Telehealth Guidelines Response to the COVID 19 Crisis

Updated 4/14/2020

Insurer	Billing Codes	Modifiers & POS ***	Co-Pay/Co-insurance	Reimbursement	Notes
Highmark	97161 - 97164; 97110, 97112 & 97116 97530; 97535	TELEHEALTH 95 OR GT 02	WAIVED	Fee Schedule	Authorization required continues be required
Highmark Advantage	G2061 - G2063	CR / GP 11	WAIVED	Fee Schedule	5 - 10 minutes cumulative time 11 - 20 minutes cumulative time 21 + minutes cumulative time Established patient (no evals) 7 days limit - can only bill for the patient once
Cigna	All CPT codes	**TELEHEALTH** GQ / 11	WAIVED	Fee Schedule	Updated - all CPT codes can be billed. Re-imbursement is same as face to face meeting.
Humana	G2061 - G2063	CR / GP 11	WAIVED		5 - 10 minutes cumulative time 11 - 20 minutes cumulative time 21 + minutes cumulative time Established patient (no evals) 7 days limit - can only bill for the patient once

UHC UHC Medicare & Medicaid	Eval(all) 97164, 97110, 97116, 97530, 97112 & 97535 *********** G2061 - G2063	**TELEHEALTH** 95 OR GT 11 NO Modifier 11	Will waive patient responsibilities only if you are in-network.	As per contract	In Network Providers ONLY Only specified CPT Codes allowed: Eval(all) 97164, 97110, 97116, 97530, 97112 & 97535. Use appropriate modifiers. 5 - 10 minutes cumulative time 11 - 20 minutes cumulative time 21 + minutes cumulative time Established patient (no evals) 7 days limit - can only bill for the patient once
Medicare	G2061 - G2063 G2010 G2012 98966-98968	**E-VISIT** CR / 11 (and GP, GN, GO) Remote Eval Virtual Check-in Telephone Assessment & Mgmt Svc. **GP, GN, GO / 11**	 $11.59 $14.25		5 - 10 minutes cumulative time 11 - 20 minutes cumulative time 21 + minutes cumulative time Established patient (no evals) 7 days limit - can only bill for the patient once Remote evaluation of recorded video/images (G2010) Virtual check-in (G2012) Telephone assessment and management services (98966-98968)

Aetna **-Commercial** **Aetna - Medicare** **Aetna Better Health of WV**	97161-97164; 97110, 97112, 97116, 97116, 97535, 97755, 97760 & 97761 ************ G2061 - G2063 G2061 - G2063	**TELEHEALTH** GT / 11 UB04 GT or 95/ 11 ************ **E-VISIT** CR / 11 **E-VISIT** CR / 11	May apply May apply May apply	As per contract	Must be via telehealth (two-way synchronous (real-time) audiovisual service. 5 - 10 minutes cumulative time 11 - 20 minutes cumulative time 21 + minutes cumulative time Established patient (no evals) 7 days limit - can only bill for the patient once 5 - 10 minutes cumulative time 11 - 20 minutes cumulative time 21 + minutes cumulative time Established patient (no evals) 7 days limit - can only bill for the patient once
WV Medicaid	All CPT codes	GT / 02		Fee schedule	NO Auth Required
WV PEIA	Not Approved				Commercial and Retirees - No Telehealth Approved at this time
Travelers (WC)	All CPT codes	Telehealth / 02	NA	Fee schedule	Case by Case basis. You MUST contact the case manager in advance.

TriCare	All 97000	**TELEHEATH** Synchronous - GT / 02 Asynchronous - GQ /11			No initial evaluation
CareSource	G2061 - G2062	**E-Visits** CR / 11	Waived		5 - 10 minutes cumulative time 11 - 20 minutes cumulative time 21 + minutes cumulative time Established patient (no evals) 7 days limit - can only bill for the patient once
Encova (Brickstreet)	All CPT (97000)	**Telehealth** * / 02	NA		Must have approval from case manager for care *at this time we do not have any modifier requirements
The Health Plan (THP) **Comm & Medicare Adv.**	G2061 - G2062	**E-Visits** CR / 11	Waived		5 - 10 minutes cumulative time 11 - 20 minutes cumulative time 21 + minutes cumulative time Established patient (no evals) 7 days limit - can only bill for the patient once
Medicaid	All CPT (97000)	**Telehealth** **02 POS only for HCFA or** **GT mod +02 for UB04**			Follow authorization requirements. If you file on a red/white HFCA only use 02 POS If you file on a UB04, include GT modifier and 02 POS

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

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."