FAQ for OHP FFS & CCO Telemedicine Billing During the COVID-19 Emergency

Questions and answers from the April 17, 2020 webinar

This document addresses the questions received but not answered[1] during the April 17 telemedicine billing webinar, which provided billing guidance for Oregon Health Plan (OHP) Fee-for-Service (FFS) professional claims as well as billing guidance for coordinated care organizations (CCOs) during the COVID-19 public health emergency (PHE). The 209 questions are organized in the following categories:

1. Behavioral Health (26 questions)
2. Nuanced Billing (30 questions)
3. Medicare Crossover Claims (9 questions)
4. Place of Service (16 questions)
5. Modifier CR – Catastrophe-related (60 questions)
6. Physical and Occupational Therapy (14 questions)
7. Federally Qualified Health Centers (11 questions)
8. Provider-Specific (10 questions)
9. Miscellaneous (33 questions). Topics covered interpretation (3), dental (5), reimbursement parity (5), pediatrics (5), consent (4), text messaging (5), tribal (1), and acupuncture (5).

Category 1 – Behavioral Health

The Behavioral Health Fee Schedule does not clearly delineate which codes are open for telemedicine use at this time, and modifiers are inconsistently paired across tabs.

The Behavioral Health Fee Schedule (updated April 2020) has been updated with the codes that are open for telemedicine use. The codes that are reimbursable through telemedicine are identified by GT in the allowable modifiers column; if a code does not have GT listed as an allowable modifier, it is not open for telemedicine.

Are traditional health workers able to conduct telemedicine visits during the COVID-19 PHE?

Yes, traditional health workers (THWs) can conduct telemedicine visits during the COVID-19 PHE. Rendering provider types are identified on the "MH Outpatient Services" tab in the Behavioral Health Fee Schedule. All codes for Peer Support Services have been opened to telemedicine. THWs employed by a Certified Substance Use Disorder (SUD) program can provide telemedicine under the direction of the SUD program, so long as the service is appropriate to be provided by a THW.

[1] 108 questions received during the webinar were directly addressed in the presentation, and so are not included in this document.

Will skills training services provided by QMHAs be covered, including H2014?

Skill reintegration (AKA skills training) services are reimbursable through telemedicine during the COVID-19 PHE. The behavioral health fee schedule has been updated to include those skill reintegration codes appropriate for telemedicine, identified by GT in the allowable modifiers column; if a code does not have GT listed as an allowable modifier, it is not open for telemedicine.

Does the 7-day rule for Method 2a and 2b codes apply for Behavioral Health codes during the PHE?

Yes.

Are codes for case management (T1016), family supports (H0038), crisis services (H2011), and G0270-G0272 covered during this time?

Codes H0038 and H2011 are open to reimbursement for telemedicine services during the COVID-19 PHE. Case Management (T1016) is a covered service for behavioral health, but currently not open to reimbursement via telemedicine. Codes G0270-G0272 are not currently open for reimbursement through FFS.

Can behavioral health providers use consultation codes (e.g., 90882) during this time?

Consultation code 90882 is available for reimbursement; however, it is not open to reimbursement via telemedicine at this time.

Category 2 – Nuanced Billing

Some practitioners bill through the hospital—can these providers continue to provide telemedicine services and bill using the hospital facility code?

The billing process has not changed. The hospital would bill on the claim under the header and then enter the therapist's Medicaid provider number under the rendering provider space. The provider would use POS 02, and all appropriate modifiers for services rendered. PT/OT providers can email our PPR team with any specific questions at OHA.PPR@dhsoha.state.or.us.

If a virtual audio/video (A/V) visit is provided and billed for, only to have an aggravation and subsequent visit within the 7-day period, how is the subsequent visit billing handled?

If you use Method 1 in-person codes with appropriate modifiers and POS 02, the 7-day rule does not apply as it only applies to telephone/online codes (Methods 2 and 3). If a telephone call is billed using Method 2a (telephone-only codes), then a subsequent call could be billed using Method 1 (in-person codes).

Per the Governor's suspension on Medicaid coverage terminations, does the patient remain with their assigned CCO or do they move to Open Card status? How are pending terminations to be billed?

OHP intends for all members to retain coverage through their current CCO during the PHE. As such, billing should continue as usual. In some cases, a patient will need to be re-enrolled through their CCO, but their coverage will continue during the COVID-19 PHE.

The "patient-initiated" requirement applies to telephonic and online codes, not in-person codes?

Correct, the requirement for patient-initiated service requests does not apply to Method 1.

Is there billing guidance for COVID-19 testing and screening for CAWEM recipients?

CAWEM recipients may obtain tests and treatment at an emergency department, clinic, or urgent care that accepts Open Card (Fee-For-Service).

Can we rebill services based on this guidance? If so, back to which date?

If the codes you want to bill are related to Method 2 or 3 (telephone codes, online codes or quick check-ins), you can bill these back to January 1, 2020, when HERC Guideline Note A5 was created. For Fee-For-Service Medicaid, these telephone codes had a reduced reimbursement. For dates of service on or after March 1, 2020, the reimbursement was raised. If claims are submitted or rebilled after May 1, 2020, payments will be higher.

If you are wanting to rebill using Method 1 (using in-person codes), you can bill back to March 13, when Guideline A5 was revised. Claims can be rebilled even if you submitted them previously using telephone-only codes. For Fee-For-Service Medicaid, some of these codes were not open on these effective dates, so if payment was not the amount expected, we recommend voiding and resubmitting the claims in accordance with the May 1st guidelines.

What are documentation requirements for online codes?

Documentation should follow standard billing requirements. Patient consent to receive services using a telemedicine platform must be obtained and documented in the medical record prior to providing services. Verbal consent may be obtained during the COVID PHE. OHA encourages providers to mail consent documents to patients receiving telemedicine services along with a self-addressed stamped envelope to request a signature, or to obtain electronic consent through a patient portal.

Are Home Healthcare Agencies able to bill telemedicine visits if it is medically appropriate?

OHA filed temporary rule OAR 333-003-1050, effective April 10, 2020 through October 6, 2020 (or until the rule is suspended when the Governor terminates the state declaration of emergency) specifying that "**all rules in OAR chapter 333, divisions 027**…**that are inconsistent with the COVID-19 Emergency Authorities are hereby suspended for all entities and facilities covered by the waivers**." Currently, it is unclear whether facilities can bill for nurses' visits per the CMS Telehealth FAQ. We advise providers refer to covered codes included on the CMS Telehealth Codes page. For additional information, see OHP's Home Health Page.

Are lactation specialists able to bill professional services? How does billing differ between hospital employees and independent contractors? For the former, are services billable by the hospital?

CMS has approved State Plan Amendment (SPA #20-0005), which adds Lactation Consultant Services as a billable provider type for OHP enrolled clients. This SPA was approved on April 24, 2020, with the effective date of April 1, 2020. Hospital-based services and billing would follow guidance in the April 17, 2020, webinar.

Can a physical therapist or physician use hospital outpatient hospital billing for telemedicine services?

Yes, a physician and/or PT can bill telemedicine services in an outpatient setting. The practitioner would bill using the facility in the header as the "Billing Provider" and enter the therapist's Medicaid provider number under the rendering provider. They must use POS 02 and modifier 95 for services performed using synchronous audio/video communication; telephonic (audio) services only need POS 02. Use codes approved for telehealth as described in the PT/OT/ ST Memorandum for Telehealth Services. Add any additional modifiers appropriate for services.

Is OHP following CMS guidance that providers may use either total encounter time or medical decision-making in selecting E/M code levels?

OHA directs providers to use level of medical decision-making when selecting E/M code levels.

Category 3 – Medicare Crossover Claims

When billing CMS as the primary payer, will OHP secondary claims be paid using CMS guidelines? If not, how should dually eligible claims be submitted?

Medicare FFS claims crossover automatically to OHA or the CCO for secondary payment where applicable. Secondary claims in OHP FFS 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.

CMS will not let providers bill E/M telemedicine codes if visits are not interactive A/V. How can providers be reimbursed by OHP for dually eligible claims?

Full benefit dual eligibles receive coverage from OHP for services that are not covered by Medicare but are covered by OHP. If a service will never be covered by Medicare, it can be billed directly to OHA or the CCO per OAR 410-120-1280.

Category 4 – Place of Service (POS)

Some CCOs as well as BCBS are requiring claims to be billed using POS 11, even for telemedicine. Do providers have to follow this requirement?

The webinar advises on how to bill for OHP FFS as well as guidance for CCOs. However, each CCOs may provide supplemental guidance for their specific claims. If these guidance conflict, follow each primary payers' specific guidelines.

Medicare requires using POS depending on the normal POS of the provider; will OHP accept telemedicine claims using POS other than 02?

If Medicare is to be primary payer, provider should submit claim as Medicare requires and claim will crossover to OHA or the CCO for secondary coverage.

Can OHA confirm that POS 02 will remain at the facility value?

OHA will pay the non-facility rate for FFS claims using POS 02.

Can providers bill using POS 02 on a UB (institutional) claim?

UB-04 claim forms don't use POS; this is only for services billed on a CMS-1500.

Should providers correct audio/video or telephone claims previously billed claims with POS 11 so that they correctly indicate POS 02?

Providers have the option to rebill given the updated OHA guidance from the April 17 telemedicine billing webinar. If the provider wishes to rebill Method 2 telephone/online codes with Method 1 in-person codes to obtain the best reimbursement, providers should resubmit claims through EDI transactions or through the web portal for faster adjudication of their claims.

Note that the same procedure will be paid out at the same rate for POS 11 or POS 02 (both non-facility RVU). During the COVID PHE, providers should bill and code all telemedicine services (A/V, audio, or online) with POS 02.

Category 5 – Modifier CR – Catastrophe Related

Our health clinic is providing all services via telemedicine to support social distancing during the COVID-19 emergency. Thus, would all our telemedicine services be coded with modifier CR?

Services delivered via telemedicine for the prevention, assessment or treatment of COVID-19 should be billed with modifier CR, in addition to other appropriate modifiers. This includes all telemedicine services rendered to support social distancing.

OHA acknowledges that Medicare and/or other payers may have different guidance regarding the use of modifier CR. However, CMS has not finalized guidance of how they will ask Medicaid programs to capture and report COVID-19-related services and spending. Thus, in order to accurately capture COVID-19-related services and spending, OHA asks all OHP providers to document telemedicine services that are COVID-19-related with modifier CR, including routine services that are conducted via telemedicine in order to prevent exposure risk to COVID-19.

If all telemedicine visits during the COVID PHE should be coded with modifier CR, what is an example of a telemedicine service that does not need to have the modifier CR?

Services that would have been rendered via telemedicine absent the COVID PHE should not be billed with modifier CR. One rule of thumb for providers in determining the appropriateness of using modifier CR is to examine past health services rendered via telemedicine and to continue to provide those telemedicine services without modifier CR.

Examples may include a weekly psychiatric service that has been regularly delivered by a behavioral specialist via telemedicine; another example could be routine telemedicine visits conducted by RHCs for rural patients. In short, do not use modifier CR for telemedicine services that would otherwise be routine, non-emergent telemedicine visits.

What is considered "prevention" for COVID-19 exposure? Must that include COVID-19 diagnoses for either the provider or patient?

Prevention measures for COVID-19 include social distancing, limiting non-essential travel, and prioritizing personal protective equipment for essential health services. Delivering physical, behavioral and oral health services via telemedicine is another prevention measure for COVID-19 exposure; there is no requirement for either the patient or provider to have an actual or suspected COVID-19 diagnosis.

Does the CR modifier apply to behavioral health services in addition to physical health services?

Yes, modifier CR applies to both physical health and behavioral health services.

During an audit, what needs to be documented in the notes to substantiate using modifier CR?

In addition to complying with standard documentation requirements, noting telemedicine delivery due to federal and state directives to practice social distancing is advisable.

Category 6 – Physical Therapy/Occupational Therapy (PT/OT)

Why are PT/OT codes that include 'direct patient contact' covered for telemedicine despite the requirement for this in-person contact? (e.g., codes 97129, 97130, 97530)

OHA is interpreting CMS guidance and Guideline Note A5 to include telemedicine coverage for CPT codes 97161-97168, 97110, 97112, 97116, 97535, 97550, 97760, 97761, 92521-92524, 92507 as well as telephone/online codes G2061, G2062, G2063, G2010, G2012, 98966, 98967 and 98968.

Are there any maximum allowable units for PT/OT services via telemedicine?

Yes, 30 habilitative and 30 rehabilitative visits per year, per recipient. Refer to OAR 410-131-0040 for more information.

Other payers require coordination through Teladoc to set up PT visits. Is this correct?

CCOs may issue their own requirements about referrals for services, including PT. Refer to each payer's billing guidance.

Category 7 – Federally Qualified Health Centers (FQHC)

Does this webinar guidance apply to FQHCs and Rural Health Centers (RHCs)? If so, will FQHCs receive the encounter rate for telemedicine services as though they had been provided in-person?

Yes, this webinar guidance does apply to FQHCs and RHCs. During the COVID-19 PHE, services provided via telemedicine (in accordance with HERC Guideline A5) that are eligible for Prospective Payment System (PPS) encounter reimbursement will be reimbursed at the PPS encounter rate. FQHC/RHC rules state OHP will not reimburse at the PPS rate incident-to, lab and radiology, and other items that are excluded from PPS reimbursement.

Are FQHCs able to count A/V and telephonic visits as encounters for their Wrap Reports?

Yes, during the COVID-19 PHE services provided via telemedicine, in accordance with HERC Guideline A5, are wraparound eligible. The general rule is if a service/code is reimbursable at the PPS encounter rate, it is also eligible, and may be reported, for the wraparound.

Other payers require modifier GT for E/M services, do we use modifier 95 or GT?

If billing in-person codes, bill POS 02; for physical health services rendered via audio/video synchronous communication, use modifier 95 and all other applicable modifiers; for behavioral health services rendered via audio/video synchronous communication, use modifier GT.

Category 8 – Provider-Specific

Does an online eConsult platform comply as a provider-to-provider teleconsultation?

Yes, so long as the eConsult platform utilized complies with HIPAA privacy standards. Further, procedure codes utilized to submit professional claims for provider-to-provider teleconsultation services must comply with correct coding standards (refer to specified requirements for each CPT code).

Some states are waiving the restriction of providers conducting telemedicine services to patients across state borders. If provider is licensed in Oregon, can they provide services to patients in Washington state?

OHA received federal authority to allow out-of-state providers to conduct telemedicine services for Oregon patients. However, OHA is unable to speak to how or if other states (e.g., Washington, Idaho) will permit Oregon-licensed practitioners to practice in their state. Oregonians who move out of state due to the COVID PHE may continue to receive services, as long as they are OHP recipients. Oregonians who are temporarily placed in an out-of-state facility may also continue to receive services.

Can optometrists, ophthalmologists, etc. provide out-of-state services without special licensure?

As long as the initial in-person visit has been met and the provider is an enrolled Oregon Medicaid provider with appropriate licensure.

Does this OHP billing guidance apply to providers that bill under the same NPI?

The same rules apply as though one is billing in-person.

Miscellaneous Questions

For communication outside of a patient portal or EHR, can text messages or email be billed for using the Quick Check-in G2012 code?

If they meet HIPAA security requirements, text message or email can be used. However, most commonly available text messaging and email services are not HIPAA-compliant. These services were not identified as acceptable media in the HHS notice of enforcement discretion related to telemedicine.

For dental telemedicine services, does the provider need to note in the record if A/V is not feasible? Is D0140, limited problem focused code, covered for telemedicine?

Yes, the provider does need to notate in the record if A/V is not feasible. For each teledentistry encounter, there will be two line items on the claim: D9995 and a fee and whatever “D” code is appropriate to the service provided and a fee. If you are triaging the patient, you would use D9995 and D0170.

Does a provider need to get a verbal consent for each visit or just the first-time telemedicine is initiated for a complaint?

Verbal consent to treat should be documented at the first telemedicine appointment. This consent is valid for one year. A new client may provide verbal consent, but must also provide written consent. OHA recommends practitioners mail consent documents to patients with a self-addressed stamped envelope for return.

Consent for the treatment provider to disclose protected treatment records: 42 CFR 2. For disclosure (to the CCO or other entity) to be properly authorized, a signature must be obtained, either in person, by mail, or by electronic signature, such as DocuSign.

Is there tribal-specific billing guidance during the COVID PHE?

There is no tribal-specific guidance during COVID – the guidance that applies to IHS, tribal, and urban Indian health providers exactly applicable to all other providers.

Will well-child visits be covered via telemedicine? If so, any additional criteria or requirements, especially regarding the physical exam component?

Yes, as long as they meet the criteria established in HERC Guideline Note A5. Most notably the clinical value of the service provided must reasonably approximate the value of an in-person service. For example, if the primary value of the well visit can be achieved without a physical examination and any required immunizations are billed separately (e.g., provided in a 'drive-by' service), then it would be covered.