

Prioritized List Guideline Note

Extracted from the March 13, 2020 Prioritized List



GUIDELINE A5, TELEHEALTH, TELECONSULTATIONS AND ELECTRONIC/TELEPHONIC SERVICES

Telehealth (Synchronous audio/video visits)

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. The originating site code Q3014 may only be used by appropriate health care sites. Codes eligible for telehealth services include 90785, 90791, 90792, 90832-90834, 90836, 90837-90840, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964-90970, 96116, 96150-96154, 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.

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.

Patient to Clinician Services (via telephone or electronic) ANCILLARY GUIDELINE A5, TELEHEALTH, TELECONSULTATIONS AND ELECTRONIC/TELEPHONIC SERVICES (CONT'D)

Telephonic and electronic services, including services related to diagnostic workup (CPT 98966-98968, 99441-99443, 99421-99423, 98970-98972, G2012, G2061-G2063) between a patient and clinician must meet the following criteria:

- A) Ensure pre-existing relationship as demonstrated by at least one prior office visit within the past 36 months.
- B) Documentation must:
 - 1) model SOAP charting, or be as described in program's OAR;
 - 2) include patient history, provider assessment, treatment plan and follow-up instructions;
 - 3) support the assessment and plan;
 - 4) be retained in the patient's medical record and be retrievable.
- C) Medical decision making (or behavioral health intervention/ psychotherapy) is necessary.
- D) Ensure permanent storage (electronic or hard copy) of the encounter.
- E) Meet HIPAA standards for privacy.
- F) Include a patient-clinician agreement of informed consent, which is discussed with and signed by the patient and documented in the medical record.

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- G) 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).
- H) 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.
- I) This service is not billed if the service results in the patient being seen within 24 hours or the next available appointment.
- J) 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 be billed separately.

Examples of reimbursable telephone or electronic services include but are not limited to:

- A) Extended counseling when person-to-person contact would involve an unwise delay.
- B) Treatment of relapses that require significant investment of provider time and judgment.
- C) Counseling and education for patients with complex chronic conditions.

Examples of non-reimbursable telephone/electronic consultations include but are not limited to:

- A) Prescription renewal.
- B) Scheduling a test.
- C) Reporting normal test results.
- D) Requesting a referral.
- E) Follow up of medical procedure to confirm stable condition, without indication of complication or new condition.
- F) Brief discussion to confirm stability of chronic problem and continuity of present management.

Clinician-to-Clinician Consultations (telephonic and electronic)

Requirements for coverage of electronic or telephonic interprofessional consultation are as follows:

Consulting Providers (99451, 99446-9)

- 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

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- 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

Requesting Providers (99452)

- 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.