TELEHEALTH REIMBURSEMENT OVERVIEW

Updated to reflect 2020 pre-Public Health Emergency (PHE) Telehealth policy.

For PHE waivers and guidance that expand this overview, see COVID-19 Telehealth Policy & Payment for Oregon Clinics & Hospitals

Medicare

OVERVIEW

⇒ The Centers for Medicare and Medicaid Services (CMS) requires that "**telehealth services**" are the "*use of an interactive audio and video telecommunications system that permits real-time communication between you at the distant site, and the beneficiary at the originating site (i.e., live video).*"

⇒ E-visits, remote patient monitoring, and virtual visits **DO NOT** fall into the CMS "telehealth services" category and are not subject to geographical criteria, nor do they require modifiers. They are billed using their respective Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes.

⇒ Medicare will reimburse **distant site** providers for a specific set of CPT/HCPCS codes based on the Medicare fee schedule. Distant site providers may only be reimbursed for those services and procedures that fall within the scope of their professional license. Each year, CMS receives formal requests for code expansion and may approve additional codes to be reimbursed.

⇒ In 2018, CMS replaced the GT modifier with Place of Service (POS) 02, "the location where health services and health-related services are provided or received, through a telecommunication system." POS 02 can be used when billing CMS claims for synchronous telemedicine visits. Please see exceptions described in "Billing" below.

⇒ List of current telehealth CPT codes eligible for Medicare reimbursement CY 2020 here.

ORIGINATING SITE

Billing

- Medicare will pay an ***originating site facility fee*** (HCPCS Code Q3014) to originating sites (where the patient is located to connect with a physician or practitioner via telehealth) for facilitating the telehealth encounter. Originating sites must bill their Medicare Administrative Contractor (MAC) for the separately billable Part B originating site facility fee. The current CY 2020 amount for HCPCS code Q3014 (telehealth originating site facility fee) is $ 26.65.

Geographic conditions

- Medicare will reimburse for services delivered to patients located at originating sites located in either:
  - A county located outside a Metropolitan Statistical Area (MSA), defined by Census Bureau; or
  - A rural Health Professional Shortage Area (HPSA) in a rural census tract, defined by the Health Resources and Services Administration (HRSA).
- Medicare does not apply originating site geographic conditions to hospital-based and CAH-based renal dialysis centers, renal dialysis facilities, and beneficiary homes when practitioners furnish monthly home dialysis ESRD-related medical evaluations. Independent renal dialysis facilities are not eligible originating sites.

Authorized originating sites

- Physician and practitioner offices;
- Hospitals (including Critical Access Hospitals (CAHs);
- Rural Health Clinics (RHCs);
- Federally Qualified Health Centers (FQHCs);
- Hospital-based or CAH-Based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNFs)
- Community Mental Health Centers (CMHCs)
- Renal Dialysis Facilities;
- Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis; and,
- Mobile Stroke Units.

Source: Medicare Learning Network Matters

DISTANT SITE

Billing

- Submit telehealth services claims, using Place of Service (POS) 02-Telehealth, to indicate you furnished the billed service as a professional telehealth service from a distant site.
- A modifier is only required for:
    - G0 (zero): Used to identify telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.
    - GQ (not used outside of Alaska or Hawaii): Asynchronous telehealth service.
    - GT: Critical Access Hospital distant site providers billing under CAH Optional Method II. This goes on an institutional claim and pays 80% of the Professional Fee Service rate.
    - GY: Notice of Liability Not Issued, Not Required Under Payer Policy. Used to report that an Advanced Beneficiary Notice (ABN) was not issued because item or service is statutorily excluded or does not meet definition of any Medicare benefit.

  Source: Center for Connected Health Policy. *Billing for Telehealth Encounters 2020.* Retrieved July, 2020.

Geographic conditions

- Distant site providers are not limited to a specific location to be eligible for reimbursement.

Eligible providers

- Medicare will reimburse for distant site services delivered by:
    - Physicians;
    - Nurse practitioners (NPs);

- Physician assistants (PAs);
- Nurse-midwives;
- Clinical nurse specialists (CNSs);
- Certified registered nurse anesthetists;
- Clinical psychologists (CPs) and clinical social workers (CSWs);*
- Clinical social workers (licensed clinical social workers); or
- Registered dietitians or nutrition specialist.

* CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or get paid for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.

Licensure

- To provide services to patients located at an originating site located in Oregon, distant site providers must hold a current Oregon license consistent with their professional discipline and, as appropriate, be credentialed to practice at the originating site facility.

REIMBURSABLE SERVICES

Live video	Services must be delivered via two-way video when the patient is present. The service must involve a "face-to-face" interaction between the distant site provider and patient. The choice of CPT/HCPCS codes depends on the type and level of intensity of the service provided. Source: CMS
Remote patient monitoring (RPM)	Medicare does not consider RPM "Telehealth" and as such is not subject to geographic limitations. However, FQHCs, RHCs and Home Health cannot bill as these services, but can claim as an expense. Remote patient monitoring. CPT codes and descriptors: • 99091 (Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days); • 99453 (Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment); • 99457 (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes);

- **99458** (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes).

Email/phone/fax

Medicare does not consider the eConsults below to be a "Telehealth" service, but rather a part of "Special Care Management" codes. *FQHCs and RHCs cannot bill for an eConsult.* CPT codes and descriptors:

- **99451** (Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, five minutes or more of medical consultative time);
- **99452** (Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes);
- **99446-99449** (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).

E-visit

Allowable Online Digital Evaluation Service (e-Visit) CPT codes and descriptors:

- **98970** (Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the seven days; 5-10 minutes);
- **98971** (Qualified nonphysician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the seven days; 11-20 minutes); and
- **98972** (Qualified nonphysician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes).

"99421-99423 are for practitioners who can independently bill E/M services while CPT codes 98970-98972 are for practitioners who cannot independently bill E/M services."

Store & forward (asynchronous)

Allowable HCPCS codes and descriptors:

- **HCPCS code G2010** (Remote evaluation of recorded video and/or images submitted by an established patient).
- FQHCs and RHCs **cannot** use this code, *but can use **G0071**.*

Virtual check-in

Allowable HCPCS codes and descriptors:

- **HCPCS code G2012** (Brief communication technology-based service, e.g. virtual check-in).
- FQHCs and RHC **cannot** use this code, *but can use **G0071***.

Sources: CMS Final Rules: 2018 (CY 2019), 2019 (CY 2020)
CMS Federally Qualified Health Centers (FQHC) Center

Oregon Medicaid—Fee for Service

OVERVIEW

⇒ For purposes of the Oregon Medicaid program, **telemedicine/telehealth is defined** as *"the use of telephonic or electronic communications of medical information from one site to another regarding a patient's health status"*.

⇒ Telemedicine encompasses different types of programs, services and delivery mechanisms for medically appropriate covered services within the patient's benefit package.

⇒ Providers shall ensure access to health care services for limited English proficient (LEP) and deaf and hard of hearing patients and their families through the use of qualified and certified health care interpreters to provide meaningful language access services as described in OAR 333-002-0040.

⇒ Coverage for physical health telemedicine services include Telemedicine (synchronous audio/video visits), Patient to Clinician services (electronic/telephonic) and Clinician to Clinician Consultations (electronic/telephonic).

⇒ OAR 410-130-0610 Oregon Medicaid law covers services that are specifically allowed in this rule per the Oregon Health Services Commission's Prioritized List of Health Services and Practice Guideline.

Sources: ORS 743A.058[1]
OAR 410-130-0610

ORIGINATING SITE

Billing

- Oregon Medicaid will pay the transmission site (where the patient is located) an originating site/transmission site fee using code Q3014. The evaluating practitioner at the distant site may bill for the evaluation, but not for the transmission.

Geographic conditions

- Health plans may not distinguish between rural or urban originating sites.

Authorized originating sites

Alternate sites (where recipient of services is evaluated and located) can be a patient's home or other location:

- Hospital;
- Rural Health Clinic;
- Federally Qualified Health Center;
- Physician's office;
- Community mental health center;
- Skilled nursing facility;
- Renal dialysis center; or
- Site where public health services are provided.

Sources: OAR 410-130-0610; Senate Bill 24 (2009)

Eligible providers

- The originating site/referring provider and the distant site provider must both be licensed to practice medicine within the state of Oregon or within the contiguous area of Oregon and must be enrolled as a Division of Medical Assistance Programs provider.
- The originating site/referring provider is not required to be present with the client for the consult.
- Addiction and Mental Health Division (AMH) providers must have an agency letter of approval, certification of approval, or license issued by AMH, be providing covered services and be authorized to submit claims for telemedicine.

Source: OR 410-130-0610

DISTANT SITE

Oregon defines a "distant site" as a clinical setting or practice location.

Geographic conditions

- Distant site providers are not limited to a specific location to eligible for reimbursement.

Eligible providers

- Performing/Rendering Providers of covered physical health telemedicine services shall:

Licensure

- Hold a current and valid license without restriction from a state licensing board where the provider is located.

Billing

- Have authority to provide physical health telemedicine services for eligible Oregon Medicaid beneficiaries; and
- Comply with correct coding standards using the most appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes.

Source: OAR 410-130-0610

REIMBURSABLE SERVICES

Coverage for physical health telemedicine services include:

1. Telemedicine (synchronous audio/video visits) resulting in real time communication between health care provider and the recipient;
2. Patient to Clinician services (electronic/telephonic); and
3. Clinician to Clinician Consultations (electronic/telephonic).

All services are covered when billed services comply with the guideline notes set forth by the Health Evidence Review Commission (HERC) and correct coding standards described in the Prioritized List. Both documents may be found here.

Live video

For purposes of physical health services, the Authority shall provide coverage for telemedicine services to the same extent that the services would be covered if they were provided in person subject to the requirements outlined in the Prioritized List and associated guideline notes. The distant site provider may bill for the service provided.

To bill for two-way (synchronous) video conferencing services:

1. Only the originating (transmission) site may bill for the transmission (originating site fee). Bill using the transmission code Q3014.
2. The originating site ("referring") practitioner may bill an evaluation and management (E/M) code only if a separately identifiable visit is performed. The visit must meet all the criteria of the E/M code billed.
3. The practitioner providing the service from the distant site may bill for the evaluation, using the most appropriate E/M code. A General Telemedicine (GT) modifier must be added to the E/M code to designate that the evaluation was done via synchronous transmission.
4. In addition, for AMH services specifically identified as allowable for telephonic delivery when appropriate, refer to the procedure code and reimbursement rates published by AMH.

Source: OAR 410-130-0610

Complex care/ chronic care management services

Allowable codes and descriptors:

- 99487 (Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; establishment of substantial revision of a comprehensive care plan; moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month);

- **99489** (Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, 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, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored);
- **99491** (Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored).

Remote patient monitoring/ Store & forward (asynchronous)

Reimbursement available for dental services (OAR 410-123-1265).

Other allowable codes and descriptors:

- **99091** (Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days);
- **99453** (Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment);
- **99454** (Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days);
- **99457** (Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month).

Email/phone/fax

Unless authorized in Excluded Services and Limitations, OAR 410-120-1200, other types of telecommunications are **not covered**, such as telephone calls *without medical decision making*, images transmitted via facsimile machines and electronic mail.

Allowable codes and descriptors:

- **99451** (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time);

- 99452 (Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes).
- 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);
- 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).

Patient consultations using telephone and online or e-mail **are covered** when:

- Billed services comply with the practice guidelines set forth by the Health Service Commission (HSC)' and
- The applicable HSC approved code requirements, delivered consistent with the HSC practice guideline.
    - *To bill for telephone or email services use the E/M code authorized in the HSC practice guideline.*

Source: OAR 410-130-0610

COORDINATED CARE ORGANIZATIONS (CCOs)

- CCOs are allowed to develop reimbursement criteria for telemedicine separate from, or additional to, the Oregon Health Authority's (OHA) FFS policy.
- CCOs are generally following the Medicaid FFS policy described in this document.
- OAR 410-130-0610 Oregon Medicaid law covers services that are specifically allowed in this rule per the Oregon Health Services Commission's Prioritized List of Health Services and Practice Guideline.

Specific questions may be directed to the respective CCO here.

Private Payer

OVERVIEW

⇒ Oregon Senate Bill 144 amends ORS 743A.058 to clarify the coverage of telemedicine services in Oregon.

⇒ Private insurers are not required to reimburse a health professional for a telemedicine service if that service is not covered in their health plan, or the health professional has not contracted with the plan.

⇒ The Public Employees Benefit Board and the Oregon Educators Benefit Board are now required to reimburse for telemedicine services.

⇒ Health benefit plans must provide coverage of a telemedical health service that is provided using synchronous two-way interactive video conferencing if:

- The plan provides coverage of the health service when provided in person by the health professional;
- The health service is medically necessary;

- The health service is determined to be safely and effectively provided using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards; and
- The application and technology used to provide the health service meets all standards required by state and federal laws governing the privacy and security of protected heath information.

Sources: Senate Bill 24 (2009); Oregon Senate Bill 144 (2015)

ORIGINATING SITE

"Originating site" means the physical location of the patient receiving a telemedical health service.

Geographic conditions

- Health plans may not distinguish between rural or urban originating sites.

Authorized originating sites

- Alternate sites (where recipient of services is evaluated and located) can be a patient's home or other location.
  - Hospital;
  - Rural Health Clinic;
  - Federally Qualified Health Center;
  - Physician's office;
  - Community mental health center;
  - Skilled nursing facility;
  - Renal dialysis center; or
  - Site where public health services are provided.

Sources: OAR 410-130-0610; Senate Bill 24 (2009)

DISTANT SITE

Oregon defines a "distant site" as a clinical setting or practice location.

Billing

- A health benefit plan must provide coverage of a telemedical health service that is provided using synchronous two-way interactive video conferencing if:
  - The plan provides coverage of the health service when provided in person by a health professional;
  - The health service is medically necessary;
  - The health service (does not duplicate or supplant a health service that is available to the patient in person) is determined to be safely and effectively provided using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards; and

    - The application and technology used to provide the health service meet all standards required by state and federal laws governing the privacy and security of protected health information.
- A health benefit plan may subject coverage of a telemedical health service to the terms and conditions of the health benefit plan, including but not limited to deductible, copayment or coinsurance requirements that are applicable to coverage of a comparable health service provided in person.
- The coverage is subject to:
    - The terms and conditions of the health benefit plans; and
    - The reimbursement specified in the contract between the plan the health professional.
- A health benefit plan is not required to reimburse a health professional for a health service that is not a covered benefit under the plan (or to reimburse a health professional who is not a covered provider under the plan); or who has not contracted with the plan.

Geographic conditions

- Distant site providers are not limited to a specific location to eligible for reimbursement.

Eligible providers

- Oregon law allows for a "health professional" to provide services telemedically.
- This person must be licensed, certified, or registered in Oregon to provide health care services or supplies.

Sources: Oregon Senate Bill 144 (2015); ORS 743A.058

REIMBURSABLE SERVICES

Live Video	Must be provided via two-way videoconferencing.
Remote Patient Monitoring	No reimbursement mandated.
Email/Phone/Fax	No reimbursement mandated.
Store & Forward (Asynchronous)	No reimbursement mandated.