APTA Massachusetts
A Chapter of the American Physical Therapy Association

Telehealth Guidelines Pertaining to Governor Baker's Executive Orders in Response to the COVID 19 Crisis

Updated 3/30/2020

Insurer	Billing Codes	Modifiers & POS ***	Co-Pay/Co-insurance	Reimbursement	Notes
BCBS of MA	97000 codes	Mod: 95; Modifier GT allows for no cost-sharing POS: "02"	Waiving cost-sharing on at this time;	Contracted rates	• **Effective for dates of service retroactive to March 16, 2020**, Blue Cross will reimburse **all** synchronous telemedicine service o defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. o The totality of the communication of information exchanged between the physician or other qualified health care professional and patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. o Modifier 95 may only be appended to the services listed in Appendix P. o Appendix P is the list of CPT codes for services that are typically performed face-to-face but may be rendered via real-time (synchronous) interactive audio and video telecommunications system services (COVID-19 AND non-COVID 19 related) whether they are telehealth, telephonic (audio) or face-to-face, at same rate as an in-person visit, for **all** provider types. Follow the same telehealth billing guidelines including the use of the following modifiers: ▪ Practitioners must use modifier GT or 95 (via interactive audio and video telecommunications

					systems) or modifier G0 to differentiate a telehealth (telemedicine) encounter from an in-person encounter with the patient.
Tufts	97000 Codes	Mod: POS: "02"	Collect co-pay/co-insurance/ deductibles that are applicable	Contracted rates	• **Effective for dates of services on or after March 6, 2020 until April 15, 2020,** coverage for Tufts Health Commercial (including Tufts Health Freedom Plan), Tufts Health Medicare Preferred HMO, Tufts Health Plan Senior Care Options (SCO), Tufts Health Public Plans (Tufts Health Direct, Tufts Health RI Together, Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans [ACPPs], and Tufts Health Unify) members is as follows: Telehealth/telemedicine • Tufts Health Plan will compensate providers at 100% of the in-office rate as specified in their provider agreements or fee schedules for telehealth • All Tufts Health Plan contracting providers can provide telemedicine services to our members (medical, behavioral health and ancillary health visits) • This will also include telephone consultation • Tufts Health Plan will waive member cost share for any primary care and behavioral health service • Documentation requirements for a telehealth service are the same as those required for any face-to-face encounter, with the addition of the following: ▪ A statement that the service was provided using telemedicine or telephone consult; ▪ The location of the patient; ▪ The location of the provider; and ▪ The names of all persons participating in the telemedicine service or telephone consultation service and their role in the encounter. • This applies for all diagnoses and is not specific to a COVID-19 diagnosis • This is intended to prevent people from having to leave their house to receive care
Allways	97000 Codes	Mod: POS: "02"	Waiving cost-sharing on at this time	Contracted rates	To expedite access to critical health care services for COVID-19 in accordance with Department of Public Health and Centers for Disease Control and Prevention (CDC) guidelines, our coverage criteria, which may be updated in response to an evolving situation, includes:

					• Removing all cost-sharing for telemedicine services to enable our members to seek care virtually, reducing the need to go to medical offices.
HPHC	97000 Codes	Mod: 95 POS: "02"	Waiving cost-sharing on at this time	Contracted rates	MA Fully Insured Plans, Medicare Advantage and Medicare Supplement Plans:
WC					**Awaiting further clarification.** There is no restriction for physical therapists to provide services via telehealth. DIA is working to clarify billing codes which should be used when telemedicine services are provided. U**pdate:** Contact the adjuster and request approval for "telehealth visits." The telehealth visit is often a separate benefit from the outpatient benefit. Be sure to request telehealth approval and document call, case #, etc.
MassHealth		Mod: POS: "02"			• Mass Health Bulletin 289 o permit qualified providers to deliver clinically appropriate, medically necessary MassHealth-covered services to MassHealth members via telehealth (including telephone and live video) For as long as this bulletin remains effective, MassHealth will permit qualified providers to deliver clinically appropriate, medically necessary MassHealth-covered services to MassHealth members via telehealth (including telephone and live video) • The performance of these functions shall be billed per usual protocols and the performance and delivery via telehealth must be clearly documented in the Member's record. Providers should bill the same procedure codes for services delivered
Medicare	G2061, G2062, G2063	Mod: CR POS: "11 or 12"	Deductible/Co-ins apply	G2061: $13.17 G2062: $23.24 G2063: $35.98	• No new evals but can do follow ups and new injury to different body part • These services can only be reported when the billing practice has an established relationship with the patient. For these E-Visits, the patient must generate the initial inquiry and communications can occur over a 7-day period." Per CMS, "E-Visits" differ from "Telehealth Visits," which encompass any "office, hospital visits and other services that generally occur in-person." PTs, OTs, and

					SLPs still are not included in the list of providers who are eligible to conduct Telehealth Visits under Medicare. • https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet • G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes • G2062: Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minute • G2063: Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes. These codes cannot be billed by PTAs. 1. Document that the patient initiated the request for the E-Visit (initial visit only) 2. Document that the patient gave verbal authorization to carry out the E-Visit (initial visit only) 3. Document that the patient was advised that these third-party applications potentially introduce privacy risks, and that you will enable all available encryption and privacy modes when using such applications 4. Document what application was utilized for each E-Visit 5. Document the need for the E-Visit - Example the patient needed guidance from the physical therapist due to pain during a specific exercise and what the assessment consisted of i.e. questions, etc. and how the therapist managed the situation and/or outcome 6. Document the amount of the E-Visit time using the 8' Rule and the G2061, G2062 or G2063 code selected

					Note: The use of E-Visit in the middle of an episode does not require a new Plan of Care unless the plan of Care expires.
Aetna	97000 codes	Mod: POS: "02"	No cost sharing at this time	Contract rates	Beginning March 6, 2020, Aetna will offer zero co-pay for covered telemedicine visits for any reason for 90 days. We will waive the cost share for all video and telephone visits through the Aetna-covered Teladoc offerings and in-network providers delivering synchronous virtual care (for all Commercial plan designs*. Self-insured plan sponsors can opt-out of this program at their discretion.
GIC - Unicare	97000 Codes	Mod: POS: "02"	Deductibles/Co-pays /Co-pays apply	Contracted rates	• **Basic, PLUS and Community Choice** members can also have a telehealth visit with any provider who is offering this service. This includes virtual visits and telephone consultations. • **For UniCare's Medicare Extension members** – Medicare covers "virtual check-ins" so you can connect with your doctor by phone or video, or even an online patient portal, to see whether you need to come in for a visit. For more information, go to medicare.gov/medicare-coronavirus#400 and choose **Telehealth and related services**.
United HC	97000 Codes	Mod: 95 POS: "02"		Contracted rates	• Designated telehealth partners can provide COVID-19 and non-COVID-19 virtual urgent care. • Telehealth coverage needs to be verified
SWH	G Codes	POS: 11 or 12	Follow Medicare	Follow Medicare	• SWH reimburses appropriate us of telehealth/telemedicine as described in the CMS regulations.
BMC Healthnet	97000 PT Codes	POS: 02		Contracted rates	• Telehealth is covered if an in-network provider is used. Telehealth appointments cost the same as in-person doctor's appointments.
Fallon					• **FCHP will not reimburse for telehealth services provided by PTs, OTs or SLPs – currently being challenged**
Health Plans Inc	97000 PT Codes	Mod: POS: 02	No Cost sharing at this time	Contracted rates	• Telehealth services**: covered in full**
Tricare	97000 Codes	POS 11		Not covered: PT and OT evals	• If a beneficiary meets all other criteria for a covered service for speech therapy and for continuation of PT/OT, (but not initiation of PT/OT), it is covered using telemedicine, using any coding modifiers as you would for a TRICARE network provider office visit.

United HC	97162 97163 97164 97110 97116 97530 97112 97535	POS: 02 Modifier:		**Must verify if telehealth is a covered benefit for each employer group.**	**Commercial** For all UnitedHealthcare commercial plans, any originating site requirements that may apply under UnitedHealthcare reimbursement policies are waived, so that telehealth services provided via a real-time audio and video communication system can be billed for members at home or another location. UnitedHealthcare will reimburse telehealth services that are: 1. Recognized by CMS and appended with modifiers GT or GQ and, 2. Recognized by the American Medical Association (AMA), included in Appendix P of CPT® and appended with modifier 95. Reimbursable codes can be found embedded in the reimbursement policy at **Telehealth and Telemedicine PolicyOpens in a new window**. **Medicaid** For all UnitedHealthcare Medicaid plans, any originating site requirements that may apply under UnitedHealthcare reimbursement policies are waived, so that telehealth services provided via a real-time audio and video communication system can be billed for members at home or another location. UnitedHealthcare Community Plan will reimburse telehealth services that are: 1. Recognized by CMS and appended with modifiers GT or GQ 2. Recognized by the AMA, included in Appendix P of CPT and appended with modifier 95 **Medicare Advantage** For all UnitedHealthcare Medicare Advantage plans, including Dual Eligible Special Needs Plans, any originating site requirements that may apply under Original Medicare are waived, so that telehealth services provided via a real-time audio and video communication system can be billed for members at home or another location. All CPT/HCPCS codes, payable as telehealth when billed with Place of Service 02 and the GQ or GT modifiers, as appropriate, under Medicare, will be covered on our Medicare Advantage plans for members at home during this time. Standard plan copays, coinsurance and deductibles will apply. Codes that are

					payable as telehealth under Medicare Advantage can be found here: **cms.govOpens in a new window**. Additionally, for commercial, Medicare Advantage and some Medicaid plans, UnitedHealthcare already reimburses appropriate claims for several technology-based communication services, including **virtual check-ins**, which may be done by telephone, and **e-visits** for established patients. Covered Codes: 97161 Physical therapy evaluation - low complexity Physical Therapy 97162 Physical therapy evaluation - moderate complexity Physical Therapy 97163 Physical therapy evaluation - high complexity Physical Therapy 97164 Physical therapy re-evaluation Physical Therapy 97110 Therapeutic procedure, one or more areas, each 15 minutes Physical Therapy 97116 Gait training Physical Therapy 97530 Therapeutic activities, one-to-one patient contact, each 15 minutes Physical Therapy 97112 Therapeutic procedure, one or more areas, each 15 minutes Physical Therapy 97535 Self-care/home management training, each 15 minutes •

Credit: New England Physical Therapy Network (NEPTN) for the input and significant efforts in providing up to date information

***** Modifiers to be updated shortly as each payers definition for the modifiers may be different**

The following is adapted from WebPT: Billing for PT and OT Telehealth Services During the COVID-19 Response
https://www.webpt.com/blog/post/billing-for-pt-and-ot-services-during-the-covid-19-response/

Sites

When billing telehealth, you must notate two "site" locations:

1. the originating site, and
2. the distance site.

The originating site is where the patient is located. The distance site is where the practitioner is located. Therapists typically must be licensed in the state in which the patient is receiving services, and while the APTA reports that recent Medicare actions "did include temporarily waiving Medicare

and Medicaid requirements that out-of-state providers hold licenses in the state where they are providing services," we strongly advise exercising caution and conferring with a legal expert before providing any services on an out-of-state basis.

Place of Service Designation

When billing CPT codes for Telehealth Visits, the place of service (POS) is 02: "The location where health services and health-related services are provided or received through a telecommunications system."

When billing Medicare's E-Visit codes, therapists should use the place of service code that indicates the location of the billing practitioner—that is, POS 11 if the therapist is located in an office, and POS 12 if the therapist is located in a home. These same POS codes apply to Telephone Visits.

Modifiers

Certain CPT codes may be billed with an appropriate modifier to designate them as telehealth services. When you use the POS code 02 in conjunction with one of these modifiers, you are attesting that you are using a HIPAA-compliant telecommunications system to deliver telehealth services—though the HHS Office for Civil Rights is temporarily waiving that requirement in the face of the COVID-19 health crisis, opening up the potential use of more consumer-friendly technologies like FaceTime for telehealth delivery.

Modifier 95

Modifier 95, when applied, designates that the services were delivered synchronously in real-time using a HIPAA-compliant program. The modifier is available for use with the new codes made available to rehab therapists as part of the COVID-19 response.

Modifier GT

Modifier GT, when applied, designates that the services were delivered synchronously in real-time using a HIPAA-compliant program. GT is the modifier that is most commonly used for telehealth claims. Per the AMA, the modifier means "via interactive audio and video telecommunications systems." You can append GT to any CPT code for services that were provided via telemedicine

Modifier GQ

Modifier GQ, when applied, designates that the services were delivered asynchronously using a HIPAA-compliant program. This is considered an "old" modifier and method of delivering telehealth, and it's slowly getting replaced by synchronous technologies.

Modifier CR

The CR modifier—which indicates that services are catastrophe/disaster-related—is mandatory when billing Medicare using the CPT codes for COVID-19-related E-Visits, which were recently made available to rehab therapists. (These codes are defined in the "Updated Coverage of Rehab Therapy Telehealth" subsection below.) This modifier is reserved for claims for which Medicare Part B payment is conditioned directly or indirectly on presence of a "formal waiver" like the one issued in response to COVID-19. It should be used for qualifying Part B items and services related to both institutional and non-institutional billing.

Documentation Recommendations to include:

1) Patient initiated the request for the PT virtual visit for …
2) Patient consented to PT virtual visit
3) Reason patient is unable to come for a face to face visit - For example – patient safety due to covid-19 and at risk due to diagnosis
4) Reason for visit
5) Document – clinical decision making associated with visit and all components of evaluation/assessment and recommendations. Clinical decision making is critical to justify that the visit was necessary.
6) Document where you conducted the visit (do not include address or location)
7) Document patient location – i.e. home
8) Document length of the visit (time start/finish)