Telehealth Billing & Reimbursement Boot Camp

Presenters

Kellie Mendoza serves as the Chief Compliance & Privacy Officer for MUSC Physicians. In this role, she has primary responsibility for the development, implementation, revision and oversight of the MUSCP Compliance Plan and activities related to privacy and access to patient health information. As the demands of the healthcare regulatory environment increase, she and her team strive to maintain and expand the visibility of corporate compliance efforts and implement compliance initiatives that reduce risk related to professional billing practices. Kellie has over 19 years of billing and coding experience with an emphasis on telehealth billing & reimbursement policies in South Carolina.

Kellie is a graduate of the Medical University of South Carolina where she earned a Bachelor of Health Science (summa cum laude) and a Master of Health Administration. She holds a Certified Professional Coder (CPC) certification from the American Academy of Professional Coders (AAPC), a Certification in Healthcare Compliance (CHC) and a Certification in Healthcare Privacy Compliance (CHPC) from the Health Care Compliance Association (HCCA).

Amanda Gardner joined the MUSC Physicians Compliance Department in 2020 and serves as the Corporate Compliance Regulatory Manager. Amanda is responsible for research/investigation and interpretation of applicable laws and regulations for the billing and business relations of MUSC Physicians and other organizations where MUSC Physicians provides compliance oversight via contract. She ensures implementation of appropriate policies and compliance training, conducts investigations, and responds to all regulatory matters. Amanda is a graduate of The Ohio State University where she earned a Bachelor of Science in Health Information Management and Systems and a Master of Health Administration. She holds a Registered Health Information Management Administrator (RHIA) certification and is a member of the American Health Information Management Association (AHIMA).

Disclaimer

This presentation and the content herein are solely based on information published in payer policies as of October 1, 2025. The materials provided in this presentation are for general information purposes only and do not constitute legal or other professional advice on the subject matter. The material provided in this presentation are not statements of advice, opinion, or information of the presenter. The presenter encourages one to seek the advice of your respective health care counsel and your compliance department for a more detailed explanation of this information and its application to your situation.

Objectives

- Describe common virtual services and documentation/billing guidelines for each
- Understand responsibilities outlined under the SC Telemedicine Act
- Review coverage rules and current state of reimbursement for telehealth, including any Public Health Emergency (PHE) extensions

Common Virtual Services: Documentation & Billing

Patient Informed Consent

- Consent requirements vary by state
- SC requires written informed consent be documented
  - Verbal vs. written
- CMS Best Practices

Video Visit

- A video visit is a visit performed using **live, interactive video and audio**
- Platform used must be **HIPAA Compliant**
- Provider to select new audio/video CPT codes OR the E/M code as if the service was provided in person based on patient status (inpatient vs. outpatient)
- Examples:
  - 99202-99215; 99242-99245 (Office or other outpatient visits)
  - 99281-99285 (Emergency department visits)
  - 99252-99255; 99221-99223; 99231-99233, 99238 (Inpatient visits)
  - G0425-G0427 (Medicare telehealth consults, emergency department or inpatient)

New Synchronous Audio/Video CPT Codes

CPT Code	Description
98000	New pt, straightforward MDM or 15 mins
98001	New pt, low MDM or 30 mins
98002	New pt, mod MDM or 45 mins
98003	New pt, high MDM or 60 mins
98004	Est. pt, straightforward MDM or 10 mins
98005	Est. pt, low MDM or 20 mins
98006	Est. pt, mod MDM or 30 mins
98007	Est. pt, high MDM or 40 mins

Video Visit Required Documentation

- Documentation must include the following:
  - A statement that the service was provided using interactive audio & video;
  - Location of the patient;
  - Location of the provider;
  - Medical necessity of the visit;
  - Total time
    - **SC Medicaid requires start and stop time only if also required for a face-to-face service**
    - All other payers allow total time, but not time ranges
  - Names of all persons participating and their role in the encounter, as applicable

Teaching Physician Regulations - Video Visits

Medicare

- Teaching Physicians are allowed to meet supervision requirements via live interactive audio/video technology through 12/31/25 if the service is furnished virtually (i.e., 3-way video visit with all parties in separate locations)
- ***EXCEPTION: For residency training sites that are located outside of a Metropolitan Statistical Area (MSA)**, i.e., Orangeburg, virtual supervision is permissible even if services are performed in person by the resident**

SC Medicaid

- Virtual supervision not permitted; Teaching Physician must be *physically present or immediately available* in same location as resident, as applicable, to meet required presence and participation

Telephone Visit/Virtual Check-in

- A telephone visit or virtual check-in is a visit using **telephone only, without video**
- Billing is based on the provider type and total time of the visit:

MD/APP Telephone Visit
- 98008 (new pt 15 mins)
- 98009 (new pt 30 mins)
- 98010 (new pt 45 mins)
- 98011 (new pt 60 mins)
- 98012 (est pt 10 mins)
- 98013 (est pt 20 mins)
- 98014 (est pt 30 mins)
- 98015 (est pt 40 mins)

MD/APP Virtual Check-in
- 98016 (5-10 mins)
- G2252 (11-20 mins)

Other Eligible Provider Types
- 98966 (5-10 mins) or G2251 (5-10 mins)
- 98967 (11-20 mins)
- 98968 (21-30 mins)

RHC/FQHC
G0071 (5 mins)

- Cannot be billed if less than 5 minutes OR for communication of test results, scheduling appointments for other communication that does not include evaluation and management services
- Virtual check-ins and all other eligible provider type CPT codes are reported only once for the same episode of care during a 7-day period; cannot report if originating from a related visit provided within the previous 7 days or if communication leads to a virtual visit within 24 hours or soonest available

Telephone Visit Required Documentation

- A statement that the patient provided verbal consent for the billing of the service (annually)
- Medical necessity of the visit
- Total time (actual, not time range)

Medicare Audio-Only

- Medicare allows audio-only telecommunications when ***any*** telehealth service is furnished to a patient in their home, but the patient **is not capable of, or does not consent to**, the use of video technology; this includes an encounter that begins as a video visit and is transitioned to an audio-only visit due to the patient's video connectivity issues or inability to use the video technology

- For all other payers or for true telephone encounters, telephone visit CPT codes should be billed

- The provider's documentation must support the reason for the audio-only encounter

Common Question

- **What do I do if I start a non-Medicare patient visit as a video visit, but the patient is unable to connect, and the service is ultimately done via telephone?**

- The service should be billed as a telephone visit based on total time

E-visit

- An e-visit is an asynchronous communication between a patient and provider through an online patient portal
- This service **may not be used** for work done by clinical staff (i.e., nurse, CMA)
- May only be reported once for the billing provider's cumulative time devoted to the service **for the same or related problem** during a 7-day period
- If separate E/M service provided during the 7-day period, time spent on e-visit must be incorporated into the separately reported E/M service; cannot be billed if less than 5 minutes

E-visit CPT Codes

MD/APP	Other Eligible Provider Types (Non-Medicare)
• 99421 (5-10 mins) • 99422 (11-20 mins) • 99423 (21+ mins)	• 98970 (5-10 mins) • 98971 (11-20 mins) • 98972 (21+ mins)

E-visit Required Documentation

- A statement that the patient provided consent for the billing of the service (annually)
- Medical necessity of the visit
- Total time (actual, not time range)

Interprofessional Consult

- Time-based service where a treating physician/APP (requester) seeks advice from a specialist (consultant) without face-to-face patient contact
- The consultant reviews relevant records (labs, imaging, meds, pathology) and provides recommendations
- Not to be used as a supplement for an appropriate transfer of care
- Not billable if:
  - In person visit occurred in past 14 days (applies to 99446 – 99451 only)
  - Transfer of care to consultant
  - More than one consult in a 7-day period (applies to 99446 – 99451 only)
  - Consulting and requesting provider are in the same specialty and entity (i.e., same tax ID)

Interprofessional Consult CPT Codes

CPT CODE	REPORTED BY	REQUIRES	TIME	HOW TIME IS SPENT
99446	Consultant	Verbal + written report	5-10 mins	Discussion and review (>50% discussion)
99447	Consultant		11-20 mins	
99448	Consultant		21-30 mins	
99449	Consultant		≥ 31 mins	
99451	Consultant	Written report only	≥ 5 mins	Medical consultative discussion and total review (>50% is in review)
99452	Requesting Provider	N/A	16-30 mins	Referral prep/communication w/ the consultant on a single date

Interprofessional Consult Required Documentation

- A statement that the patient provided verbal consent for performance and the billing of the service (each service)
- Request with reason for consultation
- Medical necessity of the visit
- Total time (actual not time range)

Examples

- Interprofessional Consult
  - Rheumatologist advises PCP on initial lab workup for suspected autoimmune disease
  - Dermatologist confirms a rash can be managed with topical therapy in primary care, with referral if no improvement

- Not an Interprofessional Consult
  - Neurologist states patient with seizures should be transferred to neurology care immediately
  - Psychiatrist responds: “This requires in-person psychiatric evaluation; unable to give management guidance via E-consult”

New vs Established?

If a physician provides an interprofessional consult for a patient they have never seen before, and then the patient presents a few months later for an office visit with the same physician, the patient will be considered a new patient.

Teaching Physician Regulations – Phone/Virtual Check-ins, E-visits, E-consults

Billing based on Teaching Physician time only

Remote Physiologic & Therapeutic Monitoring

- Provider must obtain patient's consent for all RPM and RTM services and document it in the patient's medical record
- The device must meet the definition of a medical device, as defined by the FDA
- The service must be ordered by a physician or other qualified healthcare provider
- RPM and RTM services can be billed during the same service period as Chronic Care Management (CPT codes 99487, 99489, and 99490), Transitional Care Management (CPT codes 99495 and 99496), and Behavioral Health Integration (BHI) (CPT codes 99492, 99493, 99494, and 99484)

Remote Physiologic Monitoring CPT Codes

CPT CODE	WHEN WOULD I SUBMIT THIS CODE?	TIMING	WHO CAN PROVIDE THE SERVICE?
99453-Remote monitoring of physiologic parameter(s) (i.e., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	Used to report the set-up and patient education on how to use of the device(s); per NCCI cannot report with 99091	Reported for each episode of care ; do not report 99453 if monitoring less than 16 days	Clinical staff under general supervision of the physician or physician/qualified healthcare professional
99454- Remote monitoring of physiologic parameter(s) (i.e., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	Used to report supply of the device; per NCCI cannot report with 99091	Each 30 days; do not report 99454 if monitoring less than 16 days	
99457- Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes **+99458**- each additional 20 minutes per month	Used to report time spent using results of the monitoring device to manage a patient under a specific treatment plan; *interactive communication must include two-way audio with video or other kinds of data transmission*	Every calendar month	
99091- Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time	Used to report time involved with data accession, review and interpretation, modification of care plan as necessary and associated documentation; must be initiated during a face-to-face with the **billing provider**; per NCCI cannot report 99453 or 99454 in addition to this code	Each 30 days	Limited to physician or qualified healthcare professional

Remote Therapeutic Monitoring CPT Codes

CPT CODE	WHEN WOULD I SUBMIT THIS CODE?	TIMING	WHO CAN PROVIDE THE SERVICE?
98975-Remote therapeutic monitoring (e.g., therapy adherence, therapy response); initial set-up and patient education on use of equipment	Used to report the set-up and patient education on how to use of the device(s)	Reported for each episode of care; do not report 98975 if monitoring less than 16 days	Clinical staff under general supervision of the physician or physician/qualified healthcare professional
98976- Remote therapeutic monitoring (e.g., 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	Used to report supply of the device; time spent assessing and evaluating data related to the patient's adherence and response to therapies performed on the respiratory or musculoskeletal system or to cognitive behavioral therapy services; data may be objective, such as integrated data that is device-generated, or subjective, such as input reported by the patient	Each 30 days; do not report 98976/98977/98978 if monitoring less than 16 days	
98977- Remote therapeutic monitoring (e.g., 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			
98978-Remote therapeutic monitoring (e.g., therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor *cognitive behavioral therapy*, each 30 days			
98980- Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes **+98981**- each additional 20 minutes per month	Used to report time spent reviewing and integrating the data collected during remote monitoring to inform treatment goals; monitor the patient's progress and adherence to the treatment plan, and provide clinical feedback to the patient/caregiver	Every calendar month; do not report 98980/98981 for time less than 20 minutes	Limited to physician or qualified healthcare professional

SC Telehealth & Telemedicine Modernization Act Responsibilities

(4) be licensed to practice medicine in this State; provided, however, a licensee need not reside in this State if he has a valid, current South Carolina medical license; further, provided, that a licensee who resides in this State and intends to practice medicine via telemedicine to treat or diagnose patients outside of this State shall comply with other applicable state licensing boards;

(4) verify the identity and location of the patient and inform the patient of the licensee's name, location, and professional credentials

SC Telehealth & Telemedicine Modernization Act Responsibilities

- In S.C., an in-person evaluation is required to prescribe new C-II and C-III narcotics except in the following scenarios:
  - When the practice of telemedicine is being conducted while the patient is physically located in a hospital and being treated by a practitioner acting in the usual course of professional practice
  - When buprenorphine is being prescribed as a medication for opioid use disorder
  - For patients enrolled in palliative care or hospice
  - Any other case where an exception has been approved by the S.C Medical Board
- An established patient is not required to have an in-person evaluation for the refill of a current medication as previously prescribed

State Licensure Requirements

Outlined by each state but typically require providers to be licensed in the state where the patient is located. Information on individual state licensure requirements can be found on the Federation of State Medical Boards website.

You May Want to Consider Internal Audits of Telehealth Services

- State licensure
- Provider locality for diagnostic tests
- Supervision
- Consent
- Documentation of time
- Telehealth platform log in/log out time
- Charge consistent with service performed
- HIPAA compliant technology

Current State of Reimbursement

Telehealth Reimbursement

Generally, telehealth coverage is based on:

- CPT code
- Performing provider type
- Originating site

Medicare

Coverage

- Medicare's resource for coverage and billing rules for telehealth services can be found here
- Medicare coverage is currently based on the following:
  1) Distant site provider type
  2) Service (CPT or HCPCS code)

CPT/HCPCS Code

Click here for a full list of CPT/HCPCS codes payable under the Medicare Physician Fee Schedule when furnished via telehealth

Video Visit Coverage

Report E/M code as if the service was provided in person; E/M category is based on patient status (inpatient vs. outpatient)

Telephone/Virtual Check-in Coverage

Covered services for established patients only

MD/APP	Other Eligible Provider Types	RHC/FQHC
• 98016 (5-10 mins) • G2252 (11-20 mins)	• 98966 (5-10 mins) • 98967 (11-20 mins) • 98968 (21-30 mins)	• G0071 (5 mins)

E-visit Coverage

Covered services for established patients only

MD/APP	Other Eligible Provider Types
• 99421 (5-10 mins) • 99422 (11-20 mins) • 99423 (21+ mins)	• 98970 (5-10 mins) • 98971 (11-20 mins) • 98972 (21+ mins)

Interprofessional Consult Coverage

Covered services

CPT CODE	REPORTED BY	REQUIRES	TIME	HOW TIME IS SPENT
99446	Consultant	Verbal + written report	5-10 mins	Discussion and review (>50% discussion)
99447	Consultant		11-20 mins	
99448	Consultant		21-30 mins	
99449	Consultant		≥ 31 mins	
99451	Consultant	Written report only	≥ 5 mins	Medical consultative discussion and total review (>50% is in review)
99452	Requesting Provider	N/A	16-30 mins	Referral prep/communication w/ the consultant on a single date

RPM & RTM Coverage

- RPM may only be provided to established patients
- RTM may be provided to new and established patients

RPM	RTM
• 99091 • 99453 - 99454 • 99457 - 99458	• 98975 – 98978 • 98980 - 98981

Place of Service

- **Video Visits:** POS 02 (telehealth provided other than patient home); POS 10 (telehealth provided in patient home)

- **Virtual Check-ins, Telephone Visits, E-visits, Interprofessional Consults:** POS as if the patient presented in person

Modifiers

- Video visits: 95
- Stroke: G0
- Audio-only: 93
- Mental health: FQ
- Asynchronous: GQ

Originating Site

An eligible originating site is a location outside of a Metropolitan Statistical Area (MSA) **OR** within a Rural Health Professional Shortage Area (HPSA)

**Exclusions: MSSP ACO beneficiaries, services for the diagnosis or treatment of a mental health disorder or an acute stroke, and the home of an individual for home dialysis ESRD-related clinical assessment*

Eligible Providers

- Physician
- Nurse Practitioner
- Physician Assistant
- Clinical Nurse Specialist
- Nurse Midwife
- Certified Registered Nurse Anesthetist
- Clinical Psychologist
- Licensed Independent Social Worker
- Registered Dietician
- Nutritional Professionals
- Licensed Professional Counselor
- Licensed Marriage & Family Therapist

Provider Location Reporting

Current State – December 31, 2025

Practitioners can render telehealth services from their home without reporting their home address on their Medicare enrollment

January 1, 2026 – Forward

Practitioners are required to report their home address on their Medicare enrollment if rendering telehealth services from their home

Tele Radiology Provider Location

- Tele radiology is the process of transmitting medical images from one location to another for interpretation and consultation
- Provider locality considerations:
  - Rules for interjurisdictional reassignment apply to all remote practitioners or practitioners located in another MAC jurisdiction than the practice to which they have reassigned their benefits
  - Payment varies among localities and is determined based on the location where the service is performed
  - If the provider performing the professional component is not located in the same payment locality as the technical component, the service cannot be billed globally

Physician Direct Supervision

May be virtually present and immediately available via live interactive audio/video technology for services with PC/TC status indicator of 5 (incident to direct supervision required) and 99211

Primary Care Exception: AMCs

- E/M levels 1-3 and Welcome to Medicare/Annual Wellness Visits (G0402, G0438, and G0439) may be provided by residents located in **all residency training sites**

- E-visits (99421 – 99423), interprofessional consult (99452), and virtual communications (G2010 and G2012) may be provided by residents located in **residency training sites outside of a Metropolitan Statistical Area (MSA)**

Resident & Fellow Moonlighting

Residents and fellows may furnish and separately bill for services in the inpatient, outpatient, and emergency department settings that are not related to their approved GME programs

Frequency Limitations

Current State – December 31, 2025

No frequency limitations on telehealth services

January 1, 2026 – Forward

- Subsequent Inpatient Care may only be billed **once every three days**
- Subsequent Skilled Nursing Facility Care may only be billed **once every fourteen days**
- Critical Care Consultations may only be billed **once per day**

SC Medicaid

SC Medicaid Manuals

- Community Mental Health (CMH) Services Provider Manual
- Hospital Services Provider Manual
- Physicians Services Provider Manual

**Full listing of provider manuals can be found here*

Coverage

- SC Medicaid's resource for coverage and billing rules for telehealth services can be found on the SCDHHS website and searching "telehealth"
- Current telehealth flexibilities can be found here
- Proviso of telehealth coverage can be found here
- SC Medicaid coverage is currently based on the following:
  1) Distant site provider type
  2) Service (CPT or HCPCS code)

CPT/HCPCS Code

Click here for a full list of CPT/HCPCS codes payable when furnished via telehealth

Video Visit Coverage

Report E/M code as if the service was provided in person; E/M category is based on patient status (inpatient vs. outpatient)

Telephone/Virtual Check-in Coverage

- Covered services when provided by an MD/APP for established patients only
- Non-covered for other eligible provider types

MD/APP
• 98012 (est pt 10 mins) • 98013 (est pt 20 mins) • 98014 (est pt 30 mins) • 98015 (est pt 40 mins) • 98016 (virtual check-in 5-10 mins)

E-Visits Coverage

Non-covered services

Interprofessional Consult Coverage

Non-covered services

RPM & RTM Coverage

Non-covered services

Audio-Only Services

Allows coverage for behavioral health services that would routinely be done using video/audio to be performed using only audio (i.e., telephone)

Place of Service & Modifier

- Place of service
  - Video Visits: POS 02
  - Telephone Visits, E-visits, and Interprofessional Consults: POS as if the patient presented in person
- GT modifier (video visits only)

Originating Site

- Any location, including patient home
- Referring site eligible for Q3014

Eligible Providers

Current State – December 31, 2026

- Physician
- Nurse Practitioner
- Physician Assistant
- Physical Therapist
- Occupational Therapist
- Speech Language Pathologist
- Clinical Psychologist*
- Clinical Social Worker*
- Licensed Professional Counselor*
- Licensed Marriage & Family Therapist*

*providers enrolled under CMHC, RBHS or LIP categories

January 1, 2027 – Forward

- Physician
- Nurse Practitioner
- Physician Assistant
- Clinical Psychologist*
- Clinical Social Worker*
- Licensed Professional Counselor*
- Licensed Marriage & Family Therapist*

*providers enrolled under CMHC, RBHS or LIP categories

Physician Direct Supervision

Must be physically present and immediately available

Resident & Fellow Moonlighting

Residents and fellows may furnish and separately bill for services in the **inpatient, outpatient, and emergency department** settings that are not related to their approved GME programs

Physical, Occupational and Speech Therapy Services

Current State – December 31, 2026

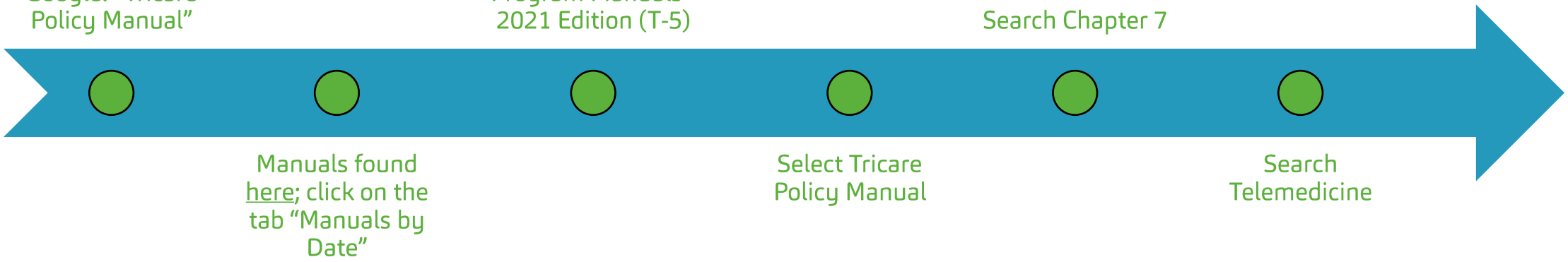
Covered services

January 1, 2027 – Forward

Non-covered services (unless provided to a member enrolled in BabyNet)

TRICARE

How Do I Find the Payer Policy?



Link to current Telemedicine policy

Coverage

TRICARE coverage is based on the following:

1) Originating site (also known as referring site)
2) Distant site provider type

CPT/HCPCS Code

The use of interactive telecommunications systems may be used to provide diagnostic and treatment services for otherwise covered TRICARE benefits when such services are medically or psychologically necessary and appropriate medical care

Place of Service & Modifier

- Place of service 02
- Modifier
  - Synchronous: GT or 95
  - Asynchronous: GQ

Originating Site

Payment is made only when the originating site is where an otherwise authorized TRICARE provider normally offers professional medical or psychological services. No payment shall be made when the originating site does not satisfy the requirement (e.g., no payment will be made when the originating site is the beneficiary's home).

Eligible Providers

TRICARE authorized provider providing services within their scope of practice under all applicable state(s) law(s) where services provided

Aetna

Coverage

Aetna's resource for coverage and billing rules for telehealth services can be found in their Telemedicine and Direct Patient Contact Payment Policy

- Aetna coverage is currently based on the following:
  1) Service (CPT or HCPCS code)

CPT/HCPCS Code

Aetna's full list of CPT/HCPCS codes payable when furnished via telehealth are listed in their Telemedicine and Direct Patient Contact Payment Policy

Video Visit Coverage

Report E/M code as if the service was provided in person; E/M category is based on patient status (inpatient vs. outpatient)

Telephone/Virtual Check-in Coverage

Non-covered services

E-visit Coverage

Non-covered services

Interprofessional Consult Coverage

Non-covered services

RPM & RTM Coverage

Non-covered services

Place of Service & Modifier

- Place of service 02
- Modifier
  - Synchronous: GT or 95
  - Asynchronous: GQ
  - Stroke: G0
  - Supervising practitioner present via two-way A/V communication: FR

Originating Site

Not addressed in telemedicine policy

Eligible Providers

All participating and nonparticipating physicians, facilities, and other qualified health care professionals

BCBS

Telemedicine and Telehealth Policies

- Medical policies found here
- Click on medical policies and then find “T” under alphabetical list
- Click on the “T” and look for the two policies:
  - CAM 032 Telemedicine
  - CAM176 Telehealth

Telemedicine vs Telehealth Policies

Telemedicine – CAM 32

- Provider to provider
- Requires two-way interactive video and audio
- Clinicians who are currently contracted and eligible to submit claims to BCBS of SC are covered providers
- Limited covered referring sites
- Services submitted with GT modifier
- Referring physician site eligible for Q3014

Telehealth – CAM 176

- Patient to clinician
- Requires two-way interactive communication
- Clinicians who are currently contracted and eligible to submit claims to BCBS of SC are covered providers
- No limitation on covered sites
- Services submitted with 95 modifier
- Q3014 not mentioned in policy

Coverage

BCBS of SC coverage is based on the following:

1) Referring site (also known as originating)
2) Distant site provider type
3) Service (CPT or HCPCS code)

CPT/HCPCS Code

Review each policy below for a full list of CPT/HCPCS codes payable when furnished via telehealth and telemedicine

- CAM176 Telehealth
- CAM 032 Telemedicine

Video Visit Coverage

Covered services

CPT Code	Description
98000	New pt, straightforward MDM or 15 mins
98001	New pt, low MDM or 30 mins
98002	New pt, mod MDM or 45 mins
98003	New pt, high MDM or 60 mins
98004	Est. pt, straightforward MDM or 10 mins
98005	Est. pt, low MDM or 20 mins
98006	Est. pt, mod MDM or 30 mins
98007	Est. pt, high MDM or 40 mins

Telephone/Virtual Check-in Coverage

Non-covered services

E-Visit Coverage

Non-covered services

Interprofessional Consult Coverage

Non-covered services

RPM & RTM Coverage

Non-covered services

Place of Service & Modifier

- Place of service
  - POS as if the patient presented in person
- Modifier
  - Telemedicine: GT
  - Telehealth: 95

Originating Site – Q3014

- Telemedicine
  - Physician office
  - Hospital
  - RHC and FQHC
  - Community Mental Health Center
  - Patient home
  - Public school
  - Act 301 Behavioral Health Centers

Eligible Providers

Telehealth

- Physician
- Nurse Practitioner
- Physician Assistant
- Clinical Nurse Specialist
- Clinical Psychologist
- Clinical Social Worker
- Licensed Professional Counselor
- Licensed Marriage & Family Therapist

Telemedicine

- Providers who meet the Plan's contracting requirements and are currently contracted are eligible to submit claims for telemedicine and telepsychiatry when the service is within the scope of their practice

Cigna

Coverage

- Cigna's coverage and billing rules for telehealth services can be found in their Virtual Care Reimbursement Policy

- Cigna coverage is based on:

1) Service (CPT or HCPCS code)

CPT/HCPCS Code

Full list of CPT/HCPCS codes payable when furnished via telehealth are found in the Virtual Care Reimbursement Policy

Video Visit Coverage

Covered services

CPT Code	Description
98000	New pt, straightforward MDM or 15 mins
98001	New pt, low MDM or 30 mins
98002	New pt, mod MDM or 45 mins
98003	New pt, high MDM or 60 mins
98004	Est. pt, straightforward MDM or 10 mins
98005	Est. pt, low MDM or 20 mins
98006	Est. pt, mod MDM or 30 mins
98007	Est. pt, high MDM or 40 mins

Telephone/Virtual Check-in Coverage

- Telephone visits covered services
- Virtual check-ins non-covered services

MD/APP
• 98008 (new pt 15 mins) • 98009 (new pt 30 mins) • 98010 (new pt 45 mins) • 98011 (new pt 60 mins) • 98012 (est pt 10 mins) • 98013 (est pt 20 mins) • 98014 (est pt 30 mins) • 98015 (est pt 40 mins

E-Visit Coverage

Non-covered services

Interprofessional Consult Coverage

Covered services

CPT CODE	REPORTED BY	REQUIRES	TIME	HOW TIME IS SPENT
99446	Consultant	Verbal + written report	5-10 mins	Discussion and review (>50% discussion)
99447	Consultant		11-20 mins	
99448	Consultant		21-30 mins	
99449	Consultant		≥ 31 mins	
99451	Consultant	Written report only	≥ 5 mins	Medical consultative discussion and total review (>50% is in review)
99452	Requesting Provider	N/A	16-30 mins	Referral prep/communication w/ the consultant on a single date

RPM & RTM Coverage

Non-covered services

Place of Service & Modifier

- Place of service 02
- Modifier
  - Synchronous: GT or 95
  - Asynchronous: GQ
  - Stroke: G0
  - Audio-only: FQ

Originating Site

Not addressed in telemedicine policy

Eligible Providers

Policy only references physician and other qualified health care professionals

United Healthcare

Policy

- Policy very similar to Medicare
- CMS designated covered providers
- CPT code list differs based on use of GT, GQ or 95 modifier
  - Synchronous & asynchronous services covered

Coverage

UHC coverage is based on the following:

1) Originating site
2) Distant site provider type
3) Service (CPT or HCPCS code)

CPT/HCPCS Code

CPT/HCPCS codes payable when furnished via telehealth:

- Telehealth Eligible Services Codes
- PT/OT/ST Telehealth Eligible Codes
- Communication Technology-Based Services and Remote Physiologic Monitoring Eligible Codes
- Telehealth Audio-Only Eligible Services Codes

Video Visit Coverage

Report E/M code as if the service was provided in person; E/M category is based on patient status (inpatient vs. outpatient)

Telephone/Virtual Check-in Coverage

- Telephone visits: covered services; report as 99202 – 99215
- Virtual check-ins covered services

Telephone Visit Code	Report As
98008	99202
98009	99203
98010	99204
98011	99205
98012	99212
98013	99213
98014	99214
98015	99215

MD/APP	Other Eligible Provider Types
• 98016 (5-10 mins) • G2252 (11-20 mins)	• 98966 (5-10 mins) • 98967 (11-20 mins) • 98968 (21-30 mins)

Bill services based on time

E-visit Coverage

Covered services

MD/APP	Other Eligible Provider Types
• 99421 (5-10 mins) • 99422 (11-20 mins) • 99423 (21+ mins)	• 98970 (5-10 mins) • 98971 (11-20 mins) • 98972 (21+ mins)

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RPM & RTM Coverage

Covered services

RPM	RTM
• 99091 • 99453 - 99454 • 99457 - 99458	• 98975 – 98978 • 98980 - 98981

Place of Service & Modifier

- Place of service
  - Telehealth provided other than patient home: POS 02
  - Telehealth provided in patient home: POS 10
- Modifier
  - 95 or GT
  - Stroke: G0
  - Mental health: FQ
  - Audio-only: 93

Originating Site – Q3014

- Physician office
- Hospital
- Critical Access Hospital
- RHC and FQHC
- Hospital-based or critical access hospital-based renal dialysis center (including satellites)
- Skilled Nursing Facility
- Community Mental Health Center
- Mobile Stroke Unit
- Patient home*

**For monthly end stage renal, ESRD-related clinical assessments or for purposes of treatment of a substance use disorder or a co-occurring mental health disorder*

Eligible Providers

- Physician
- Nurse Practitioner
- Physician Assistant
- Nurse-midwife
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetist
- Clinical Psychologist
- Clinical Social Worker
- Registered Dietitian or Nutrition Professional
- Licensed Professional Counselor
- Licensed Marriage & Family Therapist
- Speech Language Pathologist
- Occupational Therapist
- Physical Therapist

Tips When Reviewing Payer Policies

- If you don’t understand, ask your payer!
- Scenarios with request for approval are best!
- Look for changes frequently!
- Share what you learn from policies with your providers; they may be able to help you advocate coverage at some point!

Questions?

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