What payers are we going to talk about?

I know what you’re thinking….

Just tell me how to get paid already
Medicare Overview
1. The patient was seen from an “originating site” as defined by CMS.

- Physician and practitioner offices
- Critical Access Hospitals (CAHs)
- Federally Qualified Health Centers
- Mobile Stroke Units
- Hospital-based Renal Dialysis Centers (including satellites)
- Patient Homes w/ End-Stage Renal Disease (ESRD) getting home dialysis

2. The originating site must be located in the following geographic areas:

Outside of an MSA
- or-
In a Primary or Behavioral Health HPSA inside a rural census tract

Beginning July 1, 2019, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act removes the originating site geographic conditions and adds an individual’s home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder.

https://data.hrsa.gov/tools/medicare/telehealth
3. The encounter was performed at the “distant site” by an eligible practitioner. Eligible distant site practitioners are as follows:

- Physicians
- Physician assistants (PAs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs)
- Registered dietitians or nutrition professionals
- Nurse practitioners (NPs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Clinical social workers (CSWs)

*RHCs and FQHCs cannot provide services as a distant site for Medicare reimbursement. This includes bringing the specialist in to the 4 walls virtually.

4. The patient must be present and the encounter must involve interactive audio and video telecommunications that provides real-time communication between the practitioner and the Medicare beneficiary.

5. Type of Service provided must fall within the Medicare Eligible Services table.

Originating Site Fee – Q3014

The originating site is eligible to receive a facility fee for providing services via telehealth.

Medicare provides specific instructions for billing this code:

Bill your MAC for the separately billable Part B originating site facility fee. The originating site facility fee for Medicare telehealth services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate. The originating site facility fee does not count toward the number of services used to determine payment for partial hospitalization services when a CMHC serves as an originating site.
**FQHC/RHC PPS Rate**

In order to be eligible to bill Medicare for the all inclusive rate, an FQHC or RHC must have a medical need for a provider to be in the room with the patient. The facility will then bill the appropriate level of office visit without the use of telehealth modifiers or descriptors.

If a provider has no medical need to be in the room with the patient, an FQHC or RHC is only eligible to bill an originating site fee (Q3014).

For Medicare – FQHCs and RHCs are not allowed to be a distant site.
Medicare Telehealth Billing

Distant Site Clinical Services Fees

Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided without telemedicine.

• The distant site is where the physician or non-physician practitioner (NPP) is located and provides services.
  – The location must be on the provider's enrollment file. For example, if the provider uses their home as an office location, the home must be listed on the enrollment file. A hotel, boat and car are not valid locations. The provider must be licensed and enrolled in the state the services are provided in. For example, if a beneficiary is in California and the provider is in Florida, the provider must be licensed and enrolled with the Medicare Administrative Contractor (MAC) for Florida.
Distant site claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided.

As of Jan. 1, 2018, the GT modifier is no longer required to be billed with the CPT or HCPC code.

Place of Service code 02 (Telehealth) is to be used for all telehealth visits.

A medical professional is not required to present the beneficiary to the physician or practitioner unless it is medically necessary. The decision of medical necessity is made by the physician or practitioner at the distant site.

You can find all of the eligible CPT codes on the CMS Telehealth Services Fact Sheet or in the CTRC Telehealth Reimbursement Guide.

http://caltrc.org/knowledge-center/reimbursement/
Advancing Virtual Care

To support access to care using communication technology, CMS will reimburse for the following:

– Opioid Use Disorder and MAT treatment
– Virtual check-ins: brief, non-face-to-face assessments via communication technology
– Remote evaluation of patient-submitted photos or recorded video
– Interprofessional Internet Consultation

RHCs and FQHCs for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit. FQHCs and RHCs are not allowed to bill for interprofessional internet consultations (eConsult) because the PPS includes all costs associated with a billable visit, including consultations with other practitioners.

None of these services are considered “Telehealth” for CMS, therefore, they do not have the same restrictions as telehealth services.
CMS Expansion of Telehealth 2019 Overview
SUPPORT for Patients and Communities Act

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act requires CMS to remove the originating site geographic requirements for telehealth services on or after July 1, 2019 for any existing Medicare telehealth originating site (except for a renal dialysis facility) for purposes of treating substance use disorder or co-occurring mental health disorder.

The home was made an eligible originating site for purposes of treating these patients. *The home would not qualify for the Originating Site fee.

CMS has issued an interim final rule with comment period to implement these requirements. CMS also accepted comments until 1/22/19 regarding the development of a separate bundled payment for an episode of care for treatment of Substance Use Disorders (SUD), which can include elements of Medication Assisted Therapy (MAT), including potentially web-based routine counseling.
CMS Expansion of Telehealth 2019 Overview
Non FQHC/RHC Providers

BRIEF COMMUNICATION TECHNOLOGY-BASED SERVICE (AKA Virtual Check-Ins)
— When a physician or other qualified health care professional has a brief, non-face-to-face, check-in with a patient via communication technology to assess whether the established patient’s condition necessitates an office visit
— Not labeled telehealth, therefore not subject to telehealth restrictions
— Code G2012

REMOTE EVALUATION OF PRE-RECORDED PATIENT INFORMATION (AKA Store and Forward)
— Remote professional evaluation of patient-transmitted information conducted via pre-recorded “store and forward” video or image technology for established patients
— Not labeled telehealth, therefore not subject to telehealth restrictions
— Code G2010

INTERPROFESSIONAL INTERNET CONSULTATION (AKA eConsult)
— Cover consultations between professionals performed via communications technology such as telephone or internet
— Verbal consent and acknowledgement of cost sharing from patient required
— Limited to practitioners that can independently bill Medicare for E/M visits
— Codes: 99446-99449, 99451 & 99452

REMOTE PHYSIOLOGICAL MONITORING (AKA Remote Patient Monitoring)
— Codes 99453, 99454, & 99457

CHRONIC CARE MANAGEMENT
— New code added 99491
CMS Expansion of Telehealth 2019 Overview
FQHC/RHC Providers

BRIEF COMMUNICATION TECHNOLOGY-BASED SERVICE (AKA Virtual Check-Ins)
— When a physician or other qualified health care professional has a brief, non-face-to-face, check-in with a patient via communication technology to assess whether the patient’s condition necessitates an office visit
— Not labeled telehealth, therefore not subject to telehealth restrictions
— HCPC Code: G0071

REMOTE EVALUATION OF PRE-RECORDED PATIENT INFORMATION (AKA Store and Forward)
— Remote professional evaluation of patient-transmitted information conducted via pre-recorded “store and forward” video or image technology
— Not labeled telehealth, therefore not subject to telehealth restrictions
— Must be an established patient
— HCPC Code: G0071

REMOTE PHYSIOLOGICAL MONITORING (AKA Remote Patient Monitoring)

CHRONIC CARE MANAGEMENT
RHCs and FQHCs are required to bill for care management services using G0511 or G0512
Virtual Check-Ins

Virtual Check-Ins are billed with code G2012. *

These interactions take place over phone or live video and involve a physician or non-physician practitioner having a brief, at least 5 minute, check-in with a patient to assess whether the patient needs to come in for an office visit.

The virtual check-in must be for a condition not related to an E/M service provided within the previous 7 days and does not lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

There are no frequency limitations at this time.

The practitioner may respond to the patient’s concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

Billable providers are physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers. If the discussion could be conducted by a nurse, health educator, or other clinical personnel, it would not be billable as a virtual communication service.

* FQHCs/RHCs will be allowed to bill this service. Virtual Check-Ins are billed with code G0071. The rate charged will be the physician fee schedule rate, not the all-inclusive rate (AIR) or prospective payment system (PPS).
Remote Evaluation Services – Store & Forward

Remote Evaluation Services are billed with code G2012. *

The services can only be billed if the condition is not related to a service provided within the previous 7 days and does not lead to a service provided within the next 24 hours or soonest available appointment.

There are no frequency limitations at this time.

Billable by physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers. If the discussion could be conducted by a nurse, health educator, or other clinical personnel, it would not be billable as a virtual communication service.

The practitioner may respond to the patient’s concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

*FQHCs/RHCs will be allowed to bill for store-and-forward, patient-initiated visits when recorded video or images are sent to the FQHC/RHC. Remote Evaluation Services are billed with code G0071.
CCM code 99491 was added and will also be included in the rate setting for RHC & FQHC.

The new definition for RPM is “the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency.”

Under this definition, RPM will only be reimbursable when reported as a service in the provision of another skilled service.

Home visits for the purpose of supplying or maintaining RPM equipment without the provision of another skilled service will not be separately billable, but will constitute an allowable administrative cost under amendments to 42 CFR 409.46.

A correction was added to the original ruling on 3/14/19 to state: On page 59575, column 3, 3rd full paragraph, we incorrectly stated that CPT code 99457 could not be furnished by auxiliary personnel, and instead must be performed by the billing practitioner. CPT code 99457 may be furnished by auxiliary personnel, incident to the billing practitioner’s professional services.
Telehealth Services Fact Sheet

- Published Annually
  Current version revised 01/2019
- 12 pages
- All allowable codes, providers, and locations
- Provides contact information for your regional CMS rep

Region IX – San Francisco
Neal Logue
neal.logue@cms.hhs.gov
Telephone: (415) 744-3551

Target Audience: Medicare Fee-For-Service Providers

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

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Fee-For-Service Medi-Cal Overview
So what exactly does Medi-Cal pay For?

- Pays full price for both sides of the consult
- Selected Evaluation and Management services, psychiatric diagnostic interview examination, and selected psychiatric and therapeutic services
- Store and forward Dermatology, Ophthalmology, and Teledentistry
- Interpretation and report of X-rays and electrocardiograms performed after telehealth transmission
- Transmission costs (up to 90 minutes per patient, per day)
- Originating site facility fee
Medi-Cal Fee-For-Service

Originating Site
In general, an originating site is where the patient is located at the time health care services are provided via a telecommunications system, or where the asynchronous store and forward service originates.

For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the patient or by the health care provider is not limited. (W&I Code Section 14132.72(e)

Distant Site
In general, a distant site is where the health care provider is located while providing services via a telecommunication system.

– Must be licensed in the State of California
– Enrolled as a Medi-Cal provider
– Must be located in California or reside in a border community
– A health care provider who is part of a group, with an office physically located in California, may reside outside California
Medi-Cal Fee-For-Service

Modifiers

Only services rendered from the distant site are billed with modifiers. Claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided and one of the following Telemedicine modifiers:
- GT or 95 for interactive audio and video telecommunications system (live interactive)
- GQ for Store and forward applications

Originating Site Fee

The originating site is eligible to receive a facility fee for providing services via telehealth. For 2019, the site facility fee is $22.94. Sites are instructed to use HCPCS code Q3014 when submitting facility fee claims. Site fees are limited to once per day, same recipient, same provider.

Transmission Fee: Live Interactive

Medi-Cal allows payment of transmission costs associated with live interactive services. This fee can be paid to originating and distant sites. It is limited to a maximum of 90 minutes per day, same recipient, and same provider. One unit of service is equal to one minute of transmission cost.

Sites are instructed to use code T1014: telehealth transmission, per minute. For 2019 the transmission fee is $0.24 per minute.
Informed Consent

Prior to a patient receiving services via telehealth, the health care provider at the originating site shall inform the patient, where appropriate, of the option to utilize a telehealth modality and then obtain oral consent from the patient.

The health care provider at the originating site must first obtain oral consent from the patient prior to providing service via telehealth and shall document oral consent in the patient’s medical record, including the following:

- A description of the risks, benefits and consequences of telemedicine
- The patient retains the right to withdraw at any time
- All existing confidentiality protections apply
- The patient has access to all transmitted medical information
- No dissemination of any patient images or information to other entities without further written consent

Documentation

All medical information transmitted during the delivery of health care via telemedicine must become part of the patient’s medical record maintained by the licensed health care provider.
## Medi-Cal Fee-For-Service

### Current Codes for Live Video Reimbursement

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT &amp; HCPCS Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interactive complexity</td>
<td>90785</td>
</tr>
<tr>
<td>Psychiatric Diagnosis, Interview, Examination</td>
<td>90791 - 90792</td>
</tr>
<tr>
<td>Psychotherapy, outpatient and inpatient, with and without evaluation and management component</td>
<td>90832, 90837</td>
</tr>
<tr>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services</td>
<td>90863</td>
</tr>
<tr>
<td>Office or Other Outpatient Visit – New or established patient</td>
<td>99201 – 99215</td>
</tr>
<tr>
<td>Initial Hospital Care or Subsequent Hospital Care – new or established patient</td>
<td>99231 – 99233</td>
</tr>
<tr>
<td>Consultations – office or other outpatient, initial or follow-up inpatient, and confirmatory</td>
<td>99241 – 99255</td>
</tr>
<tr>
<td>Communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only</td>
<td>G0071</td>
</tr>
<tr>
<td>Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth</td>
<td>G0508</td>
</tr>
<tr>
<td>Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth</td>
<td>G0509</td>
</tr>
<tr>
<td>Remote evaluation of recorded video and/or images submitted by an established patient, 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</td>
<td>G2010</td>
</tr>
<tr>
<td>Brief communication technology-based service 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</td>
<td>G2012</td>
</tr>
</tbody>
</table>
Store and Forward Dermatology and Ophthalmology

- The images must be specific to the patient’s condition and adequate for meeting the procedural definition of the national code that is billed.

- Teleophthalmology and teledermatology by store and forward must be rendered by a physician who has completed training in an Accreditation Council for Graduate Medical Education (ACGME)-approved residency in ophthalmology or dermatology respectively.

- The health care provider shall comply with the informed consent provision of Section 2290.5 of the Business and Professions Code when a patient receives teleophthalmology and teledermatology by store and forward.

- Teleophthalmology and teledermatology does not include single mode consultations by telephone calls, images transmitted via facsimile machines or electronic mail.

- Services provided via store and forward telecommunications system must be billed with modifier GQ (service rendered by store-and-forward telecommunications system). Only the portion(s) rendered from the distant site (hub) are billed with modifier GQ.

- Services provided at the originating site (face-to-face) with the patient during service that will be provided by store and forward transaction are billed using Q3014 and T1014.
# Medi-Cal Fee-For-Service

## Current Codes for Store and Forward Reimbursement

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visit</td>
<td>99211 – 99214</td>
</tr>
<tr>
<td>Subsequent hospital care</td>
<td>99231 – 99233</td>
</tr>
<tr>
<td>Office consultation, new or established patient</td>
<td>99241 – 99243</td>
</tr>
<tr>
<td>Initial inpatient consultation</td>
<td>99251 - 99253</td>
</tr>
</tbody>
</table>
Important item to consider

A patient receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician consulted through store and forward, upon request. If requested, communication with the distant specialist physician may occur either at the time of consultation or within 30 days of the patient’s notification of the results of the consultation.
Medi-Cal Fee-For-Service DRAFT Updates

— Informed Consent
— Documentation
— Place of Service Code and Modifier
— Covered Services: eConsult

All changes are still in DRAFT. DHCS has stated that the final guidelines will be released sometime in the Spring of 2019.

Until the final changes have been released, DHCS can make changes to these guidelines.
Health care providers must also inform the patient about the use of telehealth and obtain verbal consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health.

— The consent shall be documented in the patient’s medical file (Business and Professionals Code Section 2290.5(b)) and be available to the Department upon request.

For teleophthalmology, teledermatology, or teledentistry services or benefits delivered via asynchronous store and forward, health care providers must also meet the following requirements in state statute (Welfare and Institutions Code [WIC] Section 14132.725[b]):

— A patient receiving teleophthalmology, teledermatology, or teledentistry by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician, optometrist, or dentist and shall receive an interactive communication with the distant specialist physician, optometrist, or dentist, upon request.

— If requested, communication with the distant specialist physician, optometrist, or dentist may occur either at the time of the consultation, or within 30 days of the patient’s notification of the results of the consultation.
Health care providers at the distant site must determine and document that the covered Medi-Cal service or benefit being delivered via a telehealth modality meets the procedural definition and components of the national CPT-4 or HCPCS code(s) associated with the Medi-Cal covered service or benefit, and the extended guidelines that pertain to CPT 99358 and 99359 (eConsult).

We will describe these requirements a bit later in the eConsult updates.
Medi-Cal Fee-For-Service DRAFT Updates

POS and Modifiers

Health care providers are required to document place of service code 02, which indicates that services were provided or received through a telecommunications system.

POS 02 is not applicable for FQHCs, RHCs or IH services.

Modifier 95 must be used for live video. Only the portion(s) of the telehealth service rendered at the distant site are billed with modifier 95.

Modifier GQ must be used for Store & Forward.
E-consults are reimbursable between two health care providers for the purpose of offering a coordinated multidisciplinary case review, advisory opinion, and recommendation of care for complicated symptoms or illnesses.

A health care provider at the distant site may bill for an e-consult with one or both of the CPT-4 codes listed below. When billing for e-consults, both health care providers at the originating and distant sites must clearly document all information relating to previous but related primary health care services and maintain this information in the patient’s medical record.

To bill for e-consults, the health care provider at the distant site may use the following two CPT codes:

- 99358 - Prolonged evaluation and management service before and/or after direct patient care; first hour
- 99359 - Each additional 30 minutes
The health care provider at the originating site must create and maintain the following:

- Record that the e-consult is the result of patient care that has occurred or will occur and relates to ongoing patient management;
- Record of a request for an e-consult by the health care provider at the originating site; and
- Record of patient consent for transmission of medical information.

The health care provider at the distant site must create and maintain the following:

- Record of the review and analysis of the transmitted medical information with written documentation of date of service and time spent (greater than 30 minutes);
- Record of preparing a written report of case findings and recommendations with conveyance to the originating site; and
- Record of maintenance of transmitted medical records in patient’s medical record.

Providers at the originating site may bill the originating site fee with HCPCS Code Q3014, but may not bill for the transmission fee. **FQHCs and RHCs are not eligible to bill for eConsult.**
Questions about claims and billing may be directed to the Medi-Cal Telephone Service Center (TSC) at 1-800-541-5555 or via email to: Medi-CalOutreach@Xerox.com

Providers may email questions about Medi-Cal telehealth policy to: Medi-Cal_Telehealth@dhcs.ca.gov

California Department of Health Services - Medi-Cal Program Telehealth Webpage
http://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx
Private Payers, Managed Care, and IPA
Private Payers, Managed Care, and IPA

Payers must have a telemedicine policy in place. That policy may be that they do not pay for telemedicine or that they only pay for certain services. Please check with payers to find out their reimbursement policies before providing and billing for telehealth services.

Managed care plans are allowed, and encouraged, to reimburse for services above and beyond what fee-for-service Medi-Cal reimburses for. Most managed care plans in California do not have the restrictions that fee-for-service places on FQHCs.

Follow Medi-Cal in that they pay for both ends of the consult.

Modifiers may be different (and in some cases, not existent).

Most MCPs allow FQHCs/RHCs to bill both the Q3014 and the T1014.

Most MCPs will allow an FQHC/RHC to be a distant site.
Questions?
Find me during the Summit and let’s chat!