Coding & Billing Telehealth Services

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The year is 2016, and we live in an age of technology. Instead of sending a letter and waiting for a written response (now called "snail mail"), we can email, text, tweet, snapchat, facebook, or otherwise immediately share information, pictures, opinions, activities, and our current location on earth. The world of medicine has been altered by the advent of electronic health records (EHRs), patient portals, and the transfer of data from one program to another. It is only natural that the next step in this process is the implementation of telehealth or telemedicine programs. According to the American Telemedicine Association:[1]

"Formally defined, telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. Telemedicine includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools, and other forms of telecommunication technology."

Patient consultations via videoconferencing, transmission of still images, and e-health, including patient portals, remote monitoring of vital signs, continuing medical education, consumer-focused wireless applications, and nursing call centers, among other applications, are all considered part of telemedicine and telehealth.

However, in order to be reimbursed for telehealth services, specific criteria must be met and unique procedure codes and modifiers must be appended to identify the services performed.

Medicare Coverage

On May 5, 2011, the Centers for Medicare & Medicaid Services (CMS) published a Final Rule (76 FR 25550) that was effective July 5, 2011, governing the agreements under which a hospital or Critical Access Hospital (CAH) may provide telemedicine services to its patients.[2] CMS defines "telemedicine" in this context to mean the provision of clinical services to patients by physicians and qualified practitioners from a distance via electronic communications.

According to CMS, Medicare Part B pays for a limited number of services furnished by a physician or qualified nonphysician healthcare practitioner to an eligible beneficiary via a telecommunications system.[3] The agency adds that when the telehealth service is eligible for payment, the telecommunications system substitutes for an in-person encounter.

There has been a long-standing hope that telehealth could be used to reduce rural patients' travel time to specialty physicians. Medicare covers telehealth services provided through live, interactive videoconferencing between a beneficiary located at a certified rural site and a distant practitioner. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:

- A Rural Health Professional Shortage Area (HPSA) located either outside a Metropolitan Statistical Area (MSA) or in a rural census tract; or
- A county outside of an MSA.

The Health Resources and Services Administration (HRSA) determines HPSAs, and the U.S. Census Bureau determines MSAs. A web-based tool, cms.gov/Medicare/Medicare-General-Information/Telehealth/, can help determine a potential originating site's eligibility for Medicare telehealth payment.

The term "originating site" means the location of the eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Each calendar year, the geographic eligibility of an originating site is established based on the status of the area as of December 31 of the prior calendar year; the eligibility then continues for the full calendar year. The one exception is healthcare entities that participated in a federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of Dec. 31, 2000; these locations qualify as originating sites regardless of geographic location. The originating sites authorized by law are:

- The office of physicians or practitioners
- Hospitals
- Critical Access Hospitals
- Rural health clinics
- Federally qualified health centers
- Hospital-based or CAH-based renal dialysis centers (including satellites)
- Skilled nursing facilities (SNFs)
- Community mental health centers (CMHCs).

The term "distant site" means the site where the physician or practitioner providing the professional service is located at the time

(*continued on page 14*)

Table 1. Sample Write-Off Report

CODE	DESCRIPTOR
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832–90838	Psychotherapy with patient and/or family
90845	Psychoanalysis
90846, 90847	Family psychotherapy
90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961	Monthly ESRD-related services
90963–90966	ESRD home dialysis services
96116	Neurobehavioral status exam, per hour
96150–96154	Health and behavior assessment and/or intervention
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	Medical nutrition therapy; reassessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes
99201–99205	Evaluation and management of new patient
99211–99215	Evaluation and management of established patient
99231–99233	Subsequent hospital care
99307–99310	Subsequent nursing facility care
99354–99357	Prolonged services
99495–99496	Transitional care management
G0108–G0109	Diabetes outpatient self-management training
G0270	Medical nutrition therapy, reassessment, and subsequent interventions following second referral in same year for change in diagnosis, medical condition, or treatment regimen, group (2 or more individuals), each 30 minutes
G0396, G0397	Alcohol and/or substance abuse structured assessment
G0406–G0408	Follow-up inpatient consultation, communicating with the patient via telehealth
G0420, G0421	Chronic kidney disease educational services
G0425–G0427	Telehealth consultation, emergency department or initial inpatient
G0436, G0437	Smoking and tobacco cessation counseling, asymptomatic patient
G0438, G0439	Personalized prevention plan of service
G0442	Annual alcohol misuse screening
G0443	Brief face-to-face behavioral counseling for alcohol misuse
G0444	Annual depression screening
G0445	Semiannual high-intensity behavioral counseling to prevent STIs
G0446	Annual intensive behavioral therapy for cardiovascular disease
G0447	Behavioral counseling for obesity
G0459	Inpatient telehealth pharmacologic management

(*continued from page 12*)
the service is provided via the telecommunications system.[4] Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to state law) include:

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

Of note, CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under a Medicare telehealth program (CPT codes **90792**, **90833**, **90836**, or **90838**). In addition, for End Stage Renal Disease (ESRD)-related services, a physician, NP, PA, or CNS must furnish at least one face-to-face "hands on" visit each month to examine the vascular access site.

As a condition of payment, the provider must use an interactive audio and video telecommunications system that permits real-time communication between the provider at the distant site and the beneficiary at the originating site. (Asynchronous "store and forward" technology is permitted only in federal telemedicine demonstration programs conducted in Alaska or Hawaii.)

Medicare Claims

Professional claims for telemedicine are submitted to Medicare in the same manner as claims for face-to-face services, with the appropriate modifier appended. Medicare then reimburses the fee schedule amount for the service performed, with the exception that physicians who have assigned their billing rights to a CAH will receive 80 percent of the fee schedule amount for telehealth services. In addition, CMS publishes additions or deletions to the services defined as covered for telehealth effective Jan. 1 each calendar year. For calendar year 2016, professional telehealth services are billed using one of the CPT® procedure codes included in Table 1, page 13, along with the following telehealth modifier:

- **GT:** Via interactive audio and video telecommunications systems.

By coding and billing a service with the GT modifier, the provider is certifying that the beneficiary was present at an eligible originating site while the billing provider furnished a telehealth service. For federal telemedicine demonstration programs conducted in Alaska or Hawaii, the modifier is:

- **GQ:** Via asynchronous telecommunication systems.

By reporting modifier **GQ**, the provider is certifying that the asynchronous medical file was collected and transmitted to the distant site from a federal telemedicine demonstration project conducted in Alaska or Hawaii.

Originating sites bill their Medicare contractor as well and are paid an originating site fee for telehealth services using the following HCPCS code:

- **Q3014:** Telehealth originating site facility fee.

If a hospital enters into an agreement for telemedicine services with a distant-site hospital or telemedicine entity, the agreement must be in writing. According to Appendix A of the State Operations Manual:[5]

"The hospital's governing body must grant privileges to each telemedicine physician or practitioner providing services at the hospital under an agreement with a distant-site hospital or telemedicine entity before they may provide telemedicine services. The scope of the privileges in the hospital must reflect the provision of the services via a telecommunications system. For example, a surgeon at a distant-site hospital may provide telemedicine consultation services at a hospital under agreement, but obviously would not be able to perform surgery by this means and must not have surgical privileges in the hospital as part of his/her telemedicine services privileges. If the surgeon also periodically performed surgery on-site at the hospital, then he or she would have to have privileges to do so, granted in the traditional manner provided for at §482.12(a)(1) through §482.12(a)(7) and §482.22(a)(1) and §482.22(a)(2)."

The Medicare & Medicaid Research Review 2013: Volume 3, Number 4, a publication of the CMS Office of Information Products and Data Analysis, includes the following comments regarding telehealth services:[6]

"Of the relatively few telehealth services provided to Medicare beneficiaries, the most common services are mental health services, including pharmacological management.

While telehealth can improve access for isolated rural beneficiaries, it has also been used to provide in-home care for urban individuals who could not travel for face-to-face care. For some of these patients who are in close proximity to a provider who can provide face-to-face visits, the additional costs associated with telehealth visits may not be justified."

Other Insurers

State laws surrounding telehealth or remote consultations are convoluted at best, with many states failing to weigh in on mandated third-party coverage. Some insurers that provide payment for telehealth services do so through partnerships with companies such as TelaDoc, RelayHealth, and MDLive in order to control expenses. As a result, providers may find it necessary to review state laws and regulations, as well as private payer policies relating to telehealth services.

Not Telehealth—Electronic Patient Encounters

Even if the facility or office does not meet the requirements for a telehealth program,

procedure codes exist for telephone and telephone/internet encounters. The following telephone services codes report care provided by a physician or nonphysician healthcare professional to an established patient, at the request of the patient:

- **99441:** Telephone assessment and management service provided by a physician or other qualified healthcare professional who may report evaluation and management services to an established 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: 5-10 minutes of medical discussion
- **99442:** 11-20 minutes of medical discussion
- **99443:** 21-30 minutes of medical discussion.

In addition to the codes listed above, the following set of procedure codes are reported for telephone assessments performed by healthcare professionals that do not separately bill insurance, such as social workers or dietitians:

- **98966:** Telephone assessment and management services provided by a qualified nonphysician healthcare professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- **98967:** 11-20 minutes of medical discussion
- **98968:** 21-30 minutes of medical discussion.

Medicare does not pay separately for these telephone assessment and management services and many non-governmental payers consider these services to be bundled into any face-to-face care provided.

In addition, there are a set of procedure codes for telephone/internet assessment and management services between the patient's treating physician and a physician with specialty expertise:

- **99446:** Interprofessional telephone/internet assessment and management service provided by a consultative physician, including verbal and written report to the patient's treating physician or other qualified healthcare professional: 5-10 minutes of medical consultative discussion and review
- **99447:** 11-20 minutes of medical consultative discussion and review
- **99448:** 21-30 minutes of medical consultative discussion and review
- **99449:** 31 minutes or more of medical consultative discussion and review.

As with the codes for telephone discussion, Medicare does not pay separately for these electronic consultative services. However, other payers may reimburse for these services. In addition, providers may also be able to use this information to negotiate alternative payment arrangements for services. These interprofessional services are typically provided in complex or urgent situations where a timely face-to-face service with the consultant may not be possible. When the sole purpose of the telephone/internet communication is to arrange a transfer of care or otherwise refer the patient, these codes are not reported.

The Future of Telehealth

An example of current telehealth activities is the Cleveland Clinic mobile stroke treatment unit (MSTU) that provides treatment faster than patients receive in the Emergency Department (ED).[7] MSTU is equipped with a mobile CT system and staffed by a registered nurse, paramedic, EMT, and CT technologist. In addition, a vascular neurologist is available to evaluate patients via telemedicine and a neuroradiologist immediately reviews images transmitted from the mobile CT. Time from the door to thrombolysis (breakdown of blood clot) was 32 minutes for the MTSU, as opposed to 58 minutes in the ED. If it is feasible to perform prehospital stroke evaluation and treatment using a telemedicine-enabled mobile unit, the only limit to telemedicine's use may be the availability of insurance payer reimbursement.

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