Medicaid Telemedicine and Telehealth Overview and Guidelines as of 03/01/2022

OVERVIEW

In light of the COVID-19 pandemic, the Oregon Health Authority has expanded coverage of telehealth services. The following telehealth and telemedicine services are covered through Eastern Oregon Coordinated Care Organization:

- Evaluation and management services
- Assessment and management services
- Consultations between providers in a variety of settings (by telephone or other electronic forms of communication)

Eastern Oregon Coordinated Care Organization follows Ancillary Guideline A5, telehealth, teleconsultations and electronic/telephonic services guidelines as well as OHA guidance related to coding and billing. Please visit the *Ancillary/Diagnostic Guideline Notes* for additional information.

Compliance: During the COVID-19 pandemic, the federal government has waived certain HIPAA privacy requirements, so services such as Google Hangouts, FaceTime, and Skype can be used during this crisis. For additional information, please visit HHS.gov.

- Obtaining consent/approval:
  - Verbal consent to receive services is acceptable during COVID-19 emergency
  - Clearly document in the patient record
- Advisable to also mail consent documents with a SASE or obtain written consent using patient portals (electronic signature OK)
- Release of information
- For 42 CFR Part 2 (substance use disorder), see SAMHSA Guidance
- General HIPAA privacy rules still apply

Telehealth Parity:
In accordance with OAR 410-141-3566, telemedicine visits are encouraged for all services that can reasonably approximate an in-person visit, not just those relating to a COVID-19 diagnosis. Any CPT or HCPCS code that is ordinarily covered AND for which the provider believes the clinical value reasonably approximates the clinical value of an in-person service can be billed in this manner:

- Examples of CPT codes which may be covered include office visits, physical and occupational therapies, preventive medicine, psychotherapy, etc.

- Example: CPT codes 99201-99205, 99211-99215, 99495-99496 -Ordinary office visits via synchronous audio/video (telephone acceptable during COVID-19 emergency if A/V not available or feasible)

IMPORTANT: All referral guidelines still apply to Telehealth visits. If a condition is Below-the-Line or non-funded on the prioritized list, or the provider is out of network with the Eastern Oregon Coordinated Care Organization plan, a referral will still be required for reimbursement. Above-the-Line and funded conditions with in network providers are reimbursable for active members under the Eastern Oregon Coordinated Care Organization plan with no referral on file.

Below you will find a comprehensive list of codes currently covered by the Oregon Health Authority. Eastern Oregon Coordinated Care Organization will cover and reimburse all services allowed within the scope of the providers individual agreement.

BILLING FOR TELEMEDICINE/TELEHEALTH

To receive reimbursement	• Bill covered telemedicine procedure codes with place of service 02. The use of telehealth POS 02 certifies that the service meets the telehealth requirements. • Modifier GT is required for some behavioral health services (Please see BH Fee Schedule). • The GQ modifier is still required when applicable. GQ modifier means; via Asynchronous Telecommunication systems. • Modifier 95 is allowed for telemedicine services. • Bill with the transmission site code Q3014; (where the patient is located). • The evaluating practitioner at the distant site may bill for the evaluation, but not for the transmission site code. • For members with Medicare as primary, please bill according to CMS guidelines. As secondary will process based on Medicare paid amounts, telemedicine coding doesn't have to match OHP claims coding to pay secondary in MMIS per OAR 410-120-1280 **Important information related to COVID-19 claims tracking:** OHA would like to track claims related to COVID-19. Please use the following modifiers for all claims if reason for telemedicine visit is for prevention of COVID-19 exposure (provider or patient) or for any assessment/treatment of COVID-19 (suspected or actual):

	• Modifier CR: Professional claims • Condition code DR: Institutional claims

TELEHEALTH (SYNCHRONOUS AUDIO/VIDEO VISITS)

What are the CPT codes that are allowed for Synchronous audio/video visits?	90785, 90791, 90792, 90832-90834, 90836, 90837-90840, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964-90970, 96116, 96171, 96160, 96161, 97802-4, 99201-99205, 99211-99215, 99231- 99233, 99307-99310, 99354-99357, 99406-99407, 99495-99498, G0108-G0109, G0270, G0296, G0396, G0397, G0406-G0408, G0420, G0421, G0425-G0427, G0436-G0439, G0442-G0447, G0459, G0506, G0508, G0509, G0513, G0514, G2086-G2088. See CMS's Telehealth Codes for a list of procedure codes that are also covered for telehealth services The originating site code Q3014 may only be used by appropriate health care sites. **These services can be provided by telephone when appropriate during the COVID-19 crisis.**
What are the criteria?	• Telehealth visits are defined as synchronous visits with both audio and video capability. The patient may be at home or in a health care setting. • Telehealth visits are covered for inpatient and outpatient services for new or established patients. • Telehealth consultations are covered for emergency and inpatient services. • Billing for telehealth visits requires the same level of documentation, medical necessity and coverage determinations as in-person visits.

TELEHEALTH/TELEMEDICINE VISITS RELATED TO HOME BLOOD PRESSURE MONITORING

What are the CPT codes required?	• 99473: Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration • 99474: Separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES (DMEPOS)

What is covered	Telehealth/telemedicine services may be utilized by physicians for face-to-face encounters for prescribing durable medical equipment (DME) and medical supplies. Physical therapists, occupational therapists, and speech therapists may use telehealth/telemedicine while providing evaluations and assessments for DME, when clinically appropriate. **Custom wheelchairs** When clinically appropriate, the Assistive Technology Professional (ATP) may conduct evaluation and home assessment through HIPAA-compliant, interactive, real-time audio and video telemedicine platforms. Services of the ATP, whether in-person or remotely, are not separately payable. **Home blood pressure monitoring supplies** The following supplies are covered in conjunction with telehealth/telemedicine visits. • A4663: Standard blood pressure cuffs • A4670: Automatic blood pressure cuffs ○ For both fee-for-service and CCO members, blood pressure cuffs are covered without prior authorization under OARs **410-122-0620** and **410-141-3501** if medically appropriate for an above-the-line diagnosis on the Prioritized List of Health Services.

	○ Although the individual must have an above-the-line diagnosis, a pre-existing diagnosis of hypertension is not required to qualify for a blood pressure cuff **Cpap Face-to-face visit following 3-month trial** The required follow up visit with the prescriber of the CPAP may be waived or conducted via telehealth/telemedicine.

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY SERVICES

What is Covered	97161-97168, 97110, 97112, 97116, 97535, 97550, 97760, 97761, 92521-92524, 92507 Telephone/online codes: G2061, G2062, G2063, G2010, G2012, 98966, 98967, and 98968
What is the Criteria?	The maximum allowable units have not changed. See OARs **410-131-0040**(7) (PT/ OT rule), and **410-129-0075** (Speech Language Pathology) for program-specific requirements. If you do not have a synchronous audio/visual telehealth/telemedicine platform to perform face-to-face visits for initial assessments and/or re-evaluations, you must ask OHA for approval to conduct them by phone. • To do this, submit a prior authorization request to OHA. Your supporting documentation must include a letter describing the barriers and how you will accomplish the assessment. • Other services conducted by phone **do not** require prior authorization during the COVID-19 emergency.

PATIENT TO CLINICIAN SERVICES (VIA TELEPHONE OR ELECTRONIC)

What are the CPT codes that are allowed for patient to clinical services?	Telephonic and electronic services, including services related to diagnostic workup:
	• CPT 99441-99443 (for providers who can provide evaluation and management services)
	  ○ Temporarily open for Behavioral Health
	• CPT 98966-98968 (for other types of providers)
	  ○ Temporarily open for Behavioral Health
	"Online" 99421-99423 (Physician E/M), 98970-98972 (Nonphysician E/M), G2012 (brief virtual check in) and G2061-G2063 (Any type not able to bill evaluation and management services (e.g. physical therapist, speech therapist, counselor, social worker.

What are the criteria?	• Ensure pre-existing relationship as demonstrated by at least one prior office visit within the past 36 months, except during the COVID-19 pandemic.
	• Documentation must:
	  ○ model SOAP charting, or be as described in program's OAR;
	  ○ include patient history, provider assessment, treatment plan and follow-up instructions;
	  ○ support the assessment and plan;
	  ○ be retained in the patient's medical record and be retrievable.
	• Medical decision making (or behavioral health intervention/psychotherapy) is necessary.
	• Ensure permanent storage (electronic or hard copy) of the encounter.
	• Meet HIPAA standards for privacy.
	• Include a patient-clinician agreement of informed consent, which is discussed with and signed by the patient and documented in the medical record. In the context of the COVID-19 epidemic, verbal approval is sufficient.
	• Not be billed when the same services are billed as care plan oversight or anticoagulation management (CPT codes 99339-99340, 99374-99380 or 99363-99364).
	• When a telephone or electronic service refers to an E/M service performed and billed by the physician within the previous seven days, it is not separately billable, regardless of whether it is the result of patient-initiated or physician-requested follow-up.
	• This service is not billed if the service results in the patient being seen within 24 hours or the next available appointment. If the service relates to and takes place within the postoperative period of a

	procedure provided by the physician, the service is considered part of the procedure and is not to be billed separately. •Cannot be related to a recent (<7 days) or upcoming (within 24 hours) visit. Report time spent rendering online services cumulatively over 7 days, with a single billing occurring once per 7 days • Requires patient initiation (providers can make patients aware of offering and place the call) **Additional information specific to Behavioral Health Providers:** The codes outlined above are newly open to Behavioral Health providers during the COVID-19 crisis when the service is: • Provided by a qualified nonphysician health care professional (98966-98968), physician, or other professional qualified to perform evaluation and management services (99441-99443) to a patient, parent, or guardian. • Not related to an assessment and management service provided and/or within the previous 7 days.
What are examples of these visits?	Examples of reimbursable telephone or electronic services include: • Extended counseling when person-to-person contact would involve an unwise delay. • Treatment of relapses that require significant investment of provider time and judgment. • Counseling and education for patients with complex chronic conditions. Examples of non-reimbursable telephone/electronic consultations include but are not limited to: • Prescription renewal. • Scheduling a test. • Reporting normal test results. • Requesting a referral. • Follow up of medical procedure to confirm stable condition, without indication of complication or new condition. • Brief discussion to confirm stability of chronic problem and continuity of present management.

CLINICIAN-TO-CLINICIAN CONSULTATIONS (TELEPHONIC AND ELECTRONIC)

What are the CPT codes that are allowed for consulting providers?	99451, 99446-9

What are the criteria?	• Consult must be requested by another provider. • Can be for a new or exacerbated condition. • Cannot be reported more than 1 time per 7 days for the same patient. • Cumulative time spent reported, even if time occurs over multiple days. • Cannot be reported if a transfer of care or request for face-to-face visit occurs as a result of the consultation within the next 14 days. • Cannot be reported if the patient was seen by the consultant within the past 14 days. • Request and reason for consultation request must be documented in the patient's medical record. • Requires a minimum of 5 minutes.
What are the CPT codes that are allowed for requesting providers?	99452
What are the criteria?	• eConsult must be reported by requesting provider (not for the transfer of a patient or request for face-to-face consult). • Reported only when the patient is not on-site and with the provider at the time of consultation. • Cannot be reported more than 1 time per 14 days per patient. • Requires a minimum of 16 minutes. Includes time for referral prep and/or communicating with the consultant. • Can be reported with prolonged services, non-direct. Limited information provided by one clinician to another that does not contribute to collaboration (e.g., interpretation of an electroencephalogram, report on an x-ray or scan, or reporting the results of a diagnostic test) is not considered a consultation.

SUMMARY OF CHANGES

Date of Change	Correction/Addition/Clarification	Source
3/20/2020	**Addition:** New Codes for BH providers according to Lori Coyner memo and BH fee schedule	Oregon Health Authority
3/23/2020	**Correction:** Correct the Health Behavior Assessment/Intervention codes (previously listed CPT codes 96150-96154 have been replaced with CPT 96171)	Oregon Health Authority
3/23/2020	**Clarification:** Specific to 99441-99443 and G2012, these codes can be used when: ○ The patient, family member or guardian initiates the call	

	○ The call is for telephone evaluation & management services, and ○ The call is not related to an in-person visit scheduled for the next 24 hours The call is not related to an in-person visit that has occurred during the previous 7 days.	Oregon Health Authority
3/23/2020	**Addition:** added annotations from Prioritized List-GN	Oregon Health Authority
3/24/2020	**Addition:** Telehealth guidance related to HIPAA	Department of Consumer and Business Services (DCBS)
3/24/2020	**Addition:** COVID-19 Claim Tracking- implement the use of modifier CR and condition code DR	Oregon Health Authority
4/29/2020	**Addition: Compliance section and telehealth parity,**	Oregon Health Authority
4/29/2020	**Addition: Patient to Clinician Services Criteria**	Oregon Health Authority
4/29/2020	**Clarification: COVD-19 tracking**	Oregon Health Authority
6/4/2020	**Clarification: Crossover claims and modifier 95**	Oregon Health Authority
7/16/2020	**Clarification: Prior Authorization requirements**	