CODING AND BILLING FOR TELEHEALTH and COMMUNICATIONS TECHNOLOGY-BASED SERVICES (CTBS):

OVERVIEW: ***Note: In this section as in all sections, what is provided is for informational purposes only and is not meant to be used by the reader without confirmation by own billing expert or lawyer.***

CMS MEDICARE CODING AND BILLING: Digital services are divided into 2 categories

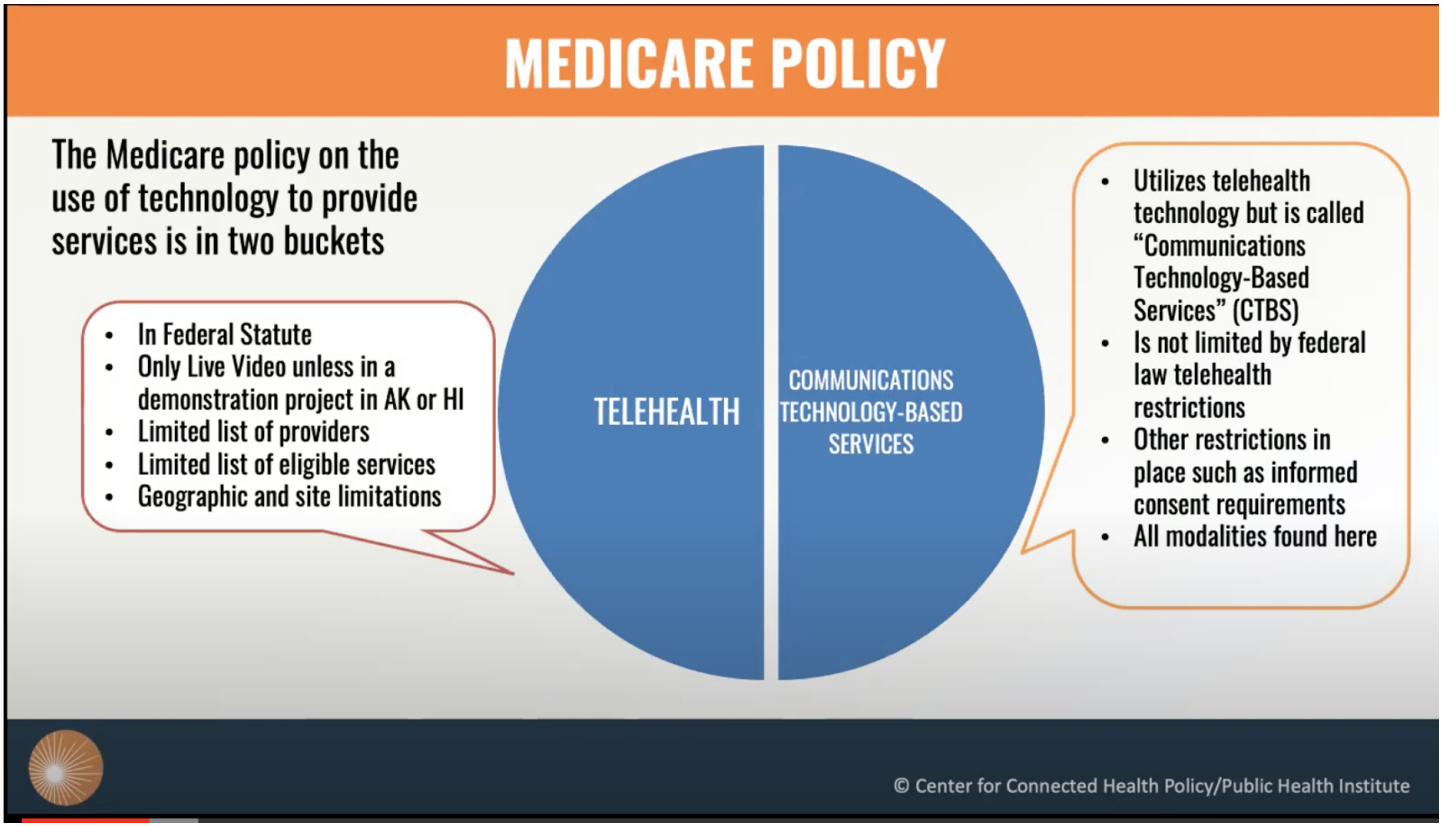
1. **Telehealth and**
2. **Communications Technology-Based Services (CTBS).**

What is the difference? Theoretically, Telehealth services REPLACE and in-person visit. CTBS technically do NOT replace an in-person service and are meant to fill in gaps in care. Determination of which category the service falls into is important as each category is subject to specific limitations and requirements.

CMS Telehealth Services: BEFORE PHE and perhaps AFTER PHE: use technology to provide services **Live Video** interaction with patients (unless in demonstration project in AK or HI where audio only allowed) by a limited list of eligible providers for a limited list of eligible services with geographic and site limitations. Exceptions to this rule (some mental health and substance use disorder patients)

CMS Communications Technology-Based Services: Service uses technology (Audio only, Secure Text Messaging, Store and Forward, Remote Physiologic Monitoring, Remote Therapeutic Monitoring, Audio Video) but is NOT LIMITED BY CMS TELEHEALTH LAW BEFORE OR AFTER THE PHE. NO GEOGRAPHIC LIMITATIONS. There are still requirements which apply, such as HIPAA and informed consent.

From Center for Connected Health Policy Jan 2022.



CODE CHANGES TO CMS TELEHEALTH IN COVID 19

A summary of changes made to CMS Telehealth Policy affecting coding and billing during the COVID 19 pandemic are summarized in the table from CCHP below.

From CCHP Jan 2022

TELEHEALTH POLICY CHANGES IN COVID-19

FEDERAL

MEDICARE ISSUE	CHANGE
Geographic Limit	Waived
Site limitation	Waived
Provider List	Expanded
Services Eligible	Added additional 80 codes
Visit limits	Waived certain limits
Modality	Live Video, Phone, some srvs
Supervision requirements	Relaxed some
Licensing	Relaxed requirements
Tech-Enabled/Comm-Based (not considered telehealth, but uses telehealth technology)	More codes eligible for phone & allowed PTs/OTs/SLPs & other use

•DEA – PHE prescribing exception/allowed phone for suboxone for OUD
•HIPAA – OCR will not fine during this time

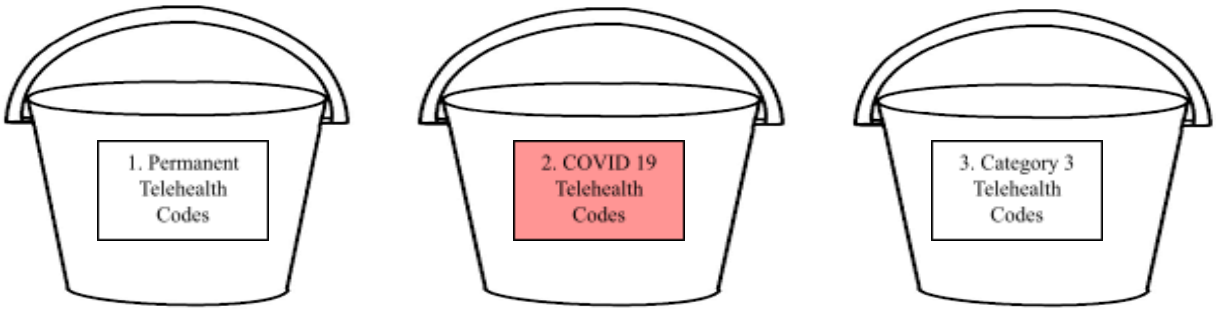
STATE (Most Common Changes)

MEDICAID ISSUE	CHANGE
Modality	Allowing phone
Location	Allowing home
Consent	Relaxed consent requirements
Services	Expanded types of services eligible
Providers	Allowed other providers such as allied health pros
Licensing	Waived some requirements

- Private payer orders range from encouragement to cover telehealth to more explicit mandates
- Relaxed some health information protections

Important Caveats:

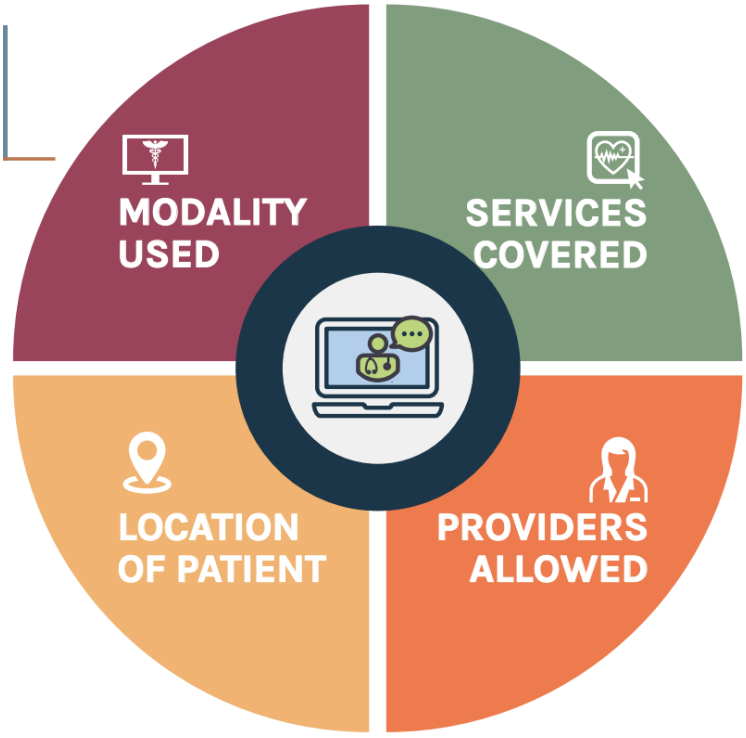
Think of CMS Telehealth Service Codes in <u>3 buckets</u>



1. **There were 103 codes representing Telehealth Services <u>prior to the COVID 19 pandemic</u> (Bucket 1). 168 service codes were added to Bucket 2 during the pandemic.**
2. **For CY2022, some services from Bucket 2 have been added to CMS Medicare telehealth coverage permanently/Bucket 1**
3. **Some services (68) from Bucket 2 have been added to the Category 3 list for CY 2022 to be evaluated by CMS for permanency and will stay active until end of 2023/Bucket 3**

4. **Some remain in a bucket 2 (COVID-19 Bucket) (99) and will be covered ONLY FOR THE COVID 19 PHE and will EXPIRE 151 days after the end of the PHE / For example: AUDIO ONLY 99441-99443 codes.**
5. **It is important to realize that services in Bucket 1: CMS PERMANENT TELEHEALTH COVERED SERVICES and those in Bucket 3: CATEGORY 3 Telehealth codes will suddenly be subject to geographic and site limitations as well as provider eligibility requirements 151 days AFTER THE PHE ENDS unless CONGRESS ACTS TO CHANGE THIS.**

IN GENERAL, TELEHEALTH Coding and Billing is based on 4 components:
(From Center for Connected Health Policy)



This is a confusing area of telehealth as there are marked differences between BEFORE the Public Health Emergency (PHE), DURING the PHE, and what will be AFTER the PHE. There are lots of moving parts at the federal and state level. PLEASE SEE THE WV TELEHEALTH INSURANCE LOG SPREADSHEET IN THE GUIDE AS A REFERENCE. **IT IS IMPORTANT THAT YOUR ORGANIZATION HAS SOMEONE WHO IS CONSIDERED AN EXPERT IN THIS AREA. IT SHOULD BE THEIR RESPONSIBILITY TO REMAIN UP TO DATE ON ALL CHANGES AND IMPLEMENT ACCORDINGLY. NOTE: CHANGES IN CODING AND BILLING CAN HAVE MARKED EFFECTS ON WORKFLOW and DOUMENTATION.**

In addition, CMS Medicare has different rules from WV Medicaid and different rules from commercial insurers. Medicare rules are generally nationally mandated by Congress. Medicaid and commercial insurer rules vary state by state. This guide is meant to give you what the understanding for West Virginia at the time the guide was revised (March 2022) but is not meant to be legally binding. Check with your billing specialists, lawyers, CMS, your insurers, and Medicaid for confirmation going forward.

GENERAL CODING and BILLING REQUIREMENTS FOR TELEHEALTH VISITS:
ALWAYS ask the following questions when coding and billing telehealth visits.
How a service is coded and billed will depend on 4 factors:

1. Is the service covered?
2. What is the location of the patient and the provider?
3. Is the provider allowed to bill for telehealth services?
4. What was the modality used to provide the service?

CMS Medicare Telehealth Services:

1. Patient must INITIATE the visit once they have been made aware of availability of telehealth.
2. Practice must obtain VERBAL or WRITTEN CONSENT, and this must be documented in the visit note or in the chart. OK to include consent in general consent for office treatment.
3. Assessment of COPAYs and DEDUCTIBLES apply except in RHC and FQHCs and for suspected or true COVID related illness during the Public Health Emergency.
4. CMS ELIGIBLE PROVIDER must provide the service.

Certain elements must be included in CONSENT for CMS patients:

- Acknowledgement that telehealth **cannot provide the same evaluation** as an in-person visit
- Make patient aware that details of visit/medical issues **may require that patient come to office** or ER/urgent care for in-person evaluation
- Inform patient the visit is **encrypted and secure, but nothing is 100%**
- Be sure patient understands their **consent can be revoked at any time**
- Consent of patient to **include any others present** for the visit

Example of simple documentation of verbal consent:
VERBAL CONSENT
Date: _____ Patient Name: _____ DOB: _____
Patient has requested and verbally consented to participation in telehealth visit. Patient acknowledges a telehealth visit cannot provide the same evaluation as an in-person visit. Medical issues discovered during the telehealth visit may require an in-person visit. This telehealth visit is conducted with encrypted and secure software. Note that copays and deductibles may apply depending on patient plan and presenting problem. Patient has the option to revoke consent at any time. Consent was obtained for all those present during the visit.

Example of more complex consent: From the National Consortium Telehealth Resource Center
https://telehealthresourcecenter.org/resources/toolkits/sample-telehealth-consent-form/

1. IS THE SERVICE COVERED?

CMS SERVICES/CODES COVERED USING TELEHEALTH

CMS determines if services are eligible for reimbursement by telehealth if they pass one of two requirements:

- Category 1 – The service is essentially similar to a service already on the eligible list.
- Category 2 – If the service is not similar to one already on the eligible list, there is evidence that demonstrates clinical benefit to the patient if it is provided via telehealth. This generally takes years and research to prove effectiveness.
- Category 3 – These are services being evaluated for permanency. Many of the codes added as covered telehealth services during the PHE, but not all, have been added to Category 3 and will be covered until the end of CY 2023 when a decision on permanency will be made. **Remember that 151 days after the PHE ends, these Category 3 services as well as the permanent Category 1 list will still only be covered if the patient meets rural geographic requirement and is located in an eligible originating site for the visit. Exception: mental health disorders which can have the originating site of their own home.**

BEFORE THE PHE: There were 103 permanent telehealth codes at the start of 2020.

DURING THE PHE: Telehealth code list grew to 271 codes during the PHE. CMS also created a Category 3 for temporary codes.

5 months AFTER THE PHE: Of codes added during the PHE, 9 codes are now permanent and additional codes were placed into a "temporary category" Category 3 (68) (services likely to provide benefit via telehealth yet lack sufficient evidence to evaluate making them permanent)

Please see the full list of eligible CMS CPT telehealth codes at the following link:

- https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

MEDICAID AND COMMERCIAL INSURANCE TELEHEALTH COVERAGE: Please refer to the WV Telehealth Insurance Tracking Log Spreadsheet in the Guide.
WV Medicaid and Commercial Insurers generally allowed coverage by telehealth during the PHE if service was covered in person prior to the PHE. WV House Bill 2404 was signed and enacted into law on March 30, 2021 making many laws regarding telehealth coverage permanent. Going forward, PEIA and Commercial Insurers must cover telehealth services for any service covered as an in-person visit and must do so at parity.

WV MEDICAID: See RVRBS for WV Medicaid Covered Services:
https://dhhr.wv.gov/bms/FEES/Documents/RBRVS Fee Schedules/2021 Physician%27s %28RBRVS%29 FS-11.19.21.pdf
New telehealth policy on WV Medicaid Website as of Jan 2022: https://dhhr.wv.gov/bms/Public Notices/Documents/Policy_519.17_TelehealthFinalPublicComment.pdf
Changes noted include coverage for patients in their home as originating site and not just for mental health services with addition of POS 10 to indicate services from home and POS 02 from any other location, AUDIO only modality allowed, and consent must be WRITTEN but can be part of general office consent.
FQHC/RHC still limited to Distant site services for mental health by psychologists and psychiatrists ONLY.

2. WHAT IS THE LOCATION OF THE PATIENT?

CMS RULES RE LOCATION OF TELEHEALTH SERVICES: LOCATION, LOCATION, LOCATION:
***Note: IF THE PROVIDER AND PATIENT ARE AT SAME LOCATION, for example, IF PATIENT IS IN THE PARKING LOT AND PROVIDER IS IN THE BUILDING USING AUDIO-VISUAL TECHNOLOGY, **IT IS NOT TELEHEALTH, it is a regular office visit.**

BEFORE THE PHE: Medicaid/Medicare Allowed telehealth if **patient located in**

- A county outside a Metropolitan Statistical Area (MSA)
- A Rural Health Professional Shortage Area(HPSA) in a rural census tract OR
- From and entity that participates in a federal telemedicine demonstration project approved by Secretary f HHS as of Dec 31, 2000 AND
- Be in a specific eligible ORIGINATING SITE to connecting to another **provider at a distant site usually for specialty services.**

To Determine if your address qualifies as a potential Medicare Telehealth Originating Site Address, go to CMS website: https://data.hrsa.gov/tools/medicare/telehealth
*Exceptions to the RURAL requirement: those receiving treatment for mental health disorders, end stage renal disease, acute stroke and substance use disorder.
DURING THE PHE: Geographic and rural requirements were relaxed. Originating and distant site requirements were relaxed. RHCs and FQHCs were allowed to be distant sites. Services were allowed at patient home, school, work, SNF, ER, Hospital without walls, home health, etc.

5 months AFTER THE PHE: Consolidated Appropriations Act passed in Dec 2020 during the pandemic, thus removing CMS geographic and site limitations permanently for all CMS patients receiving telehealth services including Audio only (with stipulations) for evaluation and treatment of **mental health disorders** (prior in-person visit stipulations apply). The law also permanently allows RHCs and FQHCs to be distant site providers for patients receiving mental health telehealth evaluation and treatment and receive PPS/AIR rate for doing so 151 days after the PHE ends (prior in-person visit stipulations apply). CMS geographic limitations will also no longer be applied to Indian Health Service Facilities permanently. ***Other Exceptions to the RURAL requirement: those receiving treatment for end stage renal disease, acute stroke and substance use disorder.**

To Determine if your address qualifies as a potential Medicare Telehealth Originating Site Address POST PHE, go to CMS website: https://data.hrsa.gov/tools/medicare/telehealth

MEDICARE: LOCATION OF THE PROVIDER: Medicare does not allow providers to provide telehealth services while PHYSICALLY LOCATED OUTSIDE OF THE USA due to the Medicare Act's Ban on foreign payments.

WV MEDICAID

From the WV BMS Policy Manual Proposed WV Telehealth Rule Jan 2022:
https://dhhr.wv.gov/bms/Public%20Notices/Documents/Policy_519.17_TelehealthFinalPublicComment.pdf

DURING COVID: No geographic limitations. Originating site requirements waived and considered to be where the patient is located including the patient's home.

PRE COVID There is no limitation to Rural or HPSA areas for services but patient must be located in an ORIGINATING SITE in Provider office, hospital, critical access hospital, RHC, FQHC, Hospital based or CAH based Renal Dialysis Center, Skilled Nursing Facility, Licensed Behavioral Health Center, School based health service site, home of members receiving substance abuse or mental health treatment disorders as identified in Chapters 503, 504, 522, 538 of the WV BMS Policy Manual.

POST COVID: Still no geographic limitations.

The authorized **originating sites** are:

- Physician and practitioner offices,
- Hospitals and Critical Access Hospitals (CAHs),
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs),
- Skilled Nursing Facilities (SNFs),
- Community Mental Health Centers (CMHCs),
- Licensed Behavioral Health Centers (LBHCs),
- Renal Dialysis Facilities including Hospital-Based or CAH-Based Renal Dialysis Centers and satellites,
- School-Based Health Centers,
- University-Based Health Centers,
- A patient's home, and
- Work location of a patient

The originating sites in red represent PROPOSED CHANGES as of Jan 21, 2022 listed on the WV Medicaid website now allowing patients to receive telehealth services in their home for more than just mental health services. They can also receive services from a University based Health Center and from their place of employment.

Authorized WV MEDICAID **distant site providers**

- Physician
- Podiatrist
- Physician Assistant (PA)
- Advanced Practice Registered Nurse (APRN)
- Certified Nurse Midwife (CNM)

- Clinical Nurse Specialist (CNS)
- Community Mental Health Center (CMHC)
- Licensed Behavioral Health Center (LBHC
- Licensed Psychologist (LP) and Supervised Psychologist (SP)
- Licensed Independent Clinical Social Worker (LICSW)
- Licensed Professional Counselor (LPC)
- **FQHC and RHC may only serve as a distant site for Telehealth services provided by a psychiatrist or psychologist and are reimbursed at the encounter rate (Starting 151 days POST PHE)**

PEIA, COMMERCIAL INSURERS:
PRE COVID: No definite policy and was handled by each insurer individually.
DURING COVID: SEE WV Telehealth Insurance Log Spreadsheet in the Guide.
POST PHE: WV House Bill 2404 stipulates services covered in person must also be covered via telehealth.

CODING OF LOCATION: PLACE OF SERVICE CODING (POS)
Prior to PHE: Medicare used **"POS 02"** to indicate services provided by Telehealth.
During the PHE: Medicare preferred **"POS 11**" with Modifier 95 to ensure providers would be paid at in-person rates during the PHE. Medicare FQHC/RHC and Medicaid as well as a host of other insurers preferred **POS 02** during the PHE**. In Jan 2022**, AMA has introduced **"POS 10"** to indicate location of services based in the home (not in hospital or other facility). Reserve POS 02 for any other location of patient for telehealth visit. **Effective Jan 4, 2022 but not implemented until April 1, 2022.**
FQHC: POS 50 if acting as originating site RHC: POS 72 if acting as originating site
As of Jan 1, 2022: Anthem and United Health Care will require commercial and Medicare Advantage plans to use POS code 10 for telehealth provided in the patient home. Use POS 02 for telehealth services provided with patient location anywhere else.
NOTE: WV MEDICAID has as of Jan 21, 2022, proposed to adopt POS 10 for telehealth services with patient location in the home and POS 02 for all other telehealth patient locations.

3. IS THE PROVIDER ELIGIBLE TO PROVIDE SERVICES?

CMS PROVIDERS ALLOWED:

BEFORE THE PHE:
Only 9 provider types were allowed to bill CMS for Telehealth Services and a limited number for Medicare services. **See WV Summary Spreadsheet in the Guide.**

- Physicians
- Nurse practitioners
- Physician assistants
- Nurse-midwives
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinical psychologists and clinical social workers
- Registered dieticians or nutritional professionals

DURING THE PHE: CMS temporarily expanded eligibility to all providers able to bill Medicare independently to include billing for telehealth services such as OT, PT, ST, FQHC, RHCs and others. WV Medicaid also expanded eligible providers. **See WV TELEHEALTH Summary Spreadsheet** in the Guide

MEDICARE 5 months AFTER THE PHE: General eligible provider rules revert to PRE COVID rules except RHCs and FQHCs can permanently provide mental health services via audio only or audiovisual visits

by a change made to the definition of "mental health services" by administration which did not require a change in law by Congress. See **WV TELEHEALTH SUMMARY SPREADSHEET** in the Guide for Provider eligibility post PHE. At time of this publication, it appears, it will revert to Pre COVID standards unless Congress makes official changes.

MEDICAID, PEIA, COMMERCIAL INSURER: ELIGIBLE providers POST PHE: West Virginia Law via WV House Bill 2404 signed March 20, 2021: Applies to Medicaid, PEIA and Commercial Payors:

- Licensed Health care providers who are in good standing in the state of WV
- Interstate Telehealth Medical Providers who are in good standing in their original state without any open malpractice claims and without restrictions and have registered with the appropriate board in the state of WV.
- **MEDICAID DISTANT SITE ELIGIBLE PROVIDERS** as of Feb 1, 2022:
  - Physician
  - Podiatrist
  - Physician Assistant (PA)
  - Advanced Practice Registered Nurse (APRN)
  - Certified Nurse Midwife (CNM)
  - Clinical Nurse Specialist (CNS)
  - Community Mental Health Center (CMHC)
  - Licensed Behavioral Health Center (LBHC)
  - Licensed Psychologist (LP) and Supervised Psychologist (SP)
  - Licensed Independent Clinical Social Worker (LICSW)
  - Licensed Professional Counselor (LPC)
  - **FQHC and RHC may only serve as a distant site for Telehealth services provided by a psychiatrist or psychologist and are reimbursed at the encounter rate**
  - *** NOTE Registered Dieticians are ABSENT from this list**

4. What was the MODALITY USED:

MODIFIERS:
Medicare Modifiers:

- **GY: Notice of liability not issued:** Used to report that an ABN was not issued because item or service is statutorily excluded or does not meet definition of any Medicare benefit. For example: when patient receives a telehealth visit and the originating site is not an ELIGIBLE originating site but the distant site is.
- **FR: Supervising practitioner** present through two-way, audio and video telehealth visit
- **FQ: Audio only: mental health services provided via Audio only** (will likely become active post PHE, stay tuned.)
- **93: Audio only telehealth services. Introduced by AMA in Jan 2022.** This allows CPT coding with modifier to indicate modality of telehealth visit. Adopted by WV Medicaid and likely to be adopted by several commercial payers. CMS plans to adopt post PHE.

Modality Coding: With each telehealth visit, it must be clear which telehealth technology was used to complete the visit. This should be documented in the note. This is most easily accomplished if incorporated into the practice's telehealth template in the "Coding" section. The easiest way to code is for providers to "code" how the visit was performed with Audio Visual or Audio only and how much time was spent. **If the visit was done via Audio Only, it should be clear if this was patient choice or because of technical difficulty.** This leaves the coder with the information required to correctly code the visit as Medicare, Medicaid and Commercial Insurers all code Audio Only differently. In Jan 2022, AMA added Modifier 93 to indicate "Audio Only". Look for CMS, Medicaid and other insurers to mandate use of these modifiers.

Is the patient New or Established?: During the PHE, Medicare, WV Medicaid and most commercial insurers allowed providers to establish a patient relationship via Audio Visual and Audio only telehealth visits. **5 months after the PHE ends**, telehealth services may be **limited to established patients** for Medicare which means "patient with In-person evaluation by provider or by same practice/same specialty with in the last 3 years". For CMS/Medicare, there may also be stipulations that telehealth must occur via synchronous, audio-visual telecommunications 5months post PHE with the exception of mental health services.
*****Audio Only Coding**: As of Jan 2022, the CMS Audio only Telephone call 99441 to 99443, heavily used during the PHE, is scheduled to go away when the PHE ends. **WV MEDICAID, PEIA and COMMERCIAL INSURERS will continue to allow audio only telehealth post PHE.**
Virtual Check In (CTBS)codes G2251, G2252, and G2253 are a direct crosswalk from the audio only 99441-99443 telehealth codes and are not considered telehealth and therefore not subject to the geographic and provider limitations. G0071 for FQHC and RHC. This may represent one way to continue to bill for NON-MENTAL HEALTH AUDIO ONLY SERVICES when the PHE ends. Unfortunately, they are reimbursed at lower rates than telephone calls during the PHE. **See WV Telehealth Insurance Tracking Log Spreadsheet for details on coding and billing as this is a fluid issue.** WV Medicaid and many WV Commercial insurers prefer that providers use usual Evaluation and Management codes to reflect telehealth and what was done during the visit during the PHE even if performed with Audio only.

AUDIO ONLY CODING

AUDIO ONLY CODING				
	Eligible Provider	**Before PHE**	**During PHE**	**Post PHE**
Patient type		Established only	New and Established	Established only except SUD/OUD
MEDICARE	MD, DO, APRN, PA	*NA*	***Distant site*:** 99441 (5-10m) (~ $46) 99442 (10-20m) (~$76) 99443 (21-30m) (~$110) POS 11 MOD 95 Watch for activation of new MOD 93 for audio only in future *FQHC/RHC*: Distant site: G2025 POS 02 MOD 95 April 1, 2022: POS 10 for patient home, POS 02 all others. **IN FUTURE look to use MOD 93**	***Distant site*: NOT TELEHEALTH (CTBS) VIRTUAL CHECK-IN** G2251 (5-10m) G2252(11-20m) G2253(21-30m) **No guidance yet on coding mental health audio only post PHE in regular offices or FQHC/RHC.**
	Qualified non-physician health care professional	Medical Nutritional Therapy 97802, 97803 with POS02	Medical Nutritional Therapy 97802, 97803 with POS02 OT/PT/ST allowed during PHE	Medical Nutritional Therapy 97802, 97803 with POS02 (Includes Audio only) NOT TELEHEALTH 98966 (5-10m)

		NOT TELEHEALTH 98966 (5-10m) 98967 (11-20m) 98968 (21-30m)	NOT TELEHEALTH 98966 (5-10m) 98967 (11-20m) 98968 (21-30m)	98967 (11-20m) 98968 (21-30m)
WV Medicaid, PEIA, Commercial	All licensed Medicaid providers. See commercial insurers for provider status.	WV Medicaid: No AUDIO ONLY allowed. See commercial insurers for details.	Generally wanted E and M codes with POS 02 or POS 11 depending on insurer. POS 10 for patients at home and 02 for all other telehealth locations for Medicaid starting Jan 1, 2022. **See WV Telehealth Insurance Log Spreadsheet and insurer websites for details.**	**Medicaid:** New patient relationship can be established by real-time audio. Audio Only telehealth services not limited to Mental Health telehealth Services **except in FQHC and RHCs (where only psychologist and psychiatrist can provide Mental health services only as distant site providers).** (Clarified through WV Medicaid Feb 2, 2022). POS 10 for services rendered in patient home or private residence. POS 02 for all others. MOD: none. Q3014 for originating site billing. G2251, G2252 NOT COVERED in WV Medicaid RVRBS. **PEIA/Commercial:** ***Originating site*** Q3014: POS 02 if originating site if anywhere but patient home. ***Distant site:*** E and M code. May need to use POS 10 for patient home. May need to use MOD 93 for Audio only.

AUDIO ONLY CMS/MEDICARE

PRE-COVID: Could not include NEW patients. ESTABLISHED patients only and was not considered "telehealth".

DURING COVID PHE: Added Audio only codes to telehealth covered services temporarily. NEW patients are now allowed. No in-person requirement in the last 12 months.
99441-99443: AUDIO ONLY BASED ON TIME SPENT WITH THE PATIENT by PROVIDER (NOT BEFORE OR AFTER) **DEFINITION:** NOT considered TELEHEALTH except temporarily during the PHE: Telephone evaluation and management service provided by a provider (MD, DO, NP or PA) to patient, parent, or guardian 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 Payment for these codes was increased to match what would be paid for in-person visits for equivalent time spent on Evaluation and Management visits starting on April 30, 2020. WRVU adjustment to create equality to in-person and Audio-visual visits did not come until Jan 1, 2021.

98966-98968: AUDIO ONLY BASED ON TIME SPENT WITH PATIENT by a qualified non-physician health care professional. (This is NOT added to telehealth services and remains a Communications Technology-Based Service.) **DEFINITION:** Telephone evaluation and management service provided by a qualified non-physician health care professional (such as OT, PT, ST, RD, RN, MA, LPN) to patient, parent, or guardian 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.

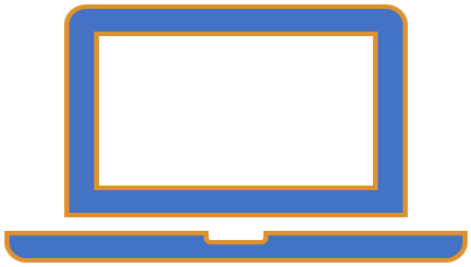
AFTER COVID PHE: 99441 to 99443 will go away when 5 months after PHE ends. Unless Congress acts, AUDIO only telehealth for Medicare patients will be available only for mental health services through a change in definition of "Mental Health services" by CMS administration.
There is a direct crosswalk from 99441-99443 codes to CTBS codes G2251-G2253 Virtual Check In codes which can be used post PHE to provide AUDIO only services to patient however at lower reimbursement rates than the 99441-99443 codes during the PHE.

AUDIO ONLY NON-MEDICARE: WV PEIA, WV MEDICAID and COMMERCIAL PAYORS

Generally, these insurers want audio only visits billed as Evaluation and Management codes with telehealth modifiers during the PHE. **See WV Telehealth Insurance Log Excel spreadsheet in the guide for details.** WV Legislature definition of Telehealth includes Audio only. WV House Bill 2404 mandated services covered by PEIA and commercial insurers in-person must also be covered by telehealth. **WV Medicaid allows AUDIO only telehealth services as of Jan 2022 going forward per WV Medicaid Website.**

NEW MODIFIER FOR AUDIO ONLY Telemedicine Visits:
Effective Jan 1, 2022: CPT Editorial Panel accepted the addition of MODIFIER 93 for Audio only telehealth.
Definition: "Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system."
Definition of Synchronous telemedicine service: is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.
Although this modifier takes effect the first day of 2022, it won't appear in the CPT manual until 2023. Adopted by Jan 2022 and active for CMS as of April 1, 2022.

AUDIO VISUAL TELEHEALTH CODING



AUDIO-VISUAL CODING				
	Eligible Provider	**Before PHE**	**During PHE**	**5 month Post PHE**
Patient type		Established only	New and Established	Established only except SUD/OUD
MEDICARE	MD, DO, APRN, PA	***Originating site:*** Q3014 POS 11 ***Distant site:*** E and M with POS 02	***Originating Site:*** *Q3014 POS 11* ***Distant site*:** E and M code POS 11 MOD 95 ***FQHC/RHC*:** Distant site: G2025 POS 02 MOD 95.	***Originating Site:*** Q3014 POS 11 ***Distant site*:** **E and M codes POS 02 No guidance yet on coding mental health audio visual post PHE in regular offices or FQHC/RHC.**

	Qualified non-physician health care professional	Medical Nutritional Therapy 97802, 97803 with POS02	Medical Nutritional Therapy 97802, 97803 with POS02 FQHC/RHC: If contracted RD, G2025	Medical Nutritional Therapy 97802, 97803 with POS02
WV Medicaid, PEIA, Commercial	All licensed Medicaid providers. See commercial insurers for provider status.	WV Medicaid: No AUDIO ONLY allowed	Generally wanted E and M codes with POS 02 or POS 11 depending on insurer. As of Jan 2022: WV Medicaid wants POS 10 if patient has services in the home. All other telehealth patient locations POS 02. See WV Telehealth Insurance Log Spreadsheet.	**Medicaid:** Audio-visual covered. POS 10 if patient in their home. **PEIA/Commercial:** ***Originating site*** Q3014: POS 02 if originating site if anywhere but patient home. ***Distant site:*** E and M code. May need to use POS 10 for patient home. May need to use MOD 93.

AUDIO-VISUAL TELEHEALTH MEDICARE:

DEFINITION: Real-time two-way audio-visual interaction between person (patient and/or caregiver) and a provider using audiovisual telecommunications technology. This type of service may serve as a substitute for an in-person encounter.

MEDICARE:

PRE-COVID: Certain rules applied:

- ORIGINATING SITE (where patient was located) had to be in an eligible telehealth originating site and could not be the patient's home. See eligibility: https://data.hrsa.gov/tools/medicare/telehealth
- Patient had to travel to the ORIGINATING SITE (clinic or hospital) to be virtually connected by **AUDIO/VISUAL** to the DISTANT SITE (provider at another center)
- RHCs and FQHCs could not be DISTANT SITES
- Patient had to be an ESTABLISHED patient within the last 3 years
- AUDIO VISUAL platform used had to be HIPAA compliant

DURING THE PHE:

- Geographic requirements for originating site removed. ORIGINATING SITE is wherever the patient happens to be WITHIN THE USA
- CMS stated they would not audit to check if patient met the established patient requirement
- Provider is allowed to be DISTANT SITE wherever they are within the USA. Provider and patient cannot be in the same location to meet requirement of "telehealth visit".
- HIPPA compliance waived during PHE. Can use any video conferencing tool except front facing such as Tik Tok and Facebook Live.
- Number of codes allowable via telehealth increased markedly

5 months POST COVID PHE:

- Some telehealth codes have been made permanent, others in temporary bucket until end of 2023 to be evaluated for permanency.
- By changing the definition of "mental health services", CMS removed the geographic restriction on telehealth provision of mental health services and has allowed all eligible providers and FQHCs and RHCs to use Audio only and Audio-Visual modality as distant site providers for mental health for established patients provided certain criteria are met. (6 and 12 months in-person rule which does not go into effect until 5 months post PHE).
- Patients undergoing treatment for Substance Use Disorder and Opioid Use Disorder can have Audio Only and Audio Visual Services for their diagnosis in their home per legislation (SUPPORT ACT) previous to the PHE.

NOTE: BILLING AND CODING/COST SHARING MEDICARE AUDIO VISUAL VISITS: Modifiers will signify that the visit was provided via telehealth

Details here are largely dependent on whether patient has traditional Medicare or managed care. Also depends on whether they are receiving care through a provider clinic, RHC or a FQHC, Critical Access Hospital, ER, Urgent Care or a Hospital Without Walls. It is also important to know when the patient is being seen for symptoms or issues related to COVID-19 as modifiers and cost-sharing potentially changes.

- *** Please see **WV Telehealth Insurance Log Spreadsheet** for more details

MEDICARE AUDIO VISUAL CODES: Use Evaluation and Management Coding **(99202 to 99205, 99211-99215**) BASED ON MEDICAL DECISION MAKING OR TIME-BASED CODING (USING TIME SPENT BEFORE THE VISIT, DURING THE VISIT AND AFTER THE VISIT ON THE DATE OF SERVICE). History and Physical Exam elements are not required but appropriate should be carried out.

IF TIME BASED CODING IS USED (ALL TIME ON DATE OF SERVICE)

- NEW PATIENTS
  - 99202: 15-29min
  - 99203: 30-44 min
  - 99204: 45-59 min
  - 99205: 75-89min
- ESTABLISHED PATIENTS
  - 99211: 5-9 min
  - 99212: 10-19 min
  - 99213: 20-29 min
  - 99214 30-39min
  - 99215 40-59 min

AUDIO-VISUAL NON-MEDICARE: WV MEDICAID, PEIA, COMMERCIAL INSURERS:

Legislative law WV House Bill 2024: AS OF March 30, 2021 **(*Passed and Permanent*) APPLIES TO PEIA and commercial payors and some applies to WV Medicaid.**

Insurance Coverage for Telehealth Services: 5-16-7(b) **Signed** April 9, 2021 but effective March 30, 2021

- PEIA, Commercial Insurers: After July 1, 2020, Telehealth services will be covered if those same services are covered through face-to-face consultation by the policy.
- PEIA, Commercial Insurers: After July 1, 2020, plan may not exclude a service for coverage solely because the service is provided through telehealth services.
- PEIA, Commercial Insurers, WV Medicaid: **"Virtual telehealth"** means a new patient or follow-up patient for acute care that does not require chronic management or scheduled medications. The plan, which issues, renews, amends, or adjusts a plan, policy, contract, or agreement on or after July 1, 2021, shall provide reimbursement for a telehealth service at a rate negotiated between the provider and the insurance company for **virtual telehealth** encounters.
- PEIA, Commercial Insurers, WV Medicaid: **"Telehealth services"** means the use of synchronous or asynchronous telecommunications technology or audio only telephone calls by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include e-mail messages, or facsimile transmissions. The plan, which issues, renews, amends, or adjusts a plan, policy, contract, or agreement on or after July 1, 2021, shall provide reimbursement for a **telehealth service for an established patient**, or care rendered on a consulting basis to a patient located in an acute care facility whether inpatient or outpatient on the same basis and at the same rate under a contract, plan, agreement, or policy as if the service is provided through an in-person encounter rather than provided via telehealth.
- PEIA, Commercial Insurers: No annual or lifetime dollar maximum on coverage for telehealth services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy
- PEIA, Commercial Insurers: An originating site may charge the plan a site fee.

- PEIA, Commercial Insurers: The coverage required by this section shall include the use of telehealth technologies as it pertains to medically necessary remote patient monitoring services to the full extent that those services are available.

WV MEDICAID SPECIFIC INFORMATION:

- Use 99201-99205 and 99211-99215. **Do not use 99441-99443 for audio-only visits
- If visit is coded on a HCFA 1500 form no modifier is needed.
- If visit is coded on a UB04 add the GT modifier.
- USE POS 10 for telehealth service with patient in their home. POS 02 for telehealth in all other locations.
- FOR RHC: use T1015 code and regular E/M codes with POS 02 with modifier GT
- OT, PT and Speech telehealth visits also covered.
- Medicaid Managed Care may provide more rules and guidance

WV House Bill 2024 states TELEHEALTH VISITS MUST INCLUDE:

1. Verify the identity and location of the patient.
2. Provide the patient with confirmation of the identity and qualifications of the physician
3. Provide the patient with the physical location and contact information of the physician
4. Establish or maintain a physician-patient relationship which conforms to the standard of care
5. Determine whether telemedicine technologies are appropriate for the patient presentation for which the practice of medicine is to be rendered
6. Obtain from the patient appropriate consent for the use of telemedicine technologies
7. Conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the patient presentation
8. Create and maintain health care records for the patient which justify the course of treatment and which verify compliance with the requirements of this section; and
9. The requirements of §30-3-13(a)(1) through §30-3-13(a)(8) of this code do not apply to the practice of pathology or radiology medicine through store and forward telemedicine.

FQHC and RHCS and TELEHEALTH

CODING FOR VIRTUAL SERVICES IN RURAL HEALTH CLINICS (RHC) AND FEDERALLY QUALIFIED HEALTH CENTERS(FQHC)

Rural Health Clinics (RHCs) are special:

- **BEFORE PHE:** RHCs could not act as distant sites.
- **During PHE**: RHCs can bill for distant site telehealth visits.
- RHC Jan 27 to June 30, 2020: Use G2025 with CG mod +/- mod 95. Paid at the RHC AIR. Can be either Originating (RHC) or Distant site.
- These claims will be automatically reprocessed in July 2020, when the Medicare claims processing system is updated with the new payment rate.
- July 1, 2020 forward: G2025 NO MODIFER. RHCs and do not need to resubmit these claims for the payment adjustment and will be paid $92.03.
- Effective March 6, 2020: Costs for furnishing distant site telehealth services will not be used to determine the RHC AIR rate but must be reported on the appropriate cost report form. RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled "Cost Other Than RHC Service".
- **5 months POST PHE:** Can be distant site providers with Audio Visual or Audio Only (if provider capable of AV and the patient choses audio only or if incapable of using AV) **for mental health services for Medicare patients.** Must have qualifying in-person visit within 6 months of first telehealth visit and within 12 months of every telehealth visit thereafter. **Medicare has not given details as to how to code and bill or on eligible providers as of Jan 26, 2022. Other Audio Only services will not be covered unless using G2251 to G2253 (not considered telehealth, falls in**

category of communications technology-based services). RHCs not reimbursed for ANY OTHER TELEHEALTH visit 5 months post PHE unless Congress acts

- **WV Medicaid allows RHC to act as distant site telehealth audio or audio-visual for mental health services only by psychiatrist or psychologist Post PHE.**

Federally Qualified Health Centers (FQHCs) are special too:

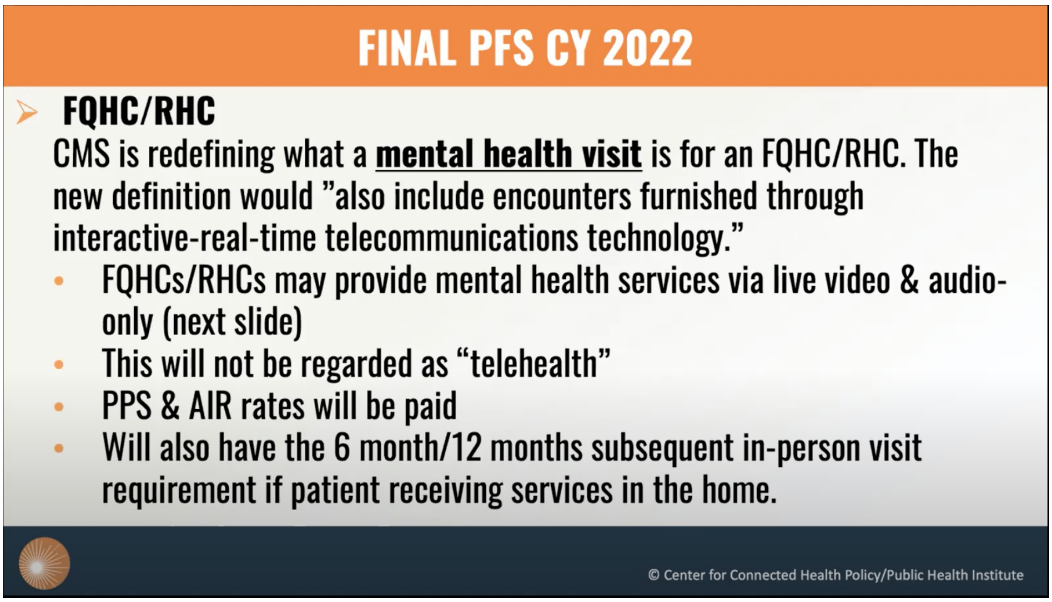
- **BEFORE COVID 19:** FQHCs could not act as distant sites
- During COVID 19 Pandemic, FQHCs can bill for distant site telehealth visits.
- For telehealth distant site services furnished between January 27, 2020, and June 30, 2020, that are also FQHC qualifying visits, FQHCs must report three HCPCS/CPT codes for distant site telehealth services:
    - 1. the FQHC Prospective Payment System (PPS) specific payment code (GO466, G0467, G0468, G0469, or G0470)
    - 2. the HCPCS/CPT code that describes the services furnished via telehealth with modifier 95 and
    - 3. G2025 with modifier 95 AND the E and M appropriate code. These claims will be paid at the FQHC PPS rate until June 30, 2020, and automatically reprocessed beginning on July 1, 2020, at the $92.03 rate. FQHCs do not need to resubmit these claims for the payment adjustment
- Costs for furnishing distant site telehealth services will not be used to determine the FQHC PPS rate but must be reported on the appropriate cost report form.
- FQHCs must report both originating and distant site telehealth costs on Form CMS-224-14, the Federally Qualified Health Center Cost Report, on line 66 of the Worksheet A, in the section titled "Other FQHC Services".
- **5 months POST PHE:** Can be distant site providers with Audio Visual or Audio Only (if provider capable of AV and the patient choses audio only or if incapable of using AV) for mental health services for Medicare patients. Must have qualifying in-person visit within 6 months of first telehealth visit and within 12 months of every telehealth visit thereafter. **Medicare has not given details as to how to code and bill or on eligible providers as of Jan 26, 2022. Other Audio Only services will not be covered unless using G0071 (not considered telehealth, falls in category of communications technology-based services). FQHCs not reimbursed for ANY OTHER TELEHEALTH visit 5 months post PHE unless Congress acts.**
- **WV Medicaid allows FQHC to act as distant site telehealth audio or audio-visual for mental health services <u>only by psychiatrist or psychologist starting 5 months Post PHE</u>.**

RHC/FQHC: TYPES OF TELEHEALTH DURING PUBLIC HEALTH EMERGENCY

- DEFINE ORIGINATING VS DISTANT SITE DESIGNATION (Coding and reimbursement is different)
- RHCs/FQHCs can be DISTANT SITES during the COVID 19 Waiver (Home, Office etc)
- TELEHEALTH TELEPHONE ONLY (G2025) $92
- TELEHEALTH AUDIO/VIDEO (G2025) $92 RHC AND (G0466-G0470) with E and M code and Modifier for FQHCs before July 1, 2020. Only G2025 after July 1, 2020
- E VISITS (G0071) $24.73

FQHC/RHC MENTAL HEALTH VISIT CODING AND BILLING POST PHE

From CCHP Jan 2022.



CODING OTHER DIGITAL/VIRTUAL SERVICES NOT CONSIDERED TO BE TELEHEALTH

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MOBILE HEALTH: Mobile health or mHealth: new, exciting and rapidly evolving aspect of technology-enabled health care, is the provision of health care services and personal health data via mobile devices. Coding/Billing determined by what information is exchanged and modality used.

REMOTE PHYSIOLOGIC MONITORING: These are considered Communications Technology-Based Services (CTBS). Coding and Billing to be described in Integrated Program Section. Still under E and M services but now Care Management Services as of 2022. **THIS IS NOT TELEHEALTH**. No modifier is required. POS is where the service was provided.

Remote physiologic monitoring (RPM) uses digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers. Consent required. Must be a medical device per Section 201(h) of the FDA and data must be electronically (automatically) collected and transmitted rather than self reported. Device supplied to the patient as part of RPM services. Example: CGM via smartphone upload direct to EHR.

CODING AND BILLING MEDICARE FOR REMOTE PHYSIOLOGIC MONITORING (Classified at E and M codes) *** Estimated Expected payment may not be accurate**

RPM CODE	WHO PERFORMS?	WHAT IS DONE?	WHAT DOES IT PAY? (AVG NAT)*	WRVUs
99453	Non-clinical staff Clinical staff Or Health Care Provider	Enrollment of patient with consent, initial set up of device, training on use of medical device recognized by the FDA and ordered by qualified health care professional.	Practice expense code: Bill once when initiating RPM service. Expected 2022 Payment: $19.04	0.00
99454	Non-clinical staff Clinical staff Or Health Care Provider	Provision of device used for monitoring. Device must be uploaded electronically remotely to clinician (does not say direct to EHR). **Device cannot be "lease to own" or owned by patient.**	Billed once every 30 days but requires at least 16 days of recording from device. Expected 2022 payment: $55.72	0.00
99457	Incident to Clinical staff Health care provider	At least 20min per month of time spent on remote monitoring of patient's physiologic data as part of care plan. Requires some form of communication of interpretation of monitoring with patient or caregiver via text, email, messaging, phone. Can be billed separately and in addition to CCM billing. In documentation: Need documentation of time spent by team members and what they monitored. Need treatment plan from provider: Give summary of monitoring, dx, ST and LT goals.	Once per calendar month no matter how many parameters are monitored. Standard Rates:2022 $50.18 non facility $32.84 facility CAN REPORT WITH CCM AND TCM	0.61
99458	Incident to Clinical Staff Health care provider	Each additional 20min per month of time spent on remote monitoring of patient's physiologic data as part of care plan.	Once each calendar month. Standard reimbursement: $40.84 non facility $32.84 facility	0.61
Potential revenue per patient per month with supply of device			$19.04 at start, then 20min $105.90 40 min $146.74 Per patient per month	0.61 to 1.22 WRVU
Potential revenue per patient wo			$19.04 to start, then 20min $50.18 40 min $40.84 per patient per month	0.61 to 1.22 WRVU

supply of device				
99091 (Allows for patient to upload to their computer or smartphone then transmit results)	Patient or caregiver stores and transmits to physician or qualified healthcare provider and does not need to come from an FDA defined device. Example: Home glucose monitoring device used multiple times and uploaded to patient computer then summarized in a secure email or text message and transmitted to provider for download and view.	**Need consent from patient** and ABN. Initial provider service has to be in physician office. Collection and interpretation of data 30min each 30 days. (EKG, BP, BS). **Provider does not need to communicate with patient after interpretation of data but at least one communication with patient to provide medical management and monitoring recommendation takes place.** Note: In reality, with the amount of time spent, it would be better have office visit or telehealth to discuss to bill these services as a 99213.	$56.41 (non-facility and facility) Expected payment 2022 CANNOT REPORT WITH 99457 or 99458 CAN report with TCM and CCM	1.10 WRVU
Potential Revenue per patient with 99091			Expected Potential revenue 2022: $59.41 per month	1.10 WRVU

REMOTE THERAPEUTIC MONITORING: **These are considered Communications Technology-Based Services (CTBS). Coding and Billing to be described in Integrated Program Section.**
DEFINITION: Designed for management of patients using medical devices that **collect non-physiological data** which indicates therapy/medication adherence or response. For example, the number of times an MDI inhaler is used to treat asthma per week. Even pain level scores could technically be recorded and monitored with RTM. However, at this time CMS has limited the conditions to respiratory and MSK and did not include an "agnostic condition" code to allow practices to supply patients with device and education to record non-physiologic data for other conditions. CMS expects these codes as primarily being billed by physiatrists, nurse practitioners, physical therapist and other eligible practitioners who cannot currently bill for RPM as RPM is and E and M code. Codes could be available to physicians and eligible providers: PT, OT, ST, PA, APRN, clinical social workers. Unlike RPM, RTM codes for device supply, education and monitoring are not time dependent. RTM requires the use of a medical device as defined under the federal Food, Drug, and Cosmetics Act (i.e., not merely a wellness device). CPT codes 98975, 98976, and 98977 require the RTM device to monitor at least 16 days of data per each 30-day period, in total. RTM data can be self-reported by the patient, as well as digitally uploaded via the device. While RTM codes still require the device used to meet the FDA's definition of a medical device, **self-reported RTM data via a smartphone app or online platform classified as Software as a Medical Device (SaMD) may qualify for reimbursement, according to CMS.**

REMOTE THERAPEUTIC MONITORING CODING AND BILLING (classified as general medical codes not E and M codes) Go Live is Jan 1, 2022.

RPM CODE	WHO PERFORMS?	WHAT IS DONE?	WHAT DOES IT PAY? (AVG NAT)	WRVUs
98975	Ordered by a provider, Carried out by Physicians and eligible health care provider. Can use clinical staff with **direct supervision**, not incident to.	PROVISION OF DEVICE: Remote therapeutic monitoring (e.g. respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment	Expense only code. BILL ONCE PER TREATMENT EPISODE (onset of RTM to when patient meets goals) Expected 2022 payment: $19.38	NONE

98976	Ordered by a Provider. Carried out by Physicians and eligible health care provider. Can use clinical staff with **direct supervision**, not incident to.	**Limited to respiratory conditions only.** Remote therapeutic monitoring (e.g. respiratory system status, musculoskeletal system status, therapy adherence, therapy response); **device(s) supply with scheduled (e.g. daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days, (must monitor for at least 16 days)**	Expense only code Expected 2022 payment: $55.72	NONE
98977	Ordered by a provider. Carried out by Physicians and eligible health care provider. Can use clinical staff with **direct supervision**, not incident to.	**Limited to MSK conditions only.** Remote therapeutic monitoring (e.g. respiratory system status, musculoskeletal system status, therapy adherence, therapy response); **device(s) supply with scheduled (e.g. daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days (must monitor for at least 16 days)**	Expense only code Expected 2022 payment: $55.72	NONE
98980	Physicians and eligible health care provider. Can use clinical staff with **direct supervision**, not incident to.	Remote therapeutic monitoring treatment, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; **first 20 minutes**	Professional fees Bill once per month Expected 2022 Payment: $50.18	NONE
98981	Physicians and eligible health care provider. Can use clinical staff with **direct supervision,** not incident to.	Remote therapeutic monitoring treatment, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; **each additional 20 minutes**	Professional Fees Bill once per month Expected 2022 Payment: $40.84	NONE

MEDICARE VIRTUAL VISIT by PROVIDER:(**Medicare established patients only):**

- **G2251-G2253 VIRTUAL CHECK IN (5-10 min, 11-20min, 21-30min) RHC /FQHCs G0071, ~$24.73,**
- **USE POS 02.**
- Definition: Meant only **for established** patients with face-to-face visit within the last 12 months. **NOT MEANT TO REPLACE AN IN-PERSON VISIT.** There can be no visit in the last 7 days in the next 24 hours for the same issue. Platform can be telephone, portal, secure text or email or audio-visual. Brief communication technology-based service by a physician or other health care professional who can report E/M services, provided to an established patient, not originating from a related E/M service or procedure with the last 7 days and not leading to an E/M service or procedure within the next 24 hours or soonest apt.

MEDICARE VIRTUAL VISIT by Non-Physician Qualified Health Care Professional:

- **98966-98968 (5-10 min, 11-20min, 21-30min)**

- **Definition: Established patients. Not meant to replace an in-person encounter.** Definition: Meant only **for established** patients with face-to-face visit within the last 12 months. **NOT MEANT TO REPLACE AN IN-PERSON VISIT.** There can be no visit in the last 7 days in the next 24 hours for the same issue. Platform can be telephone, portal, secure text or email or audio-visual. Brief communication technology-based service by a qualified non-physician health care professional provided to an established patient, not originating from a related E/M service or procedure with the last 7 days and not leading to an E/M service or procedure within the next 24 hours or soonest apt.

STORE AND FORWARD:

- **G2250, (5-10 min, $13, 0.18 WRVU) RHC/FQHCs G0071, ~$24.73, POS 02.** Store-and-forward allows electronic transmission of medical information, such as digital images, documents, and pre-recorded videos through secure email or portal communication. Example: Picture of rash messaged to EHR Portal messaging or through direct email. Remote evaluation of recorded video and/or images submitted by an established patient including interpretation 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.

E-VISITs:

Definition: Meant to be digital interaction with patient via the EHR PORTAL between regular visits. They do not replace a regular visit. Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days,

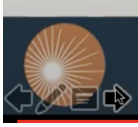
- **MD, DO, NP, PA, Nurse Midwife:**
  - **99421: 5-10 min: AVG reimbursement $14.50**
  - **99422: 11-20min: AVG reimbursement $31**
  - **99423: 21 or more min: AVG reimbursement $50**
- **Qualified non-physician healthcare professional online assessment and management**
  - 98970: 5-10 min
  - 98971: 11-20min
  - 98972: 21 or more min
- **Qualified non-physician healthcare professional online assessment and management: Such as Licensed psychologist or social worker:**
  - **G2061: 5-10min**
  - **G2062: 11-20 min**
  - **G2063: 21 or more min.**

OTHER Fee for Service Coding changes for CY 2022 *From CCHP Jan 2022*

FINAL PFS CY 2022

Other Changes

- Allow Opioid Treatment Programs (OTPs) to use audio-only to furnish therapy and counseling when live video not available to beneficiary after the PHE over. Modifier 95 will need to be used to claims for the counseling and therapy add on code G2080, but not when included in the weekly bundle and for when using live video. After the PHE, OTPs will need to document audio-only was used in patient medical record and along with a modifier. The latter requirement would apply to services taking place after PHE.
- During the PHE, CMS allowed for certain in-person supervision requirements or the availability of the supervisor in-person to be provided virtually through telehealth. After soliciting comments, CMS. Has decided that it will consider addressing the concerns raised in future rules or guidance.
- Originating site facility fee will be $27.59
- CMS is allowing for inclusion of 99441, 99442 and 99443 in the definition of primary care services used for beneficiary assignment until no longer payable under the physician fee schedule fee for service payment policies under the Shared Savings program for ACOs
- CMS declines to add telephone codes 99441-99443 as permanent services that will be reimbursed
- Medical nutrition therapy (MNT) and diabetes self-management training (DSMT) services may be provided as telehealth services when registered dietitians or nutrition professionals act as distant site practitioners.



COMPARISON of PAYMENT FOR VIRTUAL SERVICES
(AVG national reimbursement)

TIME SPENT	VIRTUAL VISIT G2010-G2012 AVG CMS reimbursement	TELEHEALTH VIDEO/AUDIO AVG CMS reimbursement	E-VISIT AVG CMS Reimbursement	TELEPHONE ONLY 99441-99443 AVG CMS reimbursement
5-10min	$15/0.25 wRVU	99211 5-9min $23.46 WRVU 0.18 G2025 $92 RHC/FQHC	99421 $14.50 G2061 G0071 $24.73 RHC/RQHC	5-10 min $14.4/$44 (after April 30, 2020) wRVU 0.70 (after Jan 1, 2021) G2025 $92 RHC/FQHC
11-20 min	N/A	99212 10-19min $46.19 WRVU 0.70 G2025 $92 RHC/FQHC	99422 $31 G2062 G0071 $24.73 RHC/RQHC	11-20 min $28.15/$74 (after Apr 30, 2020) wRVU 1.30 (after Jan 1, 2021) G2025 $92 (RHC/FQHC)
21-30 min	N/A	99213 20-29min $76.15 WRVU 1.30 G2025 $92 RHC/FQHC	99423 $50 G2063 G0071 $24.73 RHC/RQHC	21 min and greater $41.14/$110(After April 30, 2020) wRVU 1.92 (after Jan 1, 2021) G2025 $92 (RHC/FQHC)
>30		99214 30-39min $110.43 WVU 1.92 G2025 $92 RHC/FQHC		

*** Notice, according to new E and M billing guidelines Jan 2021, when billing by time spent (excluding RHCs/FQHCs), Audio only Medicare Telehealth is paying more and awarding more WRUVs than for equal time spent for in-person visits.