OHSU Health Services

Medicaid Telemedicine and Telehealth Overview and Guidelines as of 3/26/2020

OVERVIEW

In light of the COVID-19 pandemic, the Oregon Health Authority has expanded coverage of telehealth services. The following telehealth and telemedicine services are covered through OHSU Health Services:

- Evaluation and management services
- Assessment and management services
- Consultations between providers in a variety of settings (by telephone or other electronic forms of communication)

OHSU Health Services follows Ancillary Guideline A5, telehealth, teleconsultations and electronic/telephonic services guidelines as well as OHA guidance related to coding and billing. Please visit the *Ancillary/Diagnostic Guideline Notes* for additional information.

During the COVID-19 pandemic, the federal government has waived certain HIPAA privacy requirements, so services such as Google Hangouts, FaceTime, and Skype can be used during this crisis. For additional information, please visit HHS.gov.

IMPORTANT: If the condition is funded per the prioritized list or medically appropriate with a covered condition, the service is reimbursable for active members under OHSU Health Services and no prior authorization is needed. Below you will find a comprehensive list of codes currently covered by the Oregon Health Authority. OHSU Health Services will cover and reimburse all services allowed within the scope of the providers individual agreement.

BILLING FOR TELEMEDICINE/TELEHEALTH

To receive reimbursement	• Bill covered telemedicine procedure codes with place of service 02. The use of telehealth POS 02 certifies that the service meets the telehealth requirements. • Modifier GT is required when applicable (see fee schedules).

	• The GQ modifier is still required when applicable. GQ modifier means; via Asynchronous Telecommunication systems. • Do not use modifier 95 for telemedicine services. • Bill with the transmission site code Q3014; (where the patient is located). • The evaluating practitioner at the distant site may bill for the evaluation, but not for the transmission site code. For Behavioral Health Providers, please review the fee-for-service behavioral health fee schedule for all codes and required GT modifiers that allow for telemedicine reimbursement (listed here). **Important information related to COVID-19 claims tracking:** OHA would like to track claims related to COVID-19. Please use the following modifiers for all claims: • Modifier CR: Professional claims • Condition code DR: Institutional claims

TELEHEALTH (SYNCHRONOUS AUDIO/VIDEO VISITS)

What are the CPT codes that are allowed for Synchronous audio/video visits?	90785, 90791, 90792, 90832-90834, 90836, 90837-90840, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964-90970, 96116, 96171, 96160, 96161, 97802-4, 99201-99205, 99211-99215, 99231- 99233, 99307-99310, 99354-99357, 99406-99407, 99495-99498, G0108-G0109, G0270, G0296, G0396, G0397, G0406-G0408, G0420, G0421, G0425-G0427, G0436-G0439, G0442-G0447, G0459, G0506, G0508, G0509, G0513, G0514, G2086-G2088. The originating site code Q3014 may only be used by appropriate health care sites. **These services can be provided by telephone when appropriate during the COVID-19 crisis.**
What are the criteria?	• Telehealth visits are defined as synchronous visits with both audio and video capability. The patient may be at home or in a health care setting. • Telehealth visits are covered for inpatient and outpatient services for new or established patients. • Telehealth consultations are covered for emergency and inpatient services. • Billing for telehealth visits requires the same level of documentation, medical necessity and coverage determinations as in-person visits.

PATIENT TO CLINICIAN SERVICES (VIA TELEPHONE OR ELECTRONIC)

What are the CPT codes that are allowed for patient to clinical services?	Telephonic and electronic services, including services related to diagnostic workup:
	• CPT 99441-99443 (for providers who can provide evaluation and management services)
	  ○ Temporarily open for Behavioral Health
	• CPT 98966-98968 (for other types of providers)
	  ○ Temporarily open for Behavioral Health
	• 99421-99423, 98970-98972, G2012 (brief virtual check in) and G2061-G2063

What are the criteria?	• Ensure pre-existing relationship as demonstrated by at least one prior office visit within the past 36 months. **This requirement is waived during the COVID-19 pandemic**.
	• Documentation must:
	  ○ model SOAP charting, or be as described in program's OAR;
	  ○ include patient history, provider assessment, treatment plan and follow-up instructions;
	  ○ support the assessment and plan;
	  ○ be retained in the patient's medical record and be retrievable.
	• Medical decision making (or behavioral health intervention/psychotherapy) is necessary.
	• Ensure permanent storage (electronic or hard copy) of the encounter.
	• Meet HIPAA standards for privacy.
	• Include a patient-clinician agreement of informed consent, which is discussed with and signed by the patient and documented in the medical record. In the context of the COVID-19 epidemic, verbal approval is sufficient.
	• Not be billed when the same services are billed as care plan oversight or anticoagulation management (CPT codes 99339-99340, 99374-99380 or 99363-99364).
	• When a telephone or electronic service refers to an E/M service performed and billed by the physician within the previous seven days, it is not separately billable, regardless of whether it is the result of patient-initiated or physician-requested follow-up.
	• This service is not billed if the service results in the patient being seen within 24 hours or the next available appointment.
	• If the service relates to and takes place within the postoperative period of a procedure provided by the physician, the service is considered part of the procedure and is not to be billed separately.

	Additional information specific to Behavioral Health Providers: The codes outlined above are newly open to Behavioral Health providers during the COVID-19 crisis when the service is: • Provided by a qualified nonphysician health care professional (98966-98968), physician, or other professional qualified to perform evaluation and management services (99441-99443) to a patient, parent, or guardian. • Not related to an assessment and management service provided and/or within the previous 7 days.
What are examples of these visits?	Examples of reimbursable telephone or electronic services include: • Extended counseling when person-to-person contact would involve an unwise delay. • Treatment of relapses that require significant investment of provider time and judgment. • Counseling and education for patients with complex chronic conditions. Examples of non-reimbursable telephone/electronic consultations include but are not limited to: • Prescription renewal. • Scheduling a test. • Reporting normal test results. • Requesting a referral. • Follow up of medical procedure to confirm stable condition, without indication of complication or new condition. • Brief discussion to confirm stability of chronic problem and continuity of present management.

CLINICIAN-TO-CLINICIAN CONSULTATIONS (TELEPHONIC AND ELECTRONIC)

What are the CPT codes that are allowed for consulting providers?	99451, 99446-9

What are the criteria?	• Consult must be requested by another provider. • Can be for a new or exacerbated condition. • Cannot be reported more than 1 time per 7 days for the same patient. • Cumulative time spent reported, even if time occurs over multiple days. • Cannot be reported if a transfer of care or request for face-to-face visit occurs as a result of the consultation within the next 14 days. • Cannot be reported if the patient was seen by the consultant within the past 14 days. • Request and reason for consultation request must be documented in the patient's medical record. • Requires a minimum of 5 minutes.
What are the CPT codes that are allowed for requesting providers?	99452
What are the criteria?	• eConsult must be reported by requesting provider (not for the transfer of a patient or request for face-to-face consult). • Reported only when the patient is not on-site and with the provider at the time of consultation. • Cannot be reported more than 1 time per 14 days per patient. • Requires a minimum of 16 minutes. Includes time for referral prep and/or communicating with the consultant. • Can be reported with prolonged services, non-direct. Limited information provided by one clinician to another that does not contribute to collaboration (e.g., interpretation of an electroencephalogram, report on an x-ray or scan, or reporting the results of a diagnostic test) is not considered a consultation.

SUMMARY OF CHANGES

Date of Change	Correction/Addition/Clarification	Source
3/20/2020	**Addition:** New Codes for BH providers according to Lori Coyner memo and BH fee schedule	Oregon Health Authority
3/23/2020	**Correction:** Correct the Health Behavior Assessment/Intervention codes (previously listed CPT codes 96150-96154 have been replaced with CPT 96171)	Oregon Health Authority
3/23/2020	**Clarification:** Specific to 99441-99443 and G2012, these codes can be used when: ○ The patient, family member or guardian initiates the call ○ The call is for telephone evaluation & management services, and ○ The call is not related to an in-person visit scheduled for the next 24 hours The call is not related to an in-person visit that has occurred during the previous 7 days.	Oregon Health Authority
3/23/2020	**Addition:** added annotations from Prioritized List-GN	Oregon Health Authority
3/24/2020	**Addition:** Telehealth guidance related to HIPAA	Department of Consumer and Business Services (DCBS)
3/24/2020	**Addition:** COVID-19 Claim Tracking- implement the use of modifier CR and condition code DR	Oregon Health Authority