

April 1, 2020

**ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
M E M O R A N D U M**

TO: Chief Financial Officers, Member Hospitals and Health Systems
Chief Medical Officers
Government Relations Personnel
Behavioral Health Constituency Section

FROM: Lia Daniels, Director, Health Policy
Stephanie Volante, Director, Patient Financial Services

SUBJECT: IHA COVID-19 Telehealth Update #1: State Coverage and Reimbursement

As described in a [Mar. 24 IHA Memo](#), Governor Pritzker issued an [Executive Order](#) and the Department of Healthcare and Family Services (HFS) issued [Emergency Rules](#) (89 Ill. Adm. Code 140.403(e)) and a [Provider Notice](#), all focused on telehealth coverage and reimbursement.

On Mar. 30, HFS issued a [Provider Notice](#) to provide Medicaid telehealth expansion billing guidelines. The temporary policy changes are related to the current COVID-19 health emergency and apply to claims covered under Medicaid fee-for-service as well as all HealthChoice Illinois managed care plans. Below is a summary of the latest HFS Provider Notice, followed by a list of resources, including:

- The latest IHA memos related to telehealth reimbursement;
- Health Insurance Portability and Accountability Act (HIPAA) guidance related to COVID-19;
- Sample informed consent forms and telehealth templates; and
- Guidance on business associate agreements.

HFS Medicaid Telehealth Billing Update

An originating site will be eligible for a facility fee when it is a certified eligible facility or provider organization that acts as the location for the patient at the time a telehealth service is rendered. Allowable originating sites are those previously allowed (prior to the emergency telehealth changes) per the Practitioner Handbook, as well as those allowed during the COVID-19 public health emergency including, but not limited to: substance use treatment programs licensed by the Department of Human Services' Division of Substance Use Prevention and Recovery; Supportive Living Program providers; Hospice providers, Community Integrated Living Arrangement providers; and providers who receive reimbursement for a patient's room and board. **Please Note: if the participant is not receiving a telehealth service at a certified eligible facility (e.g., the participant is in his/her own home or a temporary residence), there**

is no billable originating site service.

Clinic encounter visits are allowed for new or existing patients via telephone, with the requirement being the key components necessary to bill a typical “in-person” service must be met in documentation. This applies to medical, dental, and behavioral clinic visits that will be reimbursed at the encounter rate, as long as documentation requirements are met. Evaluation and management services (e.g., CPT codes 99201 – 99215) rendered to new or existing patients via telephone may be billed as a distant site telehealth service so long as the E/M service is of an amount and nature that would be sufficient to meet the key components of a face-to-face encounter. Claims must include modifier GT and place of service 02 (POS) for accurate claims processing.

- For **medical encounters**, modifier GT is required on all detail code service lines.
- For **behavioral health encounters**, modifier GT is required on all service lines inclusive of the encounter service line. Additionally, modifier GT must be the first modifier appended, preceding any other modifier on encounter “T” code, in order for claims to price accurately.
- **Audio-only telephonic encounters (no video available)** that cannot meet key components of an “in-person” visit can alternatively be reported as either a virtual check-in or e-visit via a portal (see table below for additional details).

Virtual check-ins are brief (5-10 minutes), via telephone or other communication device, used to decide whether an office visit or other service is necessary for established patients. Documentation must still be maintained by providers (e.g., physicians, advanced practice nurses, and physician assistants) in the record to meet all HCPCS code requirements, and claims must include modifier GT and POS for accurate claim processing. **HFS has made updates to the original notice (March 20) to align reporting with Medicare, indicating providers should now report virtual check-ins with the following HCPCS codes:**

HCPCS Code	Description
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
-------	--

E-visits are communications initiated by a patient (established patients only), with their provider via an on-line portal. HFS will reimburse for the following online/patient portal activities. Documentation must still be maintained by providers (e.g., physicians, advanced practice nurses, and physician assistants) in the record to meet all HCPCS code requirements, and claims must include modifier GT and POS 02 for accurate claims processing. The following are the HCPCS codes for e-visits reported through a secure patient portal, and billed once for the cumulative time provided in a seven-day period:

HCPCS Code	Description
G2061	Qualified non-physician healthcare professional online assessment, for an established patient, for up to 7 days, cumulative time during the 7 days, 5-10 minutes.
G2062	Qualified non-physician healthcare professional online assessment, for an established patient, for up to 7 days, cumulative time during the 7 days, 11-20 minutes.
G2063	Qualified non-physician healthcare professional online assessment, for an established patient, for up to 7 days, cumulative time during the 7 days, 21 or more minutes.
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days, 5-10 minutes.
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days, 11-20 minutes.
99423	Online digital evaluation and management service, for an established patient, 21 or more minutes.

Additional Telehealth Updates and Resources

The following are recent IHA memos on telehealth reimbursement updates and HIPAA guidance related to the current COVID-19 health emergency, sample informed consent forms, telehealth templates, and guidance on business associate agreements:

- [CMS: New Waivers and Regulatory Changes \(3/31/20\)](#)

- [Temporary Telehealth Coverage Announced](#) (3/25/20)
- [COVID-19 Medicare Telehealth Coverage Expansion Authorities](#) (3/19/20)
- [Illinois HFS Section 1135 Waiver Request](#) (3/19/20)
- Federal guidance on HIPAA
 - HHS 1135 HIPAA waiver [fact sheet](#)
 - HHS Notice of Enforcement Discretion [fact sheet](#)
 - HHS Office of Civil Rights [bulletin](#)
 - HHS Office of Civil Rights [FAQs](#) on Telehealth and HIPAA during the COVID-19 nationwide public health emergency. OCR will be updating the FAQs based on feedback - so let OCR know of other questions.
 - HIPAA Security Rule [safeguards](#)
- [Sample telehealth informed consent forms](#) and other templates from the Upper Midwest Telehealth Resource Center
- [Guidance](#) on Business Associate Agreements