/ accessed March 19, 2020: Major commercial insurer Aetna announced that it would require no co-pay on telemedicine visits for any reason for 90 days—and would allow PTs to bill for e-visits consistent with the recent e-visit waiver policy announced by CMS. Collaborative efforts between APTA and Aetna led to the change and inclusion of PTs. All Aetna policy changes are retroactive to March 9. The Aetna e-visit approach is slightly different expanded from the CMS system, in that it allows PTs to bill for either codes associated with evaluation and management (98970, 98971, 98972) or as well as for assessment and management (G2061, G062, and G2063). CMS only allows PTs to bill for the G codes. Providers should check with Aetna's provider page for updates and changes.
United Health Care (UHC)	e-visit codes vs. 97000 Codes	Mod: GT POS: "02"		Contracted rates	UHC is not planning to cover PT telehealth at this time. State mandate/regulation may supersede the UHC reimbursement policy just as it would normally UHC has made the determination to cover e-visits. They don't expect this to be a high volume service given the requirements for use and relatively low reimbursement rate. The e-visit codes are likely to be audited post-payment if providers use with high frequency. Requirements for use include: The digital service must be provided via a HIPAA compliant platform, such as an electronic health record portal, secure email or other digital applications. The patient initiates the service with an inquiry through the portal. The service is documented in the medical record. If the patient had an E/M service within the last seven days, these codes may not be used for that problem. If the inquiry is about a new problem (from the problem addressed at the E/M service in the past 7 days), these codes may be billed. This is for established patients. These services may only be reported once in a 7-day period. Clinical staff time may not be included.
TriCare Humana Military					Coronavirus Disease (COVID-19) and TRICARE's telemedicine benefit. March 18, 2020 ***Update:* If a beneficiary meets all other criteria for a covered service for speech therapy and for continuation of PT/OT, (but not initiation of PT/OT), it is covered using telemedicine, using any coding modifiers as you would for a TRICARE network provider office visit. https://www.humanamilitary.com/provider/education-and-resources/quick-access/policy-updates-and-alerts/covid-19-telemedicine-031320

***** Modifiers to be updated shortly as each payers definition for the modifiers may be different**

Recommended resource:

APTA's Private Practice Section website is open to all therapists. Click this link for additional up to date resources on Telehealth and COVID related resources: https://ppsapta.org/physical-therapy-covid-19.cfm.

The following is adapted from WebPT: Billing for PT and OT Telehealth Services During the COVID-19 Response
https://www.webpt.com/blog/post/billing-for-pt-and-ot-services-during-the-covid-19-response/

Sites

When billing telehealth, you must notate two "site" locations:

1. the originating site, and
2. the distance site.

The originating site is where the patient is located. The distance site is where the practitioner is located. Therapists typically must be licensed in the state in which the patient is receiving services, and while the APTA reports that recent Medicare actions "did include temporarily waiving Medicare and Medicaid requirements that out-of-state providers hold licenses in the state where they are providing services," we strongly advise exercising caution and conferring with a legal expert before providing any services on an out-of-state basis.

Place of Service Designation

When billing CPT codes for Telehealth Visits, the place of service (POS) is 02: "The location where health services and health-related services are provided or received through a telecommunications system."

When billing Medicare's E-Visit codes, therapists should use the place of service code that indicates the location of the billing practitioner—that is, POS 11 if the therapist is located in an office, and POS 12 if the therapist is located in a home. These same POS codes apply to Telephone Visits.

Modifiers

Certain CPT codes may be billed with an appropriate modifier to designate them as telehealth services. When you use the POS code 02 in conjunction with one of these modifiers, you are attesting that you are using a HIPAA-compliant telecommunications system to deliver telehealth services—though the HHS Office for Civil Rights is temporarily waiving that requirement in the face of the COVID-19 health crisis, opening up the potential use of more consumer-friendly technologies like FaceTime for telehealth delivery.

Modifier 95

Modifier 95, when applied, designates that the services were delivered synchronously in real-time using a HIPAA-compliant program. The modifier is available for use with the new codes made available to rehab therapists as part of the COVID-19 response.

Modifier GT

Modifier GT, when applied, designates that the services were delivered synchronously in real-time using a HIPAA-compliant program. GT is the modifier that is most commonly used for telehealth claims. Per the AMA, the modifier means "via interactive audio and video telecommunications systems." You can append GT to any CPT code for services that were provided via telemedicine

Modifier GQ

Modifier GQ, when applied, designates that the services were delivered asynchronously using a HIPAA-compliant program. This is considered an "old" modifier and method of delivering telehealth, and it's slowly getting replaced by synchronous technologies.

Modifier CR

The CR modifier—which indicates that services are catastrophe/disaster-related—is mandatory when billing Medicare using the CPT codes for COVID-19-related E-Visits, which were recently made available to rehab therapists. (These codes are defined in the "Updated Coverage of Rehab Therapy Telehealth" subsection below.) This modifier is reserved for claims for which Medicare Part B payment is conditioned directly or indirectly on presence of a "formal waiver" like the one issued in response to COVID-19. It should be used for qualifying Part B items and services related to both institutional and non-institutional billing.

New Medicare Telehealth Billing Opportunities for the COVID-19 Response

As of March 17, 2020, CMS has relaxed its telehealth requirements in response to COVID-19. Per these updates, Medicare will reimburse PTs, OTs, and SLPs for certain telehealth services—as noted by the code list below—that occurred on March 6 or later.

Updated Coverage of Rehab Therapy Telehealth

As per CMS's latest update, PTs, OTs, and SLPs can bill Medicare (and receive payment) for the following telehealth services:

- **G2061**: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes

- **G2062**: Qualified non-physician healthcare 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 qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes."

It's important to note, though, that these codes apply exclusively to what CMS calls "E-Visits." According to the fact sheet for this update, "These services can only be reported when the billing practice has an established relationship with the patient. For these E-Visits, the patient must generate the initial inquiry and communications can occur over a 7-day period." Per CMS, "E-Visits" differ from "Telehealth Visits," which encompass any "office, hospital visits and other services that generally occur in-person." PTs, OTs, and SLPs still are not included in the list of providers who are eligible to conduct Telehealth Visits under Medicare. As the fact sheet states, "Distant site practitioners who can furnish and get payment for covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals."

Here are some other key things to know about E-Visits per the waiver release:

- "These services can only be reported when the billing practice has an established relationship with the patient.
- This is not limited to only rural settings. There are no geographic or location restrictions for these visits.
- Patients communicate with their doctors without going to the doctor's office by using online patient portals.
- Individual services need to be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation.
- The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable.
- The Medicare coinsurance and deductible would generally apply to these services."

Additionally, when billing Medicare for E-Visits during the COVID-19 response period, rehab therapists should use the POS 11 or 12 (indicating they are located in an office or a home, respectively) as well as the CR modifier (indicating the services are catastrophe/disaster related)—not the 95 modifier.

HHS Office for Civil Rights (OCR) will waive HIPAA violation penalties against providers who offer "good faith" services to patients through everyday communication technologies (e.g., Skype or Facetime).

Non-Coverage of Rehab Therapy Telehealth and Patient Cash-Pay

As with all medically necessary services, third-party payer coverage is only part of the patient's decision process. Consider dry needling: non-coverage in that case creates an opportunity to discuss the benefits of the service.

If a service is not covered by a payer for which you are a preferred provider, you may collect payment directly from patients at the time of service. However, before you do this, create a fee schedule for your telehealth services, and create a transparent billing process for your patients. Notify these patients (in writing) that telehealth services are not covered by their payer, and clearly establish the projected cost as well as when you expect payment. If you are not a preferred provider, you are not bound by their noncoverage of your services.

Payer Policies

Be sure to check payers' medical policies and ensure they do not classify telehealth therapy services as "not medically necessary" or "effectiveness not established." If either of these classifications apply, then you cannot balance bill the patient for telehealth services. If you proceed and bill these services to that payer, then it will assign the balance to the practice or individual therapist—not the patient. And remember, if you're a preferred provider for a commercial plan, your contract likely requires you to bill all services to that payer so it can determine the patient's liability—meaning you cannot simply collect cash from the patient upfront to bypass submitting a claim to the payer. Only Medicare has specific policies that address ABNs and notices of non-coverage.