



Adirondack Health Institute

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2020 Telehealth Billing and Reimbursement Updates

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- Session will be recorded for future access and link will be sent out in the next few days.
- We will take questions throughout the session through the Q & A box on your GoToWebinar dashboard. All questions will be answered at the end of the webinar.



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Billing Definitions

- **GT Modifier:**
 - Modifier used after appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code to indicate visit was using interactive audio and video telecommunication systems. Only for use with those services provided via synchronous telemedicine when modifier 95 cannot be used.
- **GQ Modifier:**
 - Modifier used after appropriate CPT or HCPCS code to indicate visit was using store and forward/asynchronous technology.
- **95 Modifier:**
 - This modifier can only be appended to specific services covered by Medicaid and listed in Appendix P of the AMA's CPT Professional Edition 2018 Codebook.
- **25 Modifier:**
 - This modifier indicates a significant, separately identifiable E & M service by the same physician or other qualified healthcare professional on the same day as a procedure or other service.
- **Place of Service (POS) Code 02:**
 - Centers for Medicare & Medicaid Services (CMS) code for use by physician or practitioner furnishing telehealth services from a distant site. Providers must also bill with the modifiers listed above.



Inter-agency Guidance Document

- Inter-agency guidance document in development
 - DOH, OMH, OASAS, OPWDD
- Full NYS license/certification and current registration are required for telehealth practitioners.
- All laws, rules, regulations, standards and competencies apply:
 - SED professional scope of practice
 - Privacy and confidentiality
 - Patient consent and record-keeping



Agency Approval to Deliver Services via Telehealth

- No specific approval is needed from DOH or OPWDD
 - OPWDD regulations prohibit providers approved for the reimbursement of the IPSIDD (Independent Practitioner Services for Individuals with Developmental Disabilities) rate to provide services through telehealth.
 - OPWDD's Telehealth ADM will identify services that may be delivered via Telehealth.
- OMH and OASAS require agency approval of telemental health and telepractice, respectively.
 - OMH requires approval by the field office through submission of a written plan.
- OASAS requires approval for a certified program to become designated to provide telepractice services.
 - Telepractice services are limited.
 - Designation requires submission of a written plan and attestation.



Medicaid/DOH



Eligible hub/distant site practitioners:

- Physicians
- Physician assistants
- Nurse practitioners
- Dentists
- Podiatrists
- Optometrists
- Psychologists
- Social workers
- Audiologists
- Speech language pathologists
- Credentialed alcoholism and substance abuse counselors (CASAC) credentialed by OASAS
- Home care services agencies licensed under Article 36 of PHL
- Midwives
- Physical therapists
- Occupational therapists
- Certified Diabetes Educators
- Certified Asthma Educator
- Genetic counselors
- Registered professional nurses (for RPM only)
- Hospitals licensed under Article 28 of Public Health Law (PHL), including residential health care facilities serving special needs populations
- Hospices licensed under Article 40 of PHL
- Providers authorized to provide services and service coordination under the Early Intervention (EI) Program pursuant to Article 25 of PHL



Sites of Delivery:

- **Spoke/Patient Site:**
 - Article 28 facilities (general hospitals, nursing homes, diagnostic and treatment centers)
 - Article 40 facilities (hospice programs)
 - Facilities as defined in Subdivision 6 of Section 1.03 of the Mental Hygiene Law including clinics certified under Articles 16, 31, and 32
 - Clinics licensed or certified under Article 16 of MHL
 - Certified and non-certified day and residential programs funded or operated by OPWDD
 - Any type of adult care facility licensed under Title 2 of Article 7 of SSL
 - Private physicians' or dentists' offices located in NYS
 - Public, private and charter elementary and secondary schools located in NYS
 - School-age childcare programs located in NYS
 - Child daycare centers located within NYS
 - Other providers determined by the Commissioners of DOH, OMH, OASAS, or OPWDD pursuant to regulation
 - **The members place of residence located in NYS or other temporary location within or outside the state of NY**
- **Hub/Distant Site:**
 - Any secure location where the telehealth provider is located within the fifty United States or United States territories.



Telemedicine Consent

- Documentation in the medical record must reflect that the member was made aware of the policies outlined below.
- *Patient rights policies must ensure that members receiving telehealth services:*
 1. Have the right to refuse to participate in services delivered via telehealth and must be made aware of alternatives and potential drawbacks of participating in a telehealth visit versus a face-to-face visit;
 2. Are informed and made aware of the role of the practitioner at the distant site, as well as qualified professional staff at the originating site who are going to be responsible for follow-up or ongoing care;
 3. Are informed and made aware of the location of the distant site and all questions regarding the equipment, the technology, etc., are addressed;
 4. Have the right to have appropriately trained staff immediately available to them while receiving the telehealth service to attend to emergencies or other needs;
 5. Have the right to be informed of all parties who will be present at each end of the telehealth transmission; and
 6. Have the right to select another provider and be notified that by selecting another provider, there could be a delay in service and the potential need to travel for a face-to-face visit.



Medicaid Reimbursement - Telemedicine

Telemedicine:

- Only one clinic payment will be made when both the originating site and distant site are part of the same provider network/billing entity. In these cases, only the originating site should bill Medicaid for the telemedicine encounter.
- For dual eligible (Medicare and Medicaid), if Medicare covers the telehealth encounter, Medicaid will reimburse the Part B coinsurance and deductible to the extent permitted by state law. If Medicare does not cover the service provided via telehealth, Medicaid will defer to Medicare's decision and will not cover the telehealth encounter at this time.
- For Article 28 clinic originating sites (outpatient department/clinic, emergency room) billing under Ambulatory Patient Groups (APGs), the originating site may bill only CPT code Q3014 through APGs to recoup administrative expenses associated with the telemedicine encounter.
 - *When a separate and distinct medical service, unrelated to the telemedicine encounter, is provided by a qualified practitioner at the originating site, the originating site may bill for the medical service in addition to Q3014 and the service must be appended with the 25 modifier.*



Medicaid Reimbursement - FQHCs

Telemedicine Reimbursement for FQHCs that have not “opted into” APGs:

- When services are provided via telemedicine to a patient located at an FQHC originating site, the originating site may bill only the FQHC offsite services rate code (4012) to recoup administrative expenses associated with the telemedicine encounter.
- When a separate and distinct medical service, unrelated to the telemedicine encounter, is provided by a qualified practitioner at the FQHC originating site, the originating site may bill the Prospective Payment System (PPS) rate in addition to the FQHC offsite services rate code (4012). Append the CPT code with the 25 modifier.
- If a provider who is onsite at an FQHC is providing services via telemedicine to a member who is in their place of residence or other temporary location, the FQHC should bill the FQHC off-site services rate code (4012) and report the applicable modifier (95 or GT) on the procedure code line.
- If the FQHC is providing services as a distant site provider, *the FQHC may bill their PPS rate.*



Medicaid Reimbursement – Store & Forward

Store and Forward Technology:

- Pre-recorded videos and/or static digital images, *excluding radiology*, must be specific to the member's condition as well as be adequate for rendering or confirming a diagnosis or plan of treatment.
- Reimbursement will be made to the consulting distant-site practitioner. Reimbursement for consultations provided via store-and-forward technology will be paid at **75%** of the Medicaid fee for the service provided.
- The consulting distant site practitioner must provide the requesting originating site practitioner with a written report of the consultation in order for payment to be made.
- The consulting distant site practitioner should bill the CPT code for the professional service appended with the modifier GQ.



Medicaid Reimbursement – Remote Patient Monitoring

Remote Patient Monitoring (RPM):

- Medical conditions that may be treated/monitored by RPM include, but are not limited to, CHF, diabetes, COPD, wound care, polypharmacy, mental or behavioral health problems, and technology-dependent care such as continuous oxygen, ventilator care, total parental nutrition or enteral feeding.
- RPM must be ordered and billed by a physician, nurse practitioner, or midwife, with whom the member has or has entered into a substantial and ongoing relationship. RPM can also be provided and billed by an Article 28 clinic.
- RPM must be medically necessary and shall be discontinued when the member's condition is determined to be stable or controlled. Members must be seen in-person by their practitioner as needed for follow-up care.
- Payment for RPM while a member is receiving home health services through a Certified Home Health Agency (CHHA) is pursuant to PHL Section 3614 (3-c)(a-d) and will only be made to that same CHHA.



Medicaid Reimbursement – Remote Patient Monitoring

Remote Patient Monitoring (RPM):

- Telehealth services provided by means of RPM should be billed using CPT code 99091 (collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, and/or licensure/regulation when applicable, requiring a minimum of 30 minutes of time, each 30 days).
- A fee of **\$48.00** per month will be paid for RPM. To bill for RPM, a minimum of 30 minutes per month must be spent collecting and interpreting the member's RPM data.
- Providers are not to bill 99091 more than one time per-member, per-month.



OASAS & OMH



Addiction Services and Supports



Requests for designation to provide telepractice services shall be in the form of a written proposed plan and attestation, found in *Telepractice Standards for OASAS Designated Providers* posted on the agency website, and submitted by a certified provider to the Office Bureau of Certification and the Field Office serving the area in which the applicant site is located. Such Field Office may make an on-site visit to either or both linked sites prior to final approval and designation which will be issued by the Bureau of Certification.

Criteria such as confidentiality, privacy, patient rights, translation services, emergency situations, technology transmission failure, buprenorphine prescribing, and prescriber licensing and contracting must be addressed in the written plan and attestation.



Billing Guidelines: Once the originating site has received approval from OASAS to provide telepractice, claims can be submitted for government-approved APG rates and Medicaid managed care reimbursement if the program meets the below requirements:

- Practitioners must be licensed to practice in NYS and physically located anywhere in the U.S.; they must also be enrolled in NY Medicaid and be able to bill Medicaid. They must also be employed by the OASAS-designated provider or employed by another OASAS certified provider, OR they must have an executed contract or MOU to perform such services with the designated program.
- Programs should consult the most recent DOH Medicaid Update for information on billing, code modifiers, and any allowable additional fees (whether administration or facility).



Authorized Practitioners: Medical professionals with DEA approval to prescribe and administer buprenorphine (DATA 2000 waiver): Physicians, Physician Assistants, and Nurse Practitioners in Psychiatry.

- Clinical staff (CASACs recently added to PHL) credentialed and approved by the Office and acting within their scope of practice.
- *Does not include peer advocates and student interns.*

Additional Billing Guidelines: All patients must have at least one in-person evaluation session with clinical staff prior to participation in telepractice and a statement of informed consent must be obtained prior to receiving services. *Note: Induction for buprenorphine requires a preliminary face-to-face evaluation by a DATA 2000 waived prescribing professional. Clients can now be seen in their homes.*

Valid services include: Admission Assessments, Direct Transfers, Psycho-social Evaluations and Mental Health Consultations, Medication-Assisted Treatment Prescribing and Monitoring (federal restrictions may apply), and other services as approved by the Office. *Individual and group counseling can now be provided via telepractice.*



The NYS Office of Mental Health has amended Part 596 of Title 14 NYCRR to expand the use of *telemental health services* to now include all OMH-licensed programs, including Assertive Community Treatment (ACT) and Personalized Recovery Oriented Services (PROS).

A provider of services must obtain prior written approval of the Office before utilizing *telemental health services*. The written plan must include confidentiality protections, informed consent, procedures for assessing patients to determine whether a patient may be properly treated via telemental health services, procedures for handling emergencies, etc.



OMH – Approved Practitioners

The following telemental health practitioners are eligible to provide telemental health services:

- Physician
- Psychiatrist
- Nurse Practitioner in Psychiatry
- *Licensed Mental Health Counselor*
- *Marriage & Family Therapists*
- *Creative Arts Therapists*
- *Psychoanalysts*
- *Psychologist*
- *Social Worker (LCSW or LMSW)*





OMH – Approval in ACT and PROS Settings

- Approval in Personalized Recovery Oriented Services (“PROS”) setting:
 - Telemental health services may only be delivered in a PROS setting by psychiatrists and nurse practitioners in psychiatry. The spoke site will be the physical location of the PROS program in which the participant is enrolled.
 - Telemental health services may only be used for purposes of delivering PROS clinical treatment services for a limited period of time, not to exceed one year.
 - Upon demonstration of a continued shortage, such time may be extended for a period not to exceed one additional year and originating/spoke site is limited to the physical location of the PROS program in which the patient is enrolled.
- Approval for use in Assertive Community Treatment (“ACT”) teams:
 - Telemental health services may only be delivered within an ACT team by psychiatrists and nurse practitioners in psychiatry, where there is a demonstrated shortage of psychiatrists and nurse practitioners in psychiatry.
 - When ACT visit is conducted in the community, ACT staff must be present during the delivery of telemental health services.
 - Telemental health services may only be delivered for a limited period of time, not to exceed one year.
 - Upon demonstration of a continued shortage, such time may be extended for a period not to exceed one additional year.



OMH Regulation Changes

- The originating/spoke site is now anywhere the recipient is located in NYS, or other temporary location within/outside NYS. Examples of temporary locations may include college, extended visit out of state, etc.
- Mobile technology will now be allowed.
- Pan, tilt, zoom (PTZ) will not be a requirement within the regulation. It will remain within guidance as a strong recommendation.



Additional regulation changes include:

- Telemental health practitioners must verify the identity of the patient before commencing each telemental health encounter.
- A notation must be made in the clinical record that indicates the service was provided via telemental health and specifies the time the service was started and the time it ended.
- Telemental health services provided to patients under age 18 may include staff that are qualified mental health professionals, or other appropriate staff of the originating/spoke site in the room with the patient.
- Telemental health services shall not be used for purposes of ordering medication over objection, involuntary admissions, or for restraint or seclusion ordering.



- The originating/spoke site where the patient is admitted is authorized to bill Medicaid for telemental health services. Such services are covered when medically necessary and under the following circumstances:
 - The person receiving services is located at the originating/spoke site and the telemental health practitioner is located at the distant/hub site;
 - The person receiving services is present during the telemental health encounter or consultation;
 - The telemental health practitioner is not conducting the encounter or consultation at the originating/spoke site;
 - The telemental health practitioner at the distant/hub site is licensed in NYS, practicing within his/her scope, is affiliated with the originating/spoke site facility, and is credentialed and privileged if the originating/spoke site is a hospital.



OMH – Contracting Guidance

OMH licensed or designated programs looking to contract with a Telemedicine company must be approved by OMH to deliver services in this manner.

If the proposed contracted Telemedicine company is accredited by a generally accepted and nationally recognized telemedicine accrediting entity acceptable to the Commissioner of the NYS Office of Mental Health, OMH will accept accreditation as evidence of regulatory compliance for a subset of Part 596.

If the proposed contracted Telemedicine company has not be awarded the above noted accreditation, then the program must demonstrate how the contracted company and the practitioner will be compliant with all of Part 596.





Medicare



Eligible hub/distant site practitioners:

- Physician
- Physician Assistant
- Nurse Practitioner
- Nurse-Midwives
- Clinical Nurse Specialists
- Clinical Registered Nurse Anesthetists
- Clinical Psychologists and Clinical Social Workers
- Registered Dietitian or Nutrition Professionals



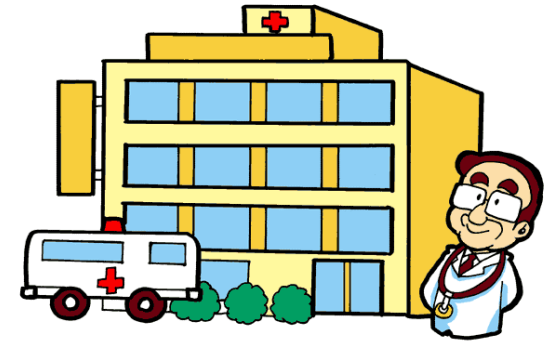
Eligible modalities:

- Telemedicine (live, interactive audio-visual communication)
- Store and forward (*only when used in Federal telemedicine demonstration programs in Alaska or Hawaii*)



Eligible spoke/patient sites:

- Reimbursement at originating sites is limited to Rural Health Professional Shortage Areas (HPSA) in a rural census tract, a county outside a Metropolitan Statistical Area (MSA), or demonstration pilots
- Offices of physicians or practitioners
- Hospitals
- Critical Access Hospitals (CAH)
- Rural Health Clinics
- Federally-Qualified Health Centers (FQHC)
- Hospital-Based or CAH-Based Renal Dialysis Centers (incl. satellites)
- Skilled Nursing Facilities (SNF)
- Community Mental Health Centers (CMHC)
- Renal Dialysis Facilities*
- Homes of beneficiaries with End-Stage Renal Disease (ESRD) receiving home dialysis*
- Mobile Stroke Units*
- Home of patient receiving treatment for SUD/ODU and co-occurring mental health disorders*



Note: Independent Renal Dialysis Facilities are not eligible originating sites.



Medicare Telehealth Expansion as of 1/1/2019

Telehealth Policy Only for Originating Sites

- Per the Bipartisan Budget Act of 2018 (H.R. 1892), Renal Dialysis Facilities, hospital-based or CAH-based renal dialysis centers, and the home will be allowable originating sites for end stage renal disease (ESRD) services only, such as clinical assessments related to home dialysis treatments.
- Acute stroke services via telehealth may take place in currently eligible originating sites and mobile stroke units, or any location deemed appropriate by the Secretary. The home is excluded in this case.
 - A new modifier will be created for acute stroke services via telehealth. That modifier will be “GO.”

Types of services and providers eligible to be reimbursed if providing these services via telehealth has not changed.



Medicare Telehealth Expansion as of 1/1/2019

Chronic Care Management – Not Called a Telehealth Service

- Codes added for remote physiological monitoring:
 - CPT Code 99453: Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment (technical component). No physician work is required to bill, this is reimbursement for the practice expense associated with furnishing RPM.
 - CPT Code 99454: Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate); device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days (Technical Component). No physician work is required to bill, this is reimbursement for the practice expense associated with furnishing RPM.
 - CPT Code 99457: Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month (Alternative to billing 99091 for professional services associated with RPM).



Medicare Telehealth Expansion as of 1/1/2019

Communication Technology-Based Services

- The following codes are services furnished remotely using communications technology and are not considered Medicare telehealth services and are therefore *not subject to* the 1834(m) SSA rurality restrictions.
 - Brief Communication Technology-based Service, a.k.a. “Virtual Check-In” – HCPCS Code G2012
 - Remote Evaluation of Pre-Recorded Patient Information – HCPCS Code G2010
 - Interprofessional Internet Consultation – CPT Codes 99446 - 99449



Medicare Telehealth Expansion as of 1/1/2019

Communication Technology-Based Services

- Brief Communication Technology-based Service – HCPCS Code G2012
 - Synchronous, real-time virtual check-in lasting 5-10 minutes;
 - May be done over the telephone;
 - Must be a patient-initiated visit with an established patient. The patient must have verbal consent *only once per year* and be aware that as a beneficiary, they may be financially liable for sharing in the cost of these services;
 - Cannot originate from an E/M visit 7 days prior nor result in an E/M visit within 24 hours or the soonest available appointment;
 - No frequency limit on the use of this code for CY 2019, utilization will be monitored;
 - Service is meant to describe and account for the resources involved when the billing practitioner furnishes the virtual check-in;
 - No service-specific documentation requirements for this service.



Medicare Telehealth Expansion as of 1/1/2019

Communication Technology-Based Services

- Remote Evaluation of Pre-Recorded Patient Information – HCPCS Code G2010
 - Asynchronous, store and forward used to determine whether or not an office visit or other service is warranted;
 - Pre-recorded, patient generated video and/or images;
 - Must be a patient-initiated visit with an established patient. The patient must have verbal or written consent *only once per year* and be aware that as a beneficiary, they may be financially liable for sharing in the cost of these services;
 - Cannot originate from an E/M visit 7 days prior nor result in an E/M visit within 24 hours or the soonest available appointment;
 - No frequency limit on the use of this code for CY 2019, utilization will be monitored;
 - Interpretation and follow-up can be done through any method, including phone call, audio/video communication, secure text messaging e-mail, or patient portal communication, and must be done within 24 hours.



Medicare Telehealth Expansion as of 1/1/2019

Interprofessional Internet Consultations

- CPT Codes 99446 through 99449 - Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a *verbal* and written report to the patient's treating/requesting physician or other qualified health care professional; 5-31 minutes of medical consultative discussion and review (depending on code).
- CPT Code 99452 - Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes.
- CPT Code 99451 - Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time.



- Both the Virtual Check-In and Remote Evaluation Codes (G2012 and G2010) will be renamed as HCPCS Code G0071 for FQHC/RHCs.
- FQHC/RHCs will not receive the Prospective Payment System rate for G0071.
- Services must be furnished by an FQHC/RHC practitioner to a patient who has had a billable visit within the previous year, and the medical discussion or remote evaluation is for a condition not related to another service provided within the previous 7 days and does not lead to another visit within 24 hours or the soonest available appointment.
- Coinsurance and deductibles apply to RHC claims for G0071 and coinsurance only applies to FQHC claims for G0071. This cost-sharing cannot be waived as CMS has no statutory authority to do so.
- FQHC/RHCs are not able to use the Interprofessional Internet Consultation Codes.



FQHC/RHC CMS Changes for CY 2019

Comments were proposed citing that FQHC/RHCs should be able to function as distant sites for telehealth. Per the 1834(m) regulations, FQHC/RHCs can serve as telehealth originating sites (where the patient is located) for qualified services and bill the Q3014 facility fee.

Other components of the Social Security Act describe distant site telehealth services and FQHC/RHCs are not included. CMS does not have the authority to allow FQHC/RHCs to furnish distant site telehealth services, therefore these facility types cannot bill as a distant site.





Medicare Telehealth Expansion as of 1/1/2020

Opioid Use Disorder Treatment Services by Opioid Treatment Programs (OTP)

- The SUPPORT Act established a Part B benefit category for OUD treatment services by an OTP beginning 1/1/2020, including medications for medication assisted treatment. It also provides for coverage of OUD treatment services and establishes a bundled payment for OTPs certified by SAMHSA for OUD treatment services during an episode of care. More information can be found here: <https://www.jdsupra.com/legalnews/cms-proposes-rules-to-implement-support-14108/>.
- CMS has finalized a duration of an episode of care that includes a one-week (or seven continuous days) period and the bundle of care which a patient receives during that period includes one substance use counseling session, one individual therapy session, one group therapy session and one toxicology test. If the patient received 51% or more of those services, then they can bill the full weekly bundle. If they received less, then the OTP could bill a partial episode of care.
- CMS acknowledges that OTPs are not eligible providers under Medicare's telehealth restrictions, but state that because they are not considered to be services provided by a physician or other practitioner, the statutory telehealth requirements of 1834(m) does not apply to OTPs.



Medicare Telehealth Expansion as of 1/1/2020

Office-Based Treatment for Opioid Use Disorder (OUD)

- HCPCS code **G2086**: Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.
- HCPCS code **G2087**: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.
- HCPCS code **G2088**: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (List separately in addition to code for primary procedure).



Medicare Telehealth Expansion as of 1/1/2020

Online Digital Evaluation Service (e-Visit) codes:

- CPT Codes **99421 - 99423**: Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10, 11-20, or 21 or more minutes);
- The above codes are for practitioners who can independently bill E & M services.
- CPT Codes **98970 - 98972**: Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10, 11-20, or 21 or more minutes).
- These codes are for practitioners who cannot independently bill E & M services (i.e. pharmacists, medical assistants, technicians, nurses, and therapists).



Medicare Advantage Plans

- Beginning 1/1/2020, Medicare Advantage plans will be allowed to offer more extensive telehealth coverage as part of their base coverage (previously was only available under supplemental benefits). Policies will vary from plan to plan.
- MA plans decide what services are offered so long as they're covered under Medicare Part B and meet certain requirements:
 - Services offered as additional telehealth benefits must also be available as in-person services;
 - Plans must use their provider directory to identify providers offering telehealth benefits;
 - Disclose these additional telehealth benefits through the Evidence of Coverage document;
 - Plans must provide information on additional telehealth benefits upon the request of CMS;
 - Plans may only provide these benefits using contracted providers.
- If the additional telehealth services are not covered under Part B, the plan may offer those services via telehealth but will have to be covered by a supplemental plan.



Third-Party Payers



Special considerations regarding telehealth reimbursement:

Telehealth is the use of electronic information and communication technologies by a healthcare provider to deliver services to a patient when the patient is located at a different site.

- **Commercial/Medicare Advantage policies**, consultations can be telephone only, e-visits, audio and video, RPM, store and forward, etc.
- **Medicaid Managed Care policies**, consultations must be audio and video only per NYS guidelines.



Special considerations regarding provider type:

- **For Commercial/Medicare Advantage products**, there is no restriction on the type of providers that can furnish and receive payment for covered telehealth services (subject to State law). As long as the provider type is covered under the plan or policy, such provider will be covered if services are rendered via telehealth.
- **For Medicaid products**, the type of provider that can furnish and receive payment for telehealth services (subject to State law) is limited to the eligible list of providers under Medicaid guidelines.



Special considerations regarding patient location:

- **For Commercial/Medicare Advantage products**, the patient may be located anywhere that is different from the provider.
- **For Medicaid Managed Care products**, the patient must be located in NY hospitals, facilities for the mentally disabled, physician or dentist office located in NY, any type of adult care facility licensed under Social Services Law Title Two, Article Seven; public and private charter elementary schools; school age childcare programs; child day care centers; and effective as of 07/11/2018, the patient may be located in the patient's home or other temporary location located within or outside of NY regardless of whether or not such patient is receiving services by means of RPM.



Participating providers can be reimbursed for telehealth services when members are enrolled in the following plans:

- **Commercial** - Policies offered on and off the New York State of Health, Child Health Plus and Medicare Advantage.
- **Safety Net** - HMOBlue Option, Blue Choice Option, Premier Option, Blue Option Plus, Essential Plan, HARP, Premier Option Plus.

Patients must provide consent prior to the telehealth services being rendered.



For questions related to telehealth reimbursement, please contact one of the following individuals:

- Pam Keough: Fidelis Behavioral Health Specialist - pkeough@fideliscare.org
- Casey Ruede: Fidelis Behavioral Health Specialist – cruede@fideliscare.org



FIDELIS CARE™



- TRICARE covers the use of interactive audio/video technology when appropriate and medically necessary to include:
 - Clinical consultation;
 - Office visits;
 - Telemental health (individual psychotherapy, psychiatric diagnostic interview examination and medication management);
 - Services for End Stage Renal Disease.
- Referrals and Authorization: As with any behavioral health care received from a TRICARE network provider, active duty service members will need a referral before getting care under the Telemental Health Care benefit. TRICARE Prime active duty family members and retirees do not need a referral or authorization to set an online care appointment with a distant provider.





- Aetna uses Teladoc as their direct-to-consumer platform for their members. Members will not have to pay more than \$40 for general medical care, however, behavioral health and dermatology may cost more.
- Aetna considers home spirometry and telespirometry medically necessary for lung transplant recipients, but not medically necessary for asthma, cystic fibrosis, idiopathic pulmonary fibrosis, and persons with COPD or emphysema. Home spirometry should not be confused with peak flow meters.
- Aetna also considers outpatient cardiac rehabilitation medically necessary based on certain selection criteria outlined on their website. For high-risk members, Aetna will cover 36 sessions (i.e. 3 times per week for 12 weeks) of supervised exercise with continuous telemetry monitoring.





- MVP Health Care[®] covers direct-to-consumer telemedicine through myVisitNow. They cover two main types of visits, urgent care and behavioral health, as well as ancillary services such as nutrition and lactation consultations. They're including the telemedicine benefit in all of their fully insured, Medicare, Medicaid, and Essential plans.
- MVP will be using American Well and the Online Care Group to provide this service.





- Providers supplying Telehealth services must adhere to MVP Protocols and all applicable laws and regulations.
 - Providers providing services via Telehealth must be licensed or certified, currently registered in accordance with NYS Education Law or other applicable law.
 - Providers providing services via Telehealth to Medicaid members must be enrolled in NYS Medicaid, with an MMIS number.
 - Telehealth services must be delivered by providers acting within their scope of practice.
 - Reimbursement will be made in accordance with existing and applicable MVP payment policies and all applicable federal and state regulations related to supervision and billing rules and requirements.
 - When services are provided by an Article 28 facility, the Telehealth Provider must be credentialed and privileged at both the originating and distant sites.
 - All services delivered via Telehealth must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements.





General Guidelines:

- Originating site definition: A site at which a Member is located at the time health care services are delivered to him or her by means of Telehealth Originating Sites shall be limited to: (1) facilities licensed under NYS PHL Articles 28 and 40; (2) facilities as defined in Subdivision Six of Section 1.03 of the Mental Health Hygiene Law; (3) certified and non-certified day and residential programs funded or operated by the Office for People with Developmental Disabilities (OPDD); (4) private physician's, or dentist's offices located within the State of New York; (5) any type of adult care facility licensed under Title 2 of Article 7 of the Social Services law; (6) public, private, and charter elementary and secondary schools, school age children's programs, and child day care centers within the State of New York; and (7) the Member's place of residence located within the state of New York or other temporary location located within or outside the state of New York.
- The member must be present and participate at the time of the Telemedicine visit;
- Telemedicine may be used in lieu of a face-to-face encounter for the following: consultations, office or other outpatient visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, end-stage renal disease related services, individual medical nutrition therapy, neurobehavioral status exam, and follow-up inpatient telehealth consultations.
- Providers should submit claims for Telemedicine services using the appropriate code for the professional service along with the Telemedicine modifier 95.
- Originating Sites are paid an Originating Site facility fee for Telehealth services as described by HCPCS code Q3014. Providers should bill MVP for the Originating Site facility fee, which is separately billable and will be reimbursed at a flat fee of \$25.00 for all providers and facilities. There is no payment for the originating site if both the distant and originating site providers are employed by the same entity.





MVP – Billing Guidelines for Professional Services

- Providers should submit claims for Telemedicine using the appropriate CPT or HCPCS code for the professional service and append Telemedicine Modifier 95, via interactive audio and video telecommunications systems (for example: 99201 95).
- Modifier GT must be used when Modifier 95 does not apply.
- There is no separate payment for Telehealth Services provided by individual Telehealth Providers in Diagnostic and Treatment Centers. MVP's APG payment to the Diagnostic and Treatment Center is all-inclusive.
- For New York Commercial and Medicare Advantage Products, MVP follows CMS guidelines and will only reimburse for CPT and HCPCS codes outlined by CMS.





MVP – Billing Guidelines for Originating and Distant Site

- When Telehealth Services are provided at an Article 28 Originating Site and a qualified Telehealth Provider is not present with the Member at the time of the encounter, the Originating Site should bill Q3014 for the audio-visual connection only. The Distant site should bill using APGs for Telehealth Services using the appropriate CPT code for the service provided, appended with the “GT” modifier.
- An Originating Site and Distant Site operating under the same Tax Identification Number (“TIN”) or within the same provider network will be reimbursed for the Distant Site only. In such cases, the Distant Site is responsible for reimbursing the Originating Site.
- Payment for Telehealth Services provided via Store and Forward Technology shall be made to the consulting physician. The physician must submit claims for the CPT Code for the professional service and attach Modifier GQ (via asynchronous telecommunications system).





MVP – Remote Patient Monitoring

- RPM must be ordered by a New York licensed physician, nurse practitioner or midwife who has examined the Member and with whom the Members has an established, documented, and ongoing relationship.
- Member health information or data may be received at the Distant Site by a New York licensed registered nurse.
- The use of RPM must be determined to be medically necessary and must be discontinued when the Member's condition is determined to be stable/controlled. RPM requires a minimum of 30 minutes per month to be spent collecting and interpreting the Member's RPM data. In addition to Telehealth Services, Members must be periodically seen in-person by a health care provider.
- Certified Home Health Agencies (CHHA) are not eligible for RPM Telehealth Services to a Member if the Member is receiving home health care services through the CHHA.
- MVP shall pay a daily fee of no more than \$4.00 for each day RPM equipment is used to monitor a Member's health; however, the maximum rate for RPM per Member per month may not exceed \$36.00.
- CPT Code 99091 must be billed for the collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the Member and/or caregiver to the Provider and must not be submitted more than once per month and must be billed on the last day of the month the services were performed.



- Eligible EmblemHealth members can use telemedicine services through Teladoc. It is covered under EmblemHealth's individual and family plans (both on and off the NYS of Health Marketplace, including Essential plans) and plans for small businesses (2-50 employees) and large group employer/business health plans.
- EmblemHealth FEHB, GHI, and HIP programs will use the AmWell app through American Well.



EmblemHealth



Emblem Health – Home Care

- EmblemHealth members enrolled in a Medicaid or Medicare-Medicaid plan are able to access telehealth services from approved home health care agencies as a covered benefit if the member is assessed by the home health care agency on an individual basis and meets specific criteria, such as:
 - Member must have a condition that requires frequent monitoring and be at-risk of acute or long-term care facility admission.
 - Telehealth services must be an adjunct to nursing care and may only be provided during an episode of home care.
 - Requires prior authorization and will only be covered if deemed medically necessary. Authorization is given in 30-day increments, with the member needing to be reassessed after 60 days.



EmblemHealth



- CDPHP offers urgent care telemedicine to commercial populations (individual and employer group) through Doctor on Demand. Doctor on Demand covers online consultations between patient and provider for minor urgent medical conditions.
- For commercial lines of business, CDPHP allows their providers to bill per their policy for telehealth, which follows state regulations (parity law), when providing it directly on their own. Specific reimbursement is in the provider contracts and is considered confidential.
- Participating telemedicine providers must bill for services with POS code 02 and with an appropriate E & M code in the following ranges: 99201-99203, 99211-99213.





Line of Business	Provider Specifications	Location Requirements	Prior Authorization	Medication Assisted Therapy (MAT)
Commercial (CDPHP, CDPHN, UBI) and Medicare Advantage	Must be specifically contracted for telemedicine services with CDPHP's vendor, Doctor on Demand	No location requirements for member or provider	No authorization requirement	Not covered under Doctor on Demand (see Telehealth payment policy for coverage guidelines)
Medicaid Select Plan, HARP, CHP	Must be participating with CDPHP Must be rendered by: MD, NP, PA, nurse midwife, CNS, psychologist, LCSW, RD, nutrition professional, dentist, RN, Optometrist, Speech pathologist, Asthma educator, Genetic counselor, Hospital, Home care agency, Hospice, CASAC cred by OASAS, EI provider, OMH clinic	Originating site limited to facilities licensed under Article 28 and 40 facilities, private physician's office within NYS, and patient's residence located within NYS, or other temporary location located within or outside NYS	No authorization requirement	Patient is being treated by and physically located in a DEA-registered hospital or clinic, OR Patient is treated by and in physical presence of DEA-registered practitioner





- CDPHP administers benefits for tele-homecare services for enrollees who have a primary or secondary diagnosis of CHF, COPD, diabetes, or coronary artery disease when the following criteria is met:
 - Member has had 2 or more inpatient hospitalizations or ED visits in the past 12 months;
 - Services are ordered by a practitioner who agrees to review the generated data and respond in a timely fashion to the home health agency;
 - Services are provided by a home health agency;
 - Services are required on a part-time intermittent basis for up to 6 weeks and are provided 7 days per week;
 - Services are provided by or under the supervision of an RN;
 - Services must relate directly and specifically to an active/written treatment plan, which has been approved by the ordering physician.





- For Select/HARP/Child Health Plus plans, the distant site provider should submit claims for covered telemedicine services using the appropriate CPT or HCPCS code for the services performed with modifier GT or 95 appended and place of service code 02 .
- The originating site providers are reimbursed an originating site facility fee for covered telemedicine services. This facility fee should be reported by billing HCPCS code Q3014. If the originating site is a facility, services must be submitted under an outpatient bill type with revenue code 0780 and corresponding HCPCS code Q3014.
- CDPHP does not cover Interprofessional Telephone/Internet Assessment and Management Services (CPT codes 99446-99449).
- Enhanced Primary Care (EPC): Procedure codes that are included on the EPC Service Codes list that are also referenced in policy will not be separately reimbursed regardless of modifier or place of service billed for those practices on the EPC payment model.



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Questions?



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