Telehealth Reimbursement Policy

Document Number: POL-2024-001 **Effective Date:** January 1, 2024 **Last Revised:** January 1, 2024 **Department:** Revenue Cycle Management / Billing **Approved By:** Chief Medical Officer, Chief Financial Officer **Review Cycle:** Annual

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I. PURPOSE AND SCOPE

A. Purpose

This policy establishes comprehensive guidelines for how healthcare providers within our organization can bill and receive appropriate reimbursement for telehealth services under current U.S. healthcare regulations. The policy aims to:

1. Ensure compliance with federal and state telehealth reimbursement regulations
2. Maximize appropriate reimbursement for virtual care services
3. Provide clear guidance to clinical and billing staff on documentation requirements
4. Maintain parity between in-person and telehealth service payments where applicable
5. Reduce claim denials related to telehealth services
6. Standardize telehealth billing practices across all departments

B. Scope

This policy applies to:

- All licensed healthcare providers (physicians, nurse practitioners, physician assistants, clinical psychologists, licensed clinical social workers, physical therapists, occupational therapists, and other eligible practitioners)
- All billing and coding staff involved in telehealth claim submission
- All administrative staff scheduling telehealth appointments
- All payers including Medicare, Medicaid, commercial insurance, and self-pay patients

This policy covers:

- Synchronous (real-time) video visits
- Asynchronous (store-and-forward) telehealth services where applicable
- Audio-only telephone visits (where covered)
- Remote patient monitoring services
- E-consults between providers

II. DEFINITIONS

Telehealth: The use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration.

Synchronous Telehealth: Real-time, two-way interaction between a patient and provider using audio-visual telecommunications technology.

Asynchronous Telehealth: Store-and-forward transmission of patient medical information (such as images, documents) that is reviewed by a provider at a later time.

Originating Site: The location of the patient at the time services are provided via telehealth.

Distant Site: The location of the healthcare provider delivering services via telehealth.

Morphine Milligram Equivalent (MME): Not applicable to this policy (included in opioid policy).

Place of Service (POS) Code: A two-digit code placed on healthcare claims to indicate the setting in which a service was provided.

III. REGULATORY BACKGROUND AND COVERAGE

A. Federal Coverage and Parity Laws

Telehealth services have gained significant regulatory support, particularly following the COVID-19 Public Health Emergency (PHE). While some emergency flexibilities have sunset, many provisions have been extended or made permanent:

Medicare Coverage:

- Medicare Part B covers telehealth services for beneficiaries enrolled in Original Medicare
- During and following the PHE, geographic restrictions were lifted, allowing telehealth from any location including the patient's home
- Many services previously requiring in-person visits now permanently allow telehealth delivery
- The Medicare Physician Fee Schedule (MPFS) is updated annually with the list of approved telehealth services

- Providers must be enrolled in Medicare and have an established provider-patient relationship (except in certain emergency circumstances)

Medicaid Coverage:

- All 50 states and DC provide some form of Medicaid reimbursement for live video telehealth
- Coverage of audio-only, remote patient monitoring (RPM), and store-and-forward varies significantly by state
- Many states require prior authorization for certain telehealth services
- State Medicaid agencies publish telehealth coverage policies that providers must consult

Commercial Payers:

- Most private insurance plans cover telehealth services
- Over 40 states have enacted telehealth parity laws requiring private payers to reimburse telehealth at the same rate as in-person care
- Specific payer policies vary; providers should verify telehealth coverage with each commercial payer
- Some plans may have network restrictions for telehealth providers

B. State-Specific Requirements

Our billing staff maintains a current database of state-specific telehealth requirements, including:

- State licensure requirements for out-of-state providers
- Informed consent requirements
- Parity law provisions
- Covered telehealth modalities (video, audio-only, RPM, etc.)
- Originating site restrictions (if any)
- Technology platform requirements

Providers must be licensed in the state where the patient is located at the time of service, unless practicing under emergency waivers or interstate compacts (such as the Interstate Medical Licensure Compact).

IV. ELIGIBLE SERVICES AND PROVIDERS

A. Eligible Provider Types

The following healthcare professionals are authorized to deliver and bill for telehealth services under this policy:

1. **Physicians** (MD/DO) - All specialties
2. **Nurse Practitioners** (NP)
3. **Physician Assistants** (PA)
4. **Clinical Nurse Specialists** (CNS)
5. **Certified Nurse-Midwives** (CNM)
6. **Clinical Psychologists and Licensed Clinical Social Workers**
7. **Registered Dietitians or Nutrition Professionals**
8. **Physical Therapists** (PT)
9. **Occupational Therapists** (OT)
10. **Speech-Language Pathologists**

All providers must:

- Be credentialed and privileged by the organization
- Hold appropriate state licensure where the patient is located
- Complete required telehealth training (see Section VIII)
- Use only approved, HIPAA-compliant technology platforms

B. Covered Services

Common services that may be provided via telehealth include:

Evaluation and Management (E/M) Services:

- Office or other outpatient visits (CPT 99202-99215)
- Established patient E/M visits
- New patient consultations (where covered)
- Follow-up visits for chronic condition management
- Preventive medicine services (annual wellness visits, certain screenings)

Behavioral Health Services:

- Individual psychotherapy (CPT 90832, 90834, 90837)
- Family psychotherapy
- Psychiatric diagnostic evaluations
- Medication management visits
- Substance use disorder counseling

Chronic Disease Management:

- Diabetes management and education
- Hypertension monitoring
- Asthma management
- Heart failure monitoring
- COPD management

Specialty Consultations:

- Dermatology (with high-quality images)
- Neurology
- Endocrinology
- Cardiology follow-ups
- Specialist second opinions

Therapy Services:

- Physical therapy evaluations and follow-ups
- Occupational therapy
- Speech therapy

Other Services:

- Remote patient monitoring (RPM) for chronic conditions
- E-consults between providers (covered by some payers)
- Chronic care management (CCM) services
- Transitional care management (TCM) when appropriate

C. Services Not Appropriate for Telehealth

The following typically require in-person evaluation:

- Initial comprehensive physical examinations (when palpation/auscultation essential)
- Procedures requiring hands-on manipulation
- Services requiring laboratory specimens collected on-site
- Emergent conditions requiring immediate physical intervention
- Any service where the provider determines in-person care is medically necessary

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V. CODING AND BILLING REQUIREMENTS

A. CPT/HCPCS Codes

Providers should use the same CPT or HCPCS codes for telehealth services as would be used for the same service delivered in person. The telehealth nature of the encounter is indicated by:

1. Place of Service code
2. Modifiers (when required by payer)

Common Telehealth CPT Codes:

- **99202-99205:** New patient office visits (levels 2-5)
- **99211-99215:** Established patient office visits (levels 1-5)
- **99421-99423:** Online digital E/M services (async)
- **99441-99443:** Telephone E/M services (audio-only)
- **G2012:** Virtual check-in (brief communication)
- **G2010:** Remote evaluation of recorded video/images
- **99453-99457, 99458:** Remote physiologic monitoring codes
- **99490, 99491:** Chronic care management services

B. Place of Service (POS) Codes

Correct POS coding is critical for telehealth claims:

- **POS 02:** Telehealth Provided Other than in Patient's Home Use when the patient is at a clinic, hospital, or other healthcare facility receiving services via telehealth from a distant provider.
- **POS 10:** Telehealth Provided in Patient's Home Use when the patient is located in their home receiving real-time telehealth services. This is now the most commonly used POS code for telehealth following PHE flexibilities.
- **POS 11:** Office May still be used with modifiers by some payers to indicate standard office visit provided via telehealth.

Important: Incorrect POS coding is a leading cause of telehealth claim denials. Billing staff must verify each payer's specific POS requirements.

C. Modifiers

Many payers require specific modifiers to identify telehealth services:

- **Modifier 95:** Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system *Most commonly required modifier for Medicare and many commercial payers*
- **Modifier GT:** Via interactive audio and video telecommunications system *Required by some Medicaid programs*
- **Modifier GQ:** Via asynchronous telecommunications system *For store-and-forward telehealth where covered*
- **Modifier FQ:** Service provided using audio-only telephone technology *For audio-only visits covered under certain circumstances*

Modifier Usage by Payer: Our billing department maintains an up-to-date payer matrix indicating which modifiers are required, optional, or prohibited for each major payer. Staff must consult this matrix before submitting telehealth claims.

Multiple Modifiers: When billing telehealth services that require multiple modifiers (e.g., professional component of a service provided via telehealth), follow standard modifier sequencing rules with the telehealth modifier typically listed last.

D. Documentation Requirements

Clinical documentation for telehealth visits must meet the same standards as in-person visits and must additionally include:

Required Documentation Elements:

1. **Patient location:** Document city and state where patient was located during the visit
2. **Provider location:** Document where the provider was located
3. **Modality used:** Specify "Synchronous video telehealth," "Audio-only telephone," etc.
4. **Technology platform:** Name of video platform used (e.g., "HIPAA-compliant video platform")
5. **Consent:** Note that patient consent for telehealth was obtained (initial visit or per payer requirement)
6. **Clinical content:** All standard elements of the E/M or service note (HPI, ROS, exam, MDM, plan, time spent, etc.)

Special Documentation Notes:

- If audio-only used, document why video was not feasible (e.g., "Patient lacks video capability; audio-only visit conducted")
- If physical exam performed, describe how (e.g., "Visual inspection via video," "Patient performed self-exam of abdomen as directed")
- When billing based on time, document total time and that >50% was spent on counseling/ coordination of care
- For remote monitoring, document data reviewed and clinical decision-making

Technical Issues: If a telehealth visit is interrupted by technical difficulties and cannot be completed, document the issue. If the visit is converted to in-person or rescheduled, adjust billing accordingly. Partial visits may not be billable; consult payer policy.

VI. PAYMENT RATES AND REIMBURSEMENT

A. Telehealth Parity

Under telehealth parity laws in many states, virtual visits must be reimbursed at the same rate as equivalent in-person visits. This means:

- A level 3 established patient visit (99213) via telehealth should be paid the same as a 99213 in the office
- Payers cannot routinely pay a lower rate solely because the service was delivered via telehealth
- Facility fees for hospital-based outpatient telehealth may differ from in-person facility fees (check specific contracts)

Verification: Our contracting department reviews all payer agreements to ensure telehealth parity clauses are included. If discrepancies arise (telehealth claims paid at lower rates than in-person), billing staff should:

1. Confirm proper coding and modifiers were used
2. Compare the payment to the contracted in-person rate for that code
3. File an appeal or contract inquiry if underpaid

B. Medicare Payment Specifics

Professional Fee: Medicare pays for telehealth professional services at the same rate as in-person services on the Medicare Physician Fee Schedule (MPFS). There is no reduction in payment solely because the service was via telehealth.

Originating Site Facility Fee: When a patient is at a healthcare facility (hospital, clinic, SNF) for a telehealth visit with a distant provider, the originating site may bill Medicare for an "originating site facility fee" using HCPCS code **Q3014**. The payment is a nominal amount (~$28) to compensate the originating site for resources. However, if the patient is at home (POS 10), there is no originating site facility fee.

Geographic Flexibility: Post-PHE, many of the geographic restrictions have been permanently removed for certain services, allowing rural and urban patients to access telehealth from home. Billing staff should consult the current MPFS for services still subject to geographic limits.

C. Medicaid Payment Specifics

Medicaid reimbursement for telehealth varies by state. Key points:

- Most states pay at parity or close to parity for live video visits
- Some states may require use of specific telehealth networks or platforms
- Prior authorization may be needed for certain telehealth services
- Audio-only visits may be covered at a different rate or not covered at all in some states

State Medicaid Manual: Billing staff must access each state Medicaid telehealth policy manual. Our compliance team reviews state Medicaid bulletins quarterly to stay updated on policy changes.

D. Commercial Payer Contracts

For commercial insurance:

- Payment rates are governed by individual payer contracts
- Verify in the contract whether telehealth services are covered and at what rate
- If a contract predates widespread telehealth adoption, request an amendment to include telehealth provisions and parity language
- Some commercial payers may bundle telehealth services differently or have specific telehealth networks (e.g., separate telemedicine platforms that pay providers per visit)

Contract Review: Our revenue cycle management team conducts an annual review of all commercial contracts to ensure telehealth coverage is explicit and rates are defined.

VII. PATIENT CONSENT AND COMMUNICATION

A. Informed Consent

Patients must provide informed consent for telehealth services. Consent may be obtained:

- **One-time written consent** on file (preferred for ongoing telehealth use)
- **Verbal consent** documented in the medical record at each visit (if payer or state requires)

Elements of Informed Consent:

1. Explanation of how telehealth works
2. Types of technology to be used (video, phone, etc.)
3. Potential risks (technical failures, limitations of remote exam)
4. Benefits (convenience, access)
5. Privacy protections (HIPAA-compliant platforms)
6. Patient's right to refuse telehealth and request in-person visit
7. Assurance that telehealth visit will be billed to their insurance similarly to in-person visit

Consent Documentation: Our EHR system includes a telehealth consent form that patients sign electronically or on paper. For established patients with prior consent, providers should confirm verbally at the beginning of each visit: "You've consented to telehealth; is it still okay to proceed with today's video visit?" and document the affirmative response.

B. Financial Communication

Patient Cost-Sharing: Patients should be informed in advance of their financial responsibility for telehealth visits:

- Co-pays for telehealth visits are typically the same as in-person visits (e.g., specialist co-pay for a specialist telehealth consult)
- Deductibles and coinsurance apply as they would for in-person care
- Some payers waived cost-sharing for telehealth during the PHE; most have reinstated normal cost-sharing

Billing Department Responsibilities:

- At time of scheduling, inform patient of expected cost-sharing based on their insurance
- Provide patients with a telehealth visit FAQ addressing billing questions
- Have staff available to answer questions about telehealth billing and coverage

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VIII. COMPLIANCE AND TRAINING

A. HIPAA and Privacy Requirements

All telehealth services must be conducted using platforms that comply with the Health Insurance Portability and Accountability Act (HIPAA). Providers must:

- Use only organization-approved telehealth platforms that have a Business Associate Agreement (BAA) in place
- Not use consumer-grade applications (e.g., personal FaceTime, Skype, standard Zoom) unless specific OCR flexibilities apply during emergencies
- Ensure audio and video are encrypted
- Conduct visits in private settings to protect patient confidentiality
- Avoid public Wi-Fi when possible; use secure, password-protected networks

Approved Platforms: Our IT department maintains a list of approved telehealth platforms (e.g., Zoom for Healthcare, Doxy.me, Epic MyChart Video Visits, Microsoft Teams for Healthcare). Providers may only use these platforms.

Patient Education: Advise patients to also be in a private location during the visit and to use a secure internet connection.

B. Staff Training Requirements

Clinical Providers: All providers delivering telehealth services must complete:

- Initial telehealth training (2-hour online module covering clinical best practices, technology use, and consent)
- Annual refresher training
- Quarterly updates on telehealth billing and regulatory changes (via department meetings or bulletins)

Billing and Coding Staff: Staff responsible for submitting telehealth claims must complete:

- Comprehensive telehealth billing training (covering CPT codes, modifiers, POS codes, payer-specific rules)
- Quarterly updates as regulations change
- Annual competency assessment on telehealth claim preparation

Documentation: The HR/Education department maintains records of all staff training completion.

C. Claims Monitoring and Audits

Pre-Submission Review: For the first 3 months after a provider begins offering telehealth, the billing compliance team will conduct a pre-submission review of a sample of telehealth claims to ensure proper coding.

Ongoing Monitoring:

- Monthly reports of telehealth claim denial rates by provider and payer
- Quarterly audits of a random sample of telehealth charts to verify documentation supports the billed service and includes required telehealth elements
- Annual comprehensive telehealth compliance audit

Denial Management: Telehealth claims denied for technical reasons (wrong POS, missing modifier, etc.) should be corrected and resubmitted promptly. The billing manager tracks denial reasons to identify trends and provide targeted education.

Goals: Our compliance targets are:

- <5% initial denial rate for telehealth claims due to coding/billing errors
- > 95% of telehealth documentation includes all required elements
- 100% of providers using approved HIPAA-compliant platforms

D. Regulatory Updates

The telehealth regulatory landscape is dynamic. Our Compliance Officer monitors:

- CMS telehealth updates and MPFS changes
- State Medicaid policy bulletins
- State legislation affecting telehealth parity and licensure
- Commercial payer policy updates
- Professional association guidance (AMA, ATA, specialty societies)

Communication: Significant regulatory changes are communicated to providers and billing staff via email alerts and discussed in department meetings. The policy is formally reviewed and updated annually, with interim updates as needed.

IX. SPECIFIC SCENARIOS AND EXAMPLES

Example 1: Established Patient Follow-Up via Video (Medicare)

- **Service:** Established patient office visit, moderate complexity (99214)
- **Modality:** Video visit, patient at home
- **Billing:** CPT 99214, Modifier 95, POS 10
- **Payment:** Same rate as in-person 99214
- **Documentation must include:** Patient location (home address city/state), provider location, "video telehealth visit conducted via [platform name], patient consent confirmed"

Example 2: New Patient Psychiatry Consultation (Commercial Insurance)

- **Service:** Psychiatric diagnostic evaluation (90791)
- **Modality:** Video visit, patient at home
- **Billing:** CPT 90791, Modifier 95, POS 10 (verify payer preference)
- **Payment:** Per contract rate for 90791 (parity law applies if in a parity state)
- **Note:** Verify patient's insurance covers telehealth psychiatry; obtain consent and provide patient with crisis resources in case of technical failure

Example 3: Telephone Visit (Audio-Only), Medicaid

- **Service:** 15-minute telephone E/M (99442)
- **Modality:** Audio-only (patient has no video capability)
- **Billing:** CPT 99442, Modifier FQ (if required by state Medicaid), POS 10
- **Payment:** Check state Medicaid policy—some states cover audio-only at parity, others at reduced rate or not at all
- **Documentation must include:** Reason video not used, phone call conducted, clinical content

Example 4: Remote Patient Monitoring for CHF

(Medicare)

- **Service:** RPM setup and monitoring for a patient with heart failure
- **Billing:**
  - CPT 99453 (initial setup, billed once per episode)
  - CPT 99454 (device supply and daily recording/transmission, billed once per 30 days)
  - CPT 99457 (first 20 minutes of clinical staff time reviewing data and communicating with patient)
  - CPT 99458 (each additional 20 minutes)
- **Payment:** Per MPFS rates for each code
- **Documentation must include:** Type of device provided, data reviewed (dates/values), time spent, and clinical management decisions based on data

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X. POLICY GOVERNANCE

A. Roles and Responsibilities

Providers:

- Deliver high-quality telehealth care
- Complete required documentation
- Use only approved platforms
- Participate in training

Billing Staff:

- Code telehealth visits accurately per this policy
- Stay current on payer requirements
- Monitor denial rates and work appeals

Compliance Officer:

- Monitor regulatory changes
- Conduct audits
- Update policy as needed

Revenue Cycle Director:

- Oversee telehealth billing operations
- Review payer contracts for telehealth coverage

- Report metrics to leadership

CMO/CFO:

- Approve policy
- Allocate resources for telehealth infrastructure and training

B. Policy Review and Updates

This policy will be reviewed annually by the Telehealth Steering Committee (comprising representatives from clinical, billing, compliance, IT, and legal departments). Interim updates will be issued via policy amendments as significant regulatory changes occur.

C. Enforcement

Non-compliance with this policy may result in:

- Claim denials and loss of revenue
- Compliance violations and potential payer audits or recoupment
- Disciplinary action for staff who repeatedly fail to follow billing guidelines or use non-compliant technology platforms

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XI. REFERENCES AND RESOURCES

1. Centers for Medicare & Medicaid Services (CMS) Telehealth Website: telehealth.hhs.gov
2. CMS Medicare Learning Network: Telehealth Services (current MLN Booklet)
3. State Medicaid Telehealth Coverage Policies (50-state scan available from CCHP)
4. American Medical Association (AMA): CPT Coding for Telehealth
5. American Telemedicine Association (ATA): Practice Guidelines for Video-Based Online Mental Health Services
6. Center for Connected Health Policy (CCHP): State Telehealth Laws and Reimbursement Policies
7. Federal Communications Commission (FCC): COVID-19 Telehealth Program resources

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XII. APPENDICES

Appendix A: Payer-Specific Modifier and POS Matrix (maintained by Billing Department, updated quarterly)

Appendix B: Telehealth Consent Form Template

Appendix C: Telehealth Documentation Checklist for Providers

Appendix D: Approved Telehealth Platforms List (maintained by IT, updated as needed)

Appendix E: State Licensure Compact Information

END OF POLICY

For questions regarding this policy, contact:

- Clinical questions: Chief Medical Officer
- Billing questions: Revenue Cycle Director
- Compliance questions: Compliance Officer
- Technology questions: IT Help Desk

Document Control:

- Version: 1.0
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