Catalyst HEALTH NETWORK

TELEHEALTH VISIT REIMBURSEMENT AND BILLING GUIDELINES

March 23, 2020

Payer and legislative guidelines related to telehealth visits are changing rapidly. Guidelines have been modified, legislation has been passed and regulations have been waived. For instance, telehealth visits conducted over the phone are now covered, physicians no longer need to have an established relationship with the patient, border restrictions have been waived, payers have reduced, or waived copay/coinsurance related to services for COVID-19 diagnoses and new diagnosis codes have been established.

Referenced in this document are telehealth visit guidelines, policies related to both COVID-19 and other telehealth visits. Key elements to document in the progress note such as what type of tele-communication method (video or audio), location of patient and provider, length of time spent with the patient. Guidance on which CPTs are payable, modifiers (95) and place of service (02) placement on the claim form.

We have consolidated the information from Novitas (Medicare), MGMA, Texas Medical Association, coding references and major payer organizations. Our goal is to provide you with timely references, tools and resources in one location to assist you during this challenging time.

KEY TELEHEALTH CMS DEFINITIONS

Originating Site- Where the patient is located

Distant Site- Site where service is provided

Distant Site Provider- Provider of the service

(CMS defines the following as eligible to provide Telehealth Services)

- Physicians
- Physicians assistants
- Nurse Practitioners
- *Clinical Nurse Specialists*
- *Clinical psychologists and clinical social workers (may not bill for psychiatric diagnostic interviews or E/M services)*
- *Nurse Midwives*
- *Certified registered nurse anesthetists*
- *Registered dieticians or nutrition professional*

VERIFICATION/PRE-VISIT

Prior to visit

- Discuss with the patient the tools needed for the visit (Internet speed, Browser recommendations, quiet space, minimize distractions, and review tele-visit consent form).
- Verify benefits prior to visit when possible via electronic methods.
  - *If you are not able to verify prior to claim submission to minimize rejections. Work with your clearinghouse to automate this process.*

During Visit

- **Obtain consent for Telehealth visit.** Consent may be obtained verbally (form can be placed on web site/emailed to patient and **documented in progress note** (see sample consent)-
- **The progress note is documented the same as in person visit (items in bold are key elements often ommited and should be included in your notes)** AHIMA guidelines:
  - Providers must document all encounters/ services within the medical record and provide that documentation to the originating site when applicable.
  - **Document that the visit occurred via telemedicine and communication method utilized**
  - **The physical location of the patient**
  - **The physical location of the provider**

- The names of all persons participating in the telemedicine service and their role in the encounter.
- **In the virtual environment, Level 3 and 4 reimbursements must be based on time rather than physical examinations**
- **Providers should document the length of time of the consultation visit and should note that more than 50 percent of the encounter was spent counseling/coordinating care**
- Differential diagnosis, active diagnosis, prognosis, risks, benefits of treatment, instruction, compliance, risk reduction, and coordination of care with other providers. **If COVID Related Visit:**
  - **Z03.818-concern of possible exposure**
  - **Z20.828-confirmed contact exposure**
  - Signs and symptoms for patients presenting with any signs/symptoms (such as fever, etc.) and where a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as: • R05 Cough • R06.02 Shortness of breath • R50.9 Fever, unspecified
    - *Note: Diagnosis code B34.2, Coronavirus infection, unspecified,not be appropriate for the COVID-19, because the cases have universally been respiratory in nature, so the site would not be "unspecified." If the provider documents "suspected", "possible" or "probable" COVID-19, do not assign code B97.29. Assign a code(s) explaining the reason for encounter (such as fever, or Z20.828).* *ICD-10-CM Interim Coding Guidance for COVID-19 (February 20, 2020).*
- Include 4+ history of present illnesses (HPI)
- Include 10+ complete review of systems (ROS)
- Include all 3 past, family, and social history (PFSH)
- Review/Order of tests
- **Statement of risk (most patients will meet a "moderate risk")**

Billing

- Telehealth visits are billed with the appropriate E&M level codes based on the documentation provided in the progress notes.
  - *Cigna requested to not bill until April 6th and for COVID related cases bill with G2012 and POS 11 and Non COVID related billed with 99421 POS 11 and no modifier. See link below* **(We are currently reaching out to local representative as we believe this is in violation of Texas Parity law)**

- Modifier is placed on E&M to identify method of communication and must be documented in note. Template is attached.
  - **Modifier 95 most often used**- (synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system)
  - GQ (via an asynchronous telecommunications system)
- **POS 02** placed in box 24 of CMS form (see sample claim form attached)
- Physician state licensure requirements have been waived temporarily as of 3/19/2020 **(source** FedsOkInsterstateLicensing**)**

Reimbursement

- Based on Parity Legislation, Health Insurance and Health Care Providers the reimbursement for Commercial and Medicare Payers must be the same as in office (exception may be self funded plans).
- Payer policy updates regarding cost sharing related to testing and COVID visits. As policies are updated Care Alerts will be updated- links listed below.
- Reimbursement analysis is imperative during the transition from in office to telehealth to ensure payers are not downcoding level of service.

TELEHEALTH REFERENCES

- Aetna Telehealth Policy
- United HealthCare
- Blue Cross Blue Shield of Texas Telehealth Policy
- Cigna Telehealth Connection Program
- Novitas Medicare JH Guidelines
- MGMA -Navigating Telehealth Billing Requirements
- AHIMA Telemedicine Toolkit
- Texas Medical Association Telehealth Guidelines
- Texas Occupations Code Regarding Consent for Telehealth

COVID-19 RELATED POLICIES/REFERENCES

- BCBSTX Lifting Telemedicine Cost-Sharing for Fully Insured Members
- UHC COVID-19 FAQ
- Aetna Healthcare Professionals COVID FAQ
- CIGNA Billing Guidance for Providers related to COVID-19
- CDC.Gov Interim Diagnosis Coding Advice

Telemedicine Informed Consent

Texas Medical Association
Physicians Caring for Texans

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting [PRACTICE NAME] at [PHONE NUMBER].
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
Witness Signature	Date

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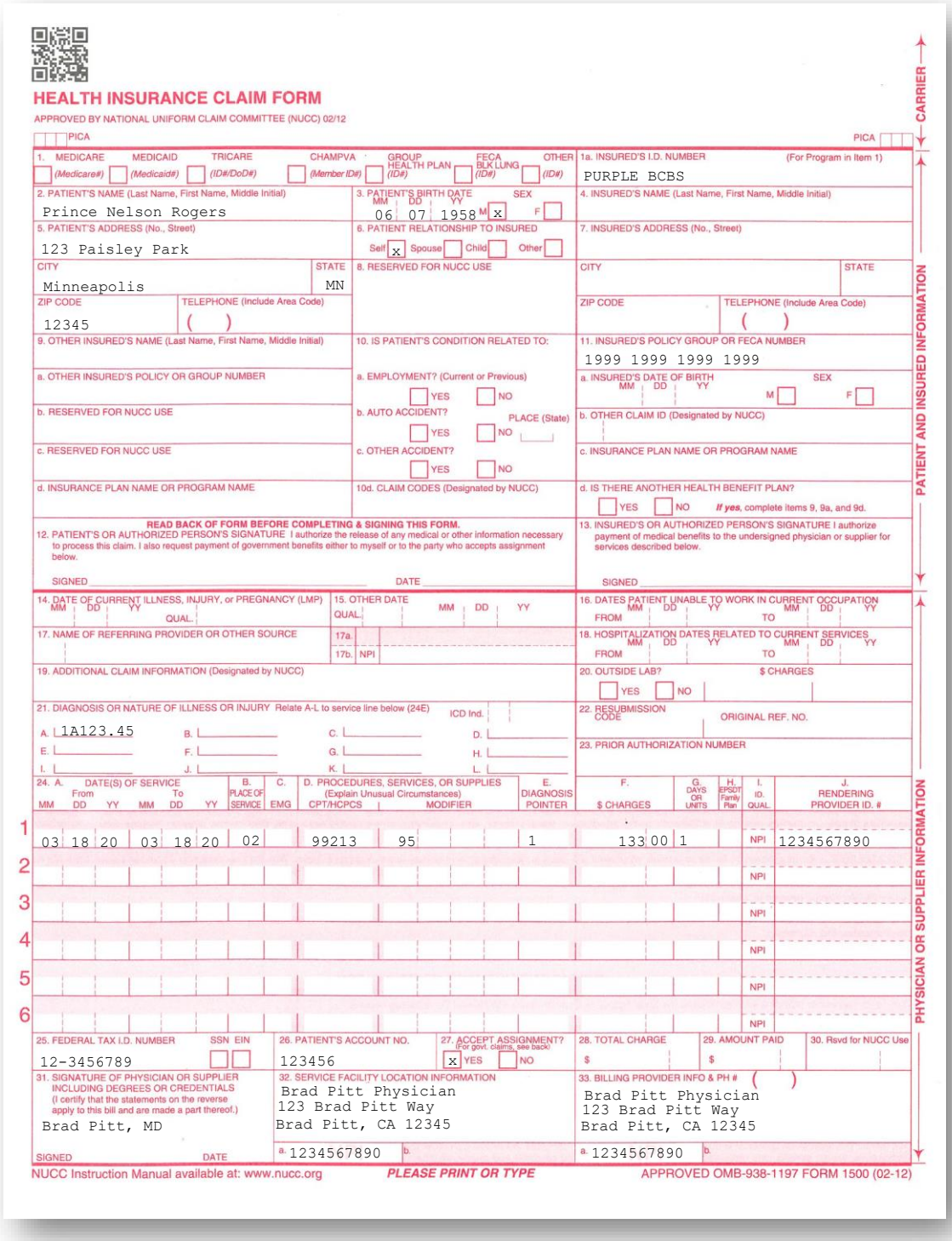
THE PHYSICIANS FOUNDATION

RELEASED: March 2020, Texas Medical Association

SAMPLE VISIT TEMPLATE



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): PURPLE BCBS

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Prince Nelson Rogers

3. PATIENT'S BIRTH DATE MM DD YY: 06 07 1958 SEX M [x] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 Paisley Park

6. PATIENT RELATIONSHIP TO INSURED: Self [x] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Minneapolis STATE: MN

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 12345 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 1999 1999 1999 1999

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 1A123.45 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 03 18 20	03 18 20	02		99213	95	1	133 00	1		NPI	1234567890
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 12-3456789 [ ]

26. PATIENT'S ACCOUNT NO.: 123456

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [x] NO [ ]

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Brad Pitt, MD

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Brad Pitt Physician
123 Brad Pitt Way
Brad Pitt, CA 12345

a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # ( )

Brad Pitt Physician
123 Brad Pitt Way
Brad Pitt, CA 12345

a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION