Centers for Medicare & Medicaid Services (CMS) Guidance

Evaluation and Management Codes (E&M)

Telehealth Specific Notes about Using Evaluation and Management Codes (E&M):

- **Must use interactive, real-time audio visual with the patient**
- Paid at non-facility rate for clinics
- Code selection can be based on Medical Decision Making (MDM) OR all time associated with the E&M on the day of the encounter. Document the total face-to-face AND non-face-to-face time
- Remove any requirements regarding documentation of history and/or physical exam in the medical record
- Can be billed by all E&M providers, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

NEW PATIENT		
	Current Procedural Terminology (CPT)® Typical Time	**CMS Typical Time**
99201	10 min.	17 min.
99202	20 min.	22 min.
99203	30 min.	29 min.
99204	45 min.	45 min.
99205	60 min.	67 min.

ESTABLISHED PATIENT		
	CPT® Typical Time	**CMS Typical Time**
99202	10 min.	16 min.
99203	15 min.	23 min.
99204	25 min.	40 min.
99205	40 min.	55 min.

CMS	**Commercial**
Bill POS where the patient would have been seen	POS 02
Services will be paid at the higher, non-facility rate	Bill Modifier GQ or GT
Bill modifier 95	

- FQHC and RHC will bill modifier 95 and G code G2025. Payment will be $ 92.00.
- Telehealth costs incurred by the RHC must be reported for both originating and distant site on Form CMS-222-17.
- Telehealth costs incurred by the FQHC must be reported for both originating and distant site on Form 224-14.
- If services are provided for COVID-19 testing, or telehealth encounters RHC and FQHC must waive coinsurance and add CS modifier

PAYMENT FOR PHONE CALLS BY E&M PROVIDER		
99441	5-10 min.	$13.32
99442	11-20 min.	$26.64
99443	21-30 min.	$39.60

*Not billable for FQHC and RHC at this rate

For registered dieticians, social workers, physical/ occupational therapists, speech-language pathologists

98966	5-10 min.	$13.32
98967	11-20 min.	$26.64
98968	21-30 min.	$39.60

Virtual Check-In	**Non-Facility Payment**	**Facility Payment**
G2012	$14.78	$13.35
G2010	$12.27	$9.38

*These codes may not be used as a follow-up from an E&M visit for the same problem or if the virtual check in or e-visit results in and E&M visit within 24 hours or soonest available appointment.

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Mountain-Pacific Quality Health

E-Visits: Online Digital E&M Services

- Established patients only; time is cumulative for a 7-day period using a patient portal
- Patient must verbally consent
- Medicare co-insurance and deductible apply
- Must use Health Insurance Portability and Accountability Act (HIPAA)-compliant platform
- Clinical staff time cannot be included or time in chronic chare management, remote monitoring, international normalized ratio (INR) management, etc.
- Must be documented in the medical record
- May not be billed by surgeons during the global period
- Report once in a 7-day period
- Must be patient-initiated through the online portal

Code	Description	National	National Facility Payment	HCPCS Codes
99421	5-10 min.	$15.52	$13.35	FQHC and RHC bill G0071 payment rate $24.76
99422	11-20 min.	$31.04	$27.43	
99423	21 or more min.	$50.16	$43.67	
G2061	Online assessment; 5-10 min.	$12.27	$12.27	For use by clinicians who do not have E&M in their scope of practice (e.g., physical/occupational therapists, registered dieticians, speech-language pathologists, social workers)
G2062	11-20 min.	$21.65	$21.65	
G2063	21 or more min.	$33.92	$33.56	

*If patient had E&M service within 7 days, these codes may not be used for that problem. If an E&M visit occurs as a result of the online visit, the time/MDM may be used to select the E&M service, but these codes cannot be used.

Questions?

Need help with any of the information in this worksheet?

Contact Amber Rogers at arogers@mpqhf.org or (406) 544-0187.

Developed by Mountain-Pacific Quality Health, the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Montana, Wyoming, Alaska, Hawaii and the U.S. Pacific Territories of Guam and American Samoa and the Commonwealth of the Northern Mariana Islands, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Contents presented do not necessarily reflect CMS policy. 12SOW-MPQHF-AS-CC-20-19

WYOMING

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Effective March 18, 2020 through June 3, 2020, BCBSWY will permit telephonic and telemedicine visits to occur to the patient's home. The below guidance is intended to assist professional providers understand the types of services permitted during this time. Other benefit and cost share rules will continue to apply. It is important to note that only services that can be rendered through telemedicine should occur. Services that cannot be safely or adequately provided through telemedicine should be avoided. These guidelines apply only to BCBSWY members. Providers should seek guidance from other Blues plans for potential changes to their policies.

BCBSWY Telemedicine Services

Type of Service	What is the Service	HCPCS/CPT Codes	Place of Service/Modifiers	Coverage	PT/OT/Speech Therapy Rules
Telehealth/ Telemedicine Visits	Any service that can safely and appropriately be rendered at a distance. Services provided should be within the provider's scope of license and meet the standard of care. Services can be rendered to the patient's home.	Any HCPCS or CPT code that can safely and appropriately be rendered at a distance. Excludes G0425 - G0427 and G0406 - G0408.	Use standard place of service codes, do not bill POS code 2. Bill modifier GT. Do not bill modifier 95.	BCBSWY has historically provided coverage for telemedicine services when a patient was located at an originating site (physician office or other place of service). During the COVID-19 crisis BCBSWY will extend benefits to services rendered at the patient's home.	Should bill standard codes without a GT modifier. To ensure that patient cost share is appropriately waived, these providers should bill 99199 with a penny charge.
Telephone Services	Telephone evaluation and management service by a physician or other qualified health professional for an established patient.	99441 99442 99443	Use standard place of service codes, do not bill POS code 2. The GT modifier is not required.	BCBSWY will benefit these services temporarily during the COVID-19 crisis.	Can bill these codes.
e-Visits	Online digital services for an established patient, through an online patient portal.	99421 G2061 99422 G2062 99423 G2063	Use standard place of service codes, do not bill POS code 2. The GT modifier is not required.	BCBSWY will benefit these services temporarily during the COVID-19 crisis.	Can bill the G-codes in this series.
Virtual Check-Ins	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.	G2010 G2012	Not applicable.	Not a benefit. These codes are not reimbursed by BCBSWY at this time.	Not applicable.

WyTN Telehealth Billing and Reimbursement Payor Panel
April 21, 2020 || 12:00 – 1:30 pm || https://zoom.us/j/948861542

BCBSWY Telehealth Billing Overview
Provided by Wendy Curran with BCBSWY

1. Where can practitioners and patients find information on billing codes/policies and specialties/services that are covered for telehealth? COVID-19 related updates to BCBSWY's telemedicine policies can be found at www.availity.com under the BCBSWY Payer Space, or on our website, https://www.bcbswy.com/providers/updates/. In addition, we have issued news releases and provided information directly to employer groups across the state.

2. Where can telemedicine encounters originate from? Do you provide reimbursement for originating site fees?
BCBSWY is temporarily allowing encounters to originate from the patient's home. BCBSWY has historically reimbursed for an originating site fee for traditional encounters from provider's office to provider's office.

3. What procedures/conditions are covered via telehealth?
Services must be safe and medically appropriate to be rendered at a distance, and within the provider's scope of license. Additionally, 99441, 99442, 99443, 99421, 99422, 99423, G2061, G2062, G2063 are temporarily permitted at this time.

4. What restrictions are there on the types of practitioners/specialties that can bill for telehealth?
Telemedicine services are not limited by provider type as long as the service is medically appropriate to be delivered by telemedicine and is within the practitioner's scope of practice. In order to ensure that telemedicine cost share is appropriately waived during the COVID-19 pandemic, PT/OT/Speech therapists need to bill 99199 with a penny charge.

5. Are any authorizations needed from your agency to deliver telehealth? From the client?
No.

6. Are specialist consultations covered? If so, what can that look like (e.g. patient-to-specialist, specialist-to-specialist, PCM-to-specialist…)?
Specialist consultations with a patient are permitted.

7. Are there any restrictions for distance/location restrictions between a patient and practitioner?
Not during the temporary expansion of telemedicine services permitted during the COVID-19 pandemic.

8. What billing codes/modifiers are needed to be used for telemedicine encounters?
A GT modifier should be billed when appropriate, except for services rendered by a PT/OT/Speech therapist. Services by these providers should not include the GT modifier and instead need a 99199 with a penny charge. Place of Service 02 should not be billed.

9. Is telemedicine reimbursed at the same rate as in-person services?
Yes, for traditional telemedicine visits. New codes for visits by phone, video or through an e-messaging portal are specified for telemedicine only and are not appropriate for in-person visits.

10. What mental health / Allied Health (OT, PT, SLP, etc.) services are covered for telemedicine?
Any HCPCS or CPT code that can safely and appropriately be rendered at a distance is permitted.

WyTN Telehealth Billing and Reimbursement Payor Panel
April 21, 2020 || 12:00 – 1:30 pm || https://zoom.us/j/948861542

Wyoming Medicaid Telehealth Billing Overview
Provided by Sara Rogers with the Wyoming Department of Health

Questions- Wyoming Medicaid

1. Where can practitioners and patients find information on billing codes/policies and specialties/services that are covered for telehealth?

https://wymedicaid.portal.conduent.com/manuals/Manual_CMS-1500_04_01_2020.pdf
Section 6.24

2. Where can telemedicine encounters originate from? Do you provide reimbursement for originating site fees?
The originating site is the location of an eligible Medicaid client at the time the service is being furnished via telecommunication system occurs.

Yes, originating site uses Q3014.

3. What procedures/conditions are covered via telehealth?

Currently, anything that is clinically appropriate can be covered via telehealth. This will be revisited once the Public Health Emergency is over.

4. What restrictions are there on the types of practitioners/specialties that can bill for telehealth?

Group Therapy sessions are limited to 2-10 clients. With the current public health emergency, we do not have any limits on providers as long as it is medically necessary.

5. Are any authorizations needed from your agency to deliver telehealth? From the client?

The client must provide consent by email, text, or verbally, and this must be properly documented with the provider.

6. Are specialist consultations covered? If so, what can that look like (e.g. patient-to-specialist, specialist-to-specialist, PCM-to-specialist…)?

Wyoming Medicaid has expanded telehealth services during the public emergency and therefore, these consultations would be covered.

7. Are there any restrictions for distance/location restrictions between a patient and practitioner?

No.

8. What billing codes/modifiers are needed to be used for telemedicine encounters?
Q3014- originating site

GT modifier must be billed by the distant site.
Please see billing examples in the link above to the provider manual and telehealth section.

9. Is telemedicine reimbursed at the same rate as in-person services?
Yes.
Q3014 reimburses $19.34. The GT modifier will not affect payment.

10. What mental health / Allied Health (OT, PT, SLP, etc.) services are covered for telemedicine?

All therapies, occupational, speech, and physical therapy are covered via telehealth during this public health emergency. Home health may incorporate telehealth if it isn't direct care.

WyTN Telehealth Billing and Reimbursement Payor Panel
April 21, 2020 || 12:00 – 1:30 pm || https://zoom.us/j/948861542

Medicare Telemedicine Billing Overview
Provided by Amber Rogers with Mountain-Pacific Quality Health

1. Where can practitioners and patients find information on billing codes/policies and specialties/services that are covered for telehealth?
https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page This link has ALL COVID-19 memos, FAQ and Fact Sheets

https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf This is a list of FAQ re billing all COVID-19 including testing, treatment and Telehealth.

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet This is the best overall resource regarding billing and which codes to use.

2. Where can telemedicine encounters originate from? Do you provide reimbursement for originating site fees?
Telemed encounters can originate from any clinic including FQHC, RHC and provider's home. Reimbursement for originating site fees only apply if the patient comes to the clinic and the patient is connected to a distant site provider (like it used to be)

The Medicare waiver allows patients to be in their home and for providers to connect with them from the provider's office or phone.

3. What procedures/conditions are covered via telehealth?
https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes There is an expanded list of services that are available. Over 80 visit types have been added. Providers can conduct telehealth visits in the inpatient, outpatient, LTC, Home Health and Hospice settings. If you are looking for a specific code- check the link above and search that it is covered under the expansion or not.

4. What restrictions are there on the types of practitioners/specialties that can bill for telehealth?
In general, all provider types that can bill and E&M code can now bill those services by telehealth as long as it is clinically appropriate and there is real time audio and visual contact with the patient. For specific codes, verify that it can be completed via telehealth by accessing the link in # 3.

All E&M Provider types and non-E&M providers can complete:

- Regular office visits
- E visit – must be initiated by the patient, usually through a patient portal. Time based across a 7 day period.
- Virtual Check in: can be via phone, text, images to discuss assessment and treatment. Time based code but can not occur as a f/u from an E&M visit or result in one.
- Phone visits

The E-visits, Virtual Check-in and Phone visits are paid at pretty low rates. There is not clear guidance from CMS yet about non-E&M provider billing which modifiers.

5. Are any authorizations needed from your agency to deliver telehealth? From the client?
No, CMS has created blanket waivers for all Medicare billing.

Consent of the patient should still be obtained for the visit and treatment.
There has also been relief for Providers to serve patients across state lines. HOWEVER, state practice laws still apply, and you need to check those prior to rendering services.

6. Are specialist consultations covered? If so, what can that look like (e.g. patient-to-specialist, specialist-to-specialist, PCM-to-specialist…)?

Yes, but need to research this more. Billing requirements include:

- A consult requires a request from another health care professional for a new or established problem for your evaluation, assessment or opinion
- After service is provided, a report is returned to the requesting clinician
- Document request in the medical record
- Transfer of care is not a consult
- Office consults are not defined as new or established

7. Are there any restrictions for distance/location restrictions between a patient and practitioner?
NO, however see state practice laws

8. What billing codes/modifiers are needed to be used for telemedicine encounters?
When billing professional claims for all telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with:

Place of Service (POS) equal to what it would have been had the service been furnished in-person

Modifier 95, indicating that the service rendered was actually performed via telehealth

AK and HI use asynchronous (store and forward) technology, use GQ modifier

Furnished for diagnosis and treatment of an acute stroke, use G0 modifier

There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

Medicare modifiers are

- **95** – Synchronous Telemedicine Service Rendered via a Real-time Interactive Audio and Video Telecommunications System
    - Use of the 95 modifier indicates a real-time interaction between a physician or other qualified health care professional and a patient who is located at another site with their physician or other qualified healthcare professional or by themselves
    - Modifier 95 may be appended to the services listed in Appendix P of the CPT Codebook or marked with a “star” in the code lists within the CPT Codebook

- **GQ** – Via Asynchronous telecommunications system (e.g. 99201-GQ)

- Use of the GQ modifier certifies that an Asynchronous telecommunications system was used, such as “Store and Forward” technologies to transmit medical or behavioral health information to the provider at the “Distant Site”

- **GT** – Via interactive audio and video telecommunication systems (e.g. 99201-GT)
  - Use of the GT modifier certifies that the member was present at an eligible “Originating Site” when the Telehealth/Telemedicine service was performed
  - This modifier is used exclusively by the “Distant Site” provider

- **G0** - Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke
  - This modifier should be appended to both the originating and distant site provider services as clinically appropriate when billing for an acute stroke telehealth service
  - This modifier should be appended on services that were rendered or furnished in such sites as a hospital, critical access hospital or mobile stroke unit.
  - Such services should also be billed with the appropriate Place of Service code on professional claims to indicate telehealth service.

9. Is telemedicine reimbursed at the same rate as in-person services? YES

10. What mental health / Allied Health (OT, PT, SLP, etc.) services are covered for telemedicine?

See number 4:

An example of an Allied health provider completing telehealth is:

A Medicare patient calls his physical therapist to cancel an upcoming appointment due to the need to shelter in place. The therapist informs the patient that he can stay in contact with the therapist—and continue receiving instruction and guidance on his home exercises and other home care elements—by initiating an e-visit. The patient agrees to do this. The therapist documents the patient’s initiation of the service as well as his consent to receive it. The therapist sets the patient up with access to a secure patient portal that allows him to send and receive messages and other materials—like exercise videos and images. The patient uses the portal to tell the therapist that he is having trouble replicating some of the exercises at home due to lack of equipment. The therapist makes suggestions on how he can adapt the exercises using household items and sends recorded videos to demonstrate those suggestions. The therapist spends 30 minutes thinking about how to adapt the exercises, preparing the materials, and sending them to the patient. The therapist does not provide any other services over the course of the seven-day period, so she bills one unit of G2063.