PT in Motion

PT in Motion PT News

Wednesday, March 18, 2020

Furnishing and Billing E-Visits: Addressing Your Questions

http://www.apta.org/PTinMotion/News/2020/03/18/E-VisitFAQs/

Recent waivers by CMS that allow for limited digital communication with patients have triggered a wave of questions. Here are our answers to the ones we hear most often.

APTA is receiving many questions about the recent regulatory waivers announced by CMS related to digital communication between providers and patients, particularly regarding e-visits and the use of HCPCS codes G2061-G2063. We've compiled this list of the most common questions we've received so far.

If you have a handle on e-visits and just want a brief review of the basics, see our "Quick Reference to Using E-Visits for Physical Therapist Services." But if the new waivers leave you with questions, continue below.

Please note that e-visits are NOT the same as telehealth or telerehab services. Congress and CMS have not modified Medicare to allow physical therapists to the roster of providers who can be reimbursed for telehealth services. With that said, APTA regulatory and payment staff are working directly with CMS and private payers to seek expansion of coverage of telehealth services to include physical therapy services.

Also important to keep in mind: If you don't find the answer to your question here, continue to consult trusted sources such as APTA (advocacy@apta.org). Avoid acting on conjecture or recommendations that you don't know to be reliable.

In addition the information here, CMS also has answers to Frequently Asked Questions about e-visits. You can find reimbursement rates for the e-visit related codes using the CMS Physician Fee Schedule Look-Up Tool.

APTA offers recordings of two recent online presentations on e-visits: an online town hall presentation from March 19 as well as a March 20 Facebook Live event.

[Editor's note: The parenthetical dates at the end of each answer indicate either the date it was created or the last time it was updated.]

In General

1. What is an e-visit?
In its 2020 physician fee schedule final rule, CMS describes e-visits as “non face-to-face patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office.” The code descriptors for the HCPSC codes related to e-visits suggest that the codes are intended to cover short-term (up to seven days) assessments and management activities that are conducted online or via some other digital platform and include any associated clinical decision-making. (March 18)

2. Is an e-visit a telehealth service?
No. An e-visit is considered a service furnished remotely using technology but is not considered a Medicare telehealth service. Under Medicare physical therapists are still not recognized as telehealth providers. An e-visit does not constitute telehealth under the Medicare definition. Under commercial payer policies, the answer varies, so check with your payer. (March 20)

3. Are PTs required to complete an 1135 waiver to bill for an e-visit?
No, it's a blanket waiver. But you must use the CR modifier. See question 15 below. (March 20)

4. What is an online patient portal?
The HHS Office of National Coordinator for Health Information Technology (ONC) describes a patient portal as a secure online website that gives patients convenient, 24-hour access to personal health information from anywhere with an internet connection. A patient portal requires a secure username and password to allow patients to securely message their provider. (March 18)

5. Is an online patient portal the only medium PTs can use for an e-visit? Can a phone call encounter without video qualify?
Under the original code description, an online patient portal is required. Although CMS has implied that they are giving providers flexibility in the platform used, please check with your Medicare Administrative Contractor (MAC) for guidance. (Revised March 20)

6. Is there a way for a PT to establish a new patient using an e-visit, for patients who do not want to come in person for an evaluation? Similarly, can a physician transfer a new patient or establish a new patient under a PT’s care in order for the PT to use the e-visit codes for an evaluation?
No. The patient must already be under the care of the therapist. Check your state practice act for additional guidance on what is considered an “established patient.” (March 20)

7. How does the assessment work? Are G2061, G2062, and G2063 the codes to use?
The assessment and management codes G2061-G2063 allow a provider to respond to a patient-initiated request for an e-visit. The term is misleading, as this is not a “visit” in the traditional sense but rather activities and correspondence that support a patient over a maximum of a seven-day period. (March 20)

8. CMS originally said there would be leniency with providing e-visits across state lines. Does this hold true for other insurances?
The 1135 provisions include a "waiver of provider licensure," but it doesn't mean much unless a state creates a waiver, too. The 1135 system wasn't created solely for pandemics — it's also used to respond to regional disasters, where out-of-state providers may be needed to respond to an emergency. That's where the licensure waiver has the most effect. While the provisions do include a waiver that allows authorized providers to render services outside their states of Medicare enrollment, in order for the provider license waiver to be of practical use, states need to create their own licensure waivers because state requirements take precedence. However, many states are passing legislation related to licensure requirements. (March 20)

Coding and Billing

9. What codes can a physical therapist bill for an e-visit?
Physical therapists are eligible to use these HCPSC codes:

- G2061: Qualified nonphysician health care professional online assessment and management, for an established patient, for up to seven days; cumulative time during the seven days, 5-10 minutes.
- G2062: Qualified nonphysician health care professional online assessment and management service, for an established patient, for up to seven days; cumulative time during the 7 days, 11-20 minutes.
- G2063: Qualified nonphysician qualified health care professional assessment and management service, for an established patient, for up to seven days; cumulative time during the 7 days, 21 or more minutes. (March 18)

10. What place of service (POS) code do PTs use when billing e-visits?
The POS is the location of the billing practitioner. In the case with remote services, the locality that is assigned to the claim is based on the place where the claims service was rendered. Therefore, in this situation, if the physician/practitioner doing the monitoring is in, for example, Maryland, and the beneficiary is in New York, the locality or POS is Maryland. The issue is "where the service was rendered," and in the example above, the service was rendered in Maryland, because that's where the physician/practitioner is located. That would come in on the claim as the place where the service was rendered. It does not matter where the corporate address of the billing provider is, nor does it matter what the beneficiaries' addresses are. It matters where the service was rendered; that is, where the biller is located. (March 18)

11. Should POS code 02 be used when billing an e-visit? What about using the 95 modifier vs. the GT modifier?
For Medicare you can only bill for an e-visit. An e-visit does not meet the definition of telehealth under Medicare, and PTs should not use POS code 02. Nor should a PT use GT modifier when billing an e-visit under Medicare. (March 20)

12. What POS code should be used if the PT has a mobile or home office?
In this instance, we believe POS code 12 would be correct. (March 20)

13. Alternatively, what POS code should be used if the PT has a brick and mortar office but is responding to the e-visit while at home?
In this instance, we believe the POS code 11 would be correct. (March 20)

14. Can a PTA in an outpatient clinic use one of the codes for this service if under direct supervision in the clinic?
No. (March 20)

15. What modifier is required to be appended to the claim?
Because a public health emergency has been declared, CMS guidance instructs providers to apply the CR (catastrophe/disaster related) modifier for both institutional and noninstitutional Part B billing. (These are claims submitted using the ASC X12 837 professional claim format or paper Form CMS-1500.) Please note: For institutional billing, the DR condition code and CR modifier is required. For noninstitutional billing, only the CR modifier is required. The March 18 CMS MLN Matters article explains further. See also MCPM Chapter 38. (March 20)

16. Is the GP modifier required to be appended to the claim, whether institutional or noninstitutional?
CMS has indicated to APTA that the e-visit codes will be described as "sometimes therapy" codes and will need the GP modifier. PTs also must append the CR modifier for noninstitutional

billing, and both the CR modifier and the DR condition code for institutional Part B billing. See question 15. (March 23)

17. How do institutional settings differentiate between outpatient PT, OT, and SLP services?
Institutional providers should use the appropriate revenue codes for reporting outpatient rehabilitation services:

- 0420 - physical therapy services
- 0430 – occupational therapy services
- 0440 – speech-language pathology services

For more information about Part B billing, see MCPM Chapter 5. (March 23)

18. Will Medicare coinsurance and the annual Part B deductible apply to these codes?
Yes. According to the CMS fact sheet, the annual Medicare Part B deductible and 20% coinsurance apply to these codes. (March 18)

19. If someone has a secondary insurance with a per-visit copay, does this apply to the e-visit?
This varies by payer. Many payers are waiving copays and deductibles for these services, but PTs will need to check their payers' policies. (March 20)

20. Can PTs bill CPT codes 99421, 99422 and 99423 for an e-visit?
No. These are evaluation and management, or E/M, codes, for e-visits and PTs are not permitted to independently bill for E/M visits. The non-physician e-visit codes are CPT codes 98970-98972 for commercial payers and HCPCS codes G2061-G2063 for Medicare. (March 18)

21. Can PTs bill CPT codes 99441-99443?
99441-99443 are E/M codes for telephone services that cannot be billed by physical therapists. The non-physician codes for telephonic assessments are 98966-98968. Medicare has not provided any guidance on the use of these codes by physical therapists at this time. (March 18)

22. When can I use CPT code 98966, Under Non-Face-to-Face Nonphysician Telephone Services?
CPT code 98966 is a medical procedural code under the Non-Face-to-Face Nonphysician Telephone Services. Generally, this code has not been approved for use by PTs. APTA is seeking clarification from payers regarding PTs' use of this code, and we will continue to provide updates. PTs also can contact their payers directly. (March 20)

23. Will commercial payers pay for an e-visit?
Payer policies may vary, so check with each insurance carrier, including Medicare Advantage plans, as to whether they will pay for an e-visit with HCPCS codes G2061, G2062, and G2063, or CPT codes 98970, 98971, and 98972. (March 18)

APTA is urging any private payers that are not already covering telehealth services delivered by PTs to remove those limitations now. APTA is in direct contact with several large commercial payers advocating for expanded remote and/or telehealth policies that would allow PTs and PTAs to maintain contact with and care for patients who are unable to come to the clinic. APTA is also providing resources for PTs to use to communicate directly with payers regarding provision of and payment for remote and/or telehealth services. (March 18)

Seven-Day Period

24. What is meant by “established patient”? Can the PT put something on their website to state this is currently available, or if a patient calls to schedule an appointment would the PT notify them of this option?
E-visits currently are available for patients who are already under the care of the therapist. Please check your state practice act for guidance on what constitutes “established patient.” (March 18)

25. If the patient came in person for an evaluation visit, could they switch to telehealth for the second visit?
Keep in mind that these are not telehealth visits in the truest sense. This is a means by which a PT can manage the care of a patient over a period of up to seven consecutive days when the patient is unable to or does not need to come into the clinic. (updated March 20)

26. What is meant by “for up to seven days; cumulative time for the seven days”?
The PT would bill the appropriate code based on the cumulative amount of time spent over a seven-day period. (March 18)

27. When does the seven-day period begin? Is it defined, such as always Sunday to Saturday, or is it from the start of the first e-visit to seven consecutive days thereafter?
The seven-day assessment and management period begins when the provider responds to the patient's request for an e-visit. The period ends after seven consecutive calendar days. (updated March 20)

28. Does the seven-day period mean the seven days between the first e-visit to the last e-visit? Can there be multiple e-visits within the seven-day period?
The seven-day period is seven consecutive calendar days beginning when the provider responds to the patient’s request for an e-visit. All of the cumulative activities occurring within the seven-day period support the selection of the appropriate code for that seven-day period based on the time spent. (March 20)

29. Can a PT bill more than one code per seven-day period?
No. You can only bill one code per seven-day period. (March 18)

30. Can other CPT codes be billed in the seven-day period; for example, if a PTA is able to treat onsite on day three of the seven, and the PT performs e-visits on days 2, 5, or 7?
An e-visit cannot be billed if a face-to-face visit occurs within seven days before or within seven days after the e-visit. As a reminder, an e-visit is not a treatment session. It is the means by which a provider addresses a specific question or outreach from a patient, and it is an aggregate of interactions and actions taken over a period of a maximum of seven consecutive days. (March 25)

31. Can the codes only be used once within a given episode of care, or can they be billed more than once (during two or more different seven-day periods within the episode of care)?
There is a lack of clarity around what would happen if a provider billed any of these codes more than once in an episode of care. We are seeking guidance as to whether there can be billing for multiple seven-day periods. (March 20)

32. Does the PT have to make sure that the patient is not seen for at least seven days before or after the e-visit?
The comparable CPT codes do limit the use of these codes to seven days after and before a face-to-face visit. PTs should follow the rules about the number of visits that limit the use of these codes to seven days after and before a face-to-face visit. (March 20)

33. If the patient’s issue is resolved in three days, does the PT have to wait seven days to document or bill the e-visit?
No. For example, if the PT determines via the assessment and management e-visit that the

patient needs to be referred to another provider and the PT will not continue interaction with the patient, then the PT can document and bill the assessment and management activities at that time. The seven-day period is a maximum. (March 20)

34. Does this also mean a PT can only submit this code every seven days?
Yes, the appropriate code would be submitted once for the seven-day period for the same patient within the same episode of care. (March 18)

35. Does "seven days" refer to seven consecutive days or to up to seven different visits spread out?
The seven days is a period of time over seven consecutive days during which the assessment and management services occur as needed for the individual patient. The patient must generate the initial inquiry, and communications can occur over a seven-day period. (March 18)

Practice

36. What if patients need regular consultation? Can the PT set up a weekly e-visit with them?
Remember, the patient must initiate [emphasis added] the e-visit, which is intended to serve as an alternative to the traditional in-person visit for nonurgent medical issues. The online digital assessment and management is also intended to address a specific patient issue, problem, or need and is not intended to be an ongoing consultation model. (March 18)

37. Does an "in-person" evaluation refer to one performed by an MD or by a physical therapist? If an MD does an E/M, can the PT then do e-visits and use the G-codes?
For a therapist to bill for this cumulative assessment and management service, the patient must already be under the care of the physical therapist, meaning the physical therapist must have already performed the evaluation. (March 18)

38. What if a patient's start of care was two months ago, before the pandemic started, and the physical therapist did not educate them about an e-visit then; is the therapist unable do it now and bill for it?
The physical therapist can educate the patient about the availability of an e-visit any time during the episode of their care. (March 18)

39. If the evaluation has been cosigned by the referring provider and it did not include e-visits within the developed plan of care, can an e-visit be performed?
An e-visit does not need to be delineated in a developed plan of care; it is the exception to the plan of care. (March 20)

40. Does an e-visit count against the number of visits permitted under a NCD, such as for cardiac rehab?
We do not believe an e-visit counts against the number of visits permitted under Medicare coverage rules. (March 20)

41. How does an e-visit affect the count toward the 10-visit requirement for a progress report? Does each encounter count toward the 10, or does billing the code once for all the encounters within the seven-day period count as one visit?
E-visit services do not count toward the 10-visit progress report requirement. (March 20)

42. Can a home health agency use e-visits?
An e-visit is a Medicare Part B covered service that can be billed by either an institutional setting, such as a home health agency, or a professional, such as a PT in private practice. An e-visit is not reimbursable under Medicare Part A. (March 20)

Documentation

43. What are the documentation requirements to support the billing of these codes?
Document that the patient initiated the e-visit and the service(s) provided, including your clinical decision-making associated with the service. Since the services may be intermittent over a seven-day period, document all components of patient assessment and management performed during the time period. (March 18)

44. Do PTs still follow the plan of care regarding frequency of visits per week?
APTA suggests documenting the reason why the patient is unable to come in for an office visit and then document the e-visit. The e-visit would not need to be done in compliance with the frequency of the plan of care, as the visit would be documented as inability to come for in-person visit/cancellation. (March 18)

45. Are daily notes required for reimbursement for these e-visit CPT codes? What if the CPT code was not approved under the original plan of care?
The e-visit code does not have to be part of the original plan of care. Document all activities and interactions that occur within the seven-day period as you do them. Also document that the patient initiated and consented to the e-visit, as well as your clinical decision making. (March 20)

46. What if plan of care is expired or it has been over 30 days since the patient's last visit?
This is a gray area without a clear answer. We are seeking clarification from CMS. (March 20)

HIPAA

47. Does the online patient portal need to be HIPAA-compliant?
APTA advises using a secure, HIPAA-compliant platform. However, per the CMS Fact Sheet issued on March 17, 2020, "Effective immediately, the HHS Office for Civil Rights will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency." However, for purposes of e-visits FaceTime or Skype is not appropriate. CMS' mention of FaceTime and Skype refers to the delivery of telehealth services. (March 20)

Posted by News Now Staff at 2:44 PM

Labels: APTA Working For You, Practice Tips, Health Care Headlines

Comments

- Once a pt has been contacted through an e-visit do they have to be seen in the office again before another 7 consecutive day period can be initiated for another e-visit under the same plan of care?

  Posted by Kelly Vredeveld on 3/18/2020 5:05 PM

- How does all this apply to school based services? Can they be provided for several months?

  Posted by Julie Wissink, P.T. on 3/18/2020 5:31 PM

- Thank you for this information although I'm still not clear on the seven day period that you're talking about. If we use one code in a seven day period for a patient that we've

already started with that agrees to the EVvisits, why aren’t we able to do this weekly until they aren’t needing the care or until we can see them one on one?

Posted by Linda Sylvester on 3/18/2020 5:57 PM

- Thanks-this is very helpful!

  Posted by Marsha Lawrence -> ?GQ_? on 3/18/2020 6:14 PM

- The key question is what does it reimburse. A range or estimate is needed.

  Posted by Brad Van Pelt on 3/18/2020 7:27 PM

- HI, You don't address if the issue of if this is only for Part B or if Part A home health is also covered by E-visit. Please clarify.

  Posted by Keri Jackson on 3/18/2020 7:30 PM

- Can therapists bill for e-visits in the home health setting? Thanks

  Posted by Lauren on 3/18/2020 7:56 PM

- I have many staff PT's who have concerns about billing and coding. Will these be addressed in the seminar on Thursday ?

  Posted by David L. Wetzel on 3/18/2020 11:49 PM

- We should be able to use our normal codes say 97530, 97112, 97110 with the place of service as 02 and with a modifier that is designated for telecommunications ie GQ. The actual service is the same, just not in person. The payment even for the G2063 code is not adequate. Patients normally seen for 60 minutes 1-2 times in a 7 day period should be able to receive the same via video communication. If we could use our normal codes with the 02 place of service and GQ modifier modifications, the evisit billing would be smooth and jive with in clinic visits if there’s a combination. The G2061-3 are a nice start, but billing for what we actually do is better in my opinion

  Posted by Jb on 3/19/2020 12:45 AM

- Further thought lead me to this. Using Triwest’s code descriptions as an example: The 97 codes for physical therapy state nothing about face to face in person treatment. There is no verbiage that states video treatments cannot be conducted and billed say under 97110, 97112. Furthermore “direct” contact refers to one on one care per TriWest, nothing states in person vs video conduction of treatment. The actual treatment could be considered 01 because the treatment was given from an office/clinic. The treatment was not a home visit. Therefore, we as PTs should be able to bill per usual for treatment whether by video or in person using the same codes. The G codes are set up for physicians it seems. Our codes should be able to be used per reasoning stated.

  Posted by Jb on 3/19/2020 7:00 AM

- Can telehealth be used be used for the pediatric population?

  Posted by Sarah Lynn Jones on 3/19/2020 7:59 AM

- Can PTA's provide this service?

  Posted by baljeet kaur -> DJY`DK on 3/19/2020 10:51 AM

- Is there any opportunity for a PT to use an e-visit to provide guidance for new patients that are not currently under the care of the PT? Thank you!

Posted by McKenzie on 3/19/2020 1:45 PM

- I own a pediatric OP clinic, what are the limitations on e-visit/tele-health w/ children, parent education, HEP updates, etc. thank you!

  Posted by Dawn L Welborn-Mabrey on 3/19/2020 3:51 PM

- Can PTA's provide an e-vist in a home health setting?

  Posted by Amie on 3/19/2020 3:53 PM

- Our only question is: Can the patient have an E-visit within 7 days after an in-office visit? Or do we have to wait 7 days before the patient can request an E-visit? Thank you for this FAQ..it was VERY helpful!!

  Posted by Catrina on 3/19/2020 4:49 PM

- can you let us know the reimbursement for codes: G2061, G2062 G2063? Do we use the GP modifier on these codes? Do we use the CR code as well or is this just for telemedicine?

  Posted by carol on 3/19/2020 8:50 PM

- Are the G0261-G0263 codes applicable to an outpatient rehab department of a hospital? These therapists currently do not bill for professional services and the services are billed on a UB04.

  Posted by Andrea on 3/19/2020 9:02 PM

- I understand POS and that billing happens in the state where the provider is located. Does that mean we are allowed to treat/ do phone consulatations across state lines?

  Posted by Shefali Christopher -> @IV`DG on 3/20/2020 7:27 AM

- The public school has requested us to provide tele-PT for our present population. 1. If we can only provide for 7 days, students who receive once a week PT will only be able to receive one session. The schools are looking to provide services via tele-PT possibly for the remainder of the school year. Please give me information regarding providing pediatric PT via a long term tele system thank you and stay healthy!

  Posted by Maryann Huzar on 3/20/2020 8:36 AM

- Need guidance for how this applies to school based PT please.

  Posted by Cindy Baird on 3/20/2020 10:42 AM

- Here is some current info for OT and PT school based practice in lite of covid19 in Texas. Hope this helps. TXSPOT.org/blog/default.aspx Titled: March 19th. Preliminary Guidance: Telehealth for School Based OT and PT

  Posted by Dana on 3/20/2020 11:18 AM

- Are the G0261-3 billable on a UB claim form by a hospital department? If not, can a hospital department offering OP rehab bill for eVisits? We can't find anything to confirm this. We know that there are edits in place if we bill G codes like this on a UB they won't even get out of a clearinghouse.

  Posted by Kim on 3/20/2020 12:08 PM

- Can a hospital based outpatient facility bill for e-visits? If so, how?

Posted by Karen Whitesell on 3/20/2020 2:00 PM

- I am wondering about JB's comment as well. We should be able to use our normal codes say 97530, 97112, 97110 with the place of service as 02 and with a modifier that is designated for telecommunications ie GQ. The actual service is the same, just not in person. The payment even for the G2063 code is not adequate. Patients normally seen for 60 minutes 1-2 times in a 7 day period should be able to receive the same via video communication. If we could use our normal codes with the 02 place of service and GQ modifier modifications, the evisit billing would be smooth and jive with in clinic visits if there's a combination. The G2061-3 are a nice start, but billing for what we actually do is better in my opinion

  Posted by Rebecca on 3/20/2020 3:22 PM

- I am a licensed Physical Therapist Assistant in the state of New Mexico. On the FB live today for CMS and APTA guidelines for e calls, I heard that PTA's are not able to perform e calls as this is an assessment and management service and that the G-codes provided can only be billed for payment by a Physical Therapist. If this is true and I will not be able to perform e calls then I need documentation of this to provide to my employer. If it is not true then please also let me know, Thank you! Kristin Provost, PTA, BS

  Posted by Kristin Provost, PTA, BS on 3/20/2020 5:22 PM

- While this is better than nothing, the e-visits will allow us to regain only a minuscule number of the treatments and subsequent revenue that an in office or tele-health sessions could offer. I have closed my rural private practice clinic for at least 2 weeks in order to protect my patients from potential unneeded exposure, to protect my staff and myself (not to mention our families) and to "flatten the curve". I suspect that the closure will be much longer. We need to fight for tele-health in order to effectively reach out to our patients and provide a service that can patch them through effectively without unneeded exposure to them or to us. Continuing to see patients in the clinic who are not in urgent need is,in my opinion, as bad as going to work sick. Is there hope on the horizon to be able to offer more than e-visits to our patients?

  Posted by Melinda McConnell -> =KY\DK on 3/20/2020 5:46 PM

- I have two questions after reviewing all of this helpful information: 1. What are the reimbursement rates for G2061-G2063? 2. If there was more than one date where patient care was initiated and an e-visit took place during the 7 day window, what date of service do you bill?

  Posted by Juliann S. on 3/20/2020 7:11 PM

- As a Clinical Psychologist, who sees patients in SNFs, I'm at loss as to how I can continue continuity of care during this "lock-down". I can provide care through FaceTime or Messenger, but the patients cannot request the service. How to bill for psychotherapy by the above modes?

  Posted by Wes Ledom, Ph.d. on 3/21/2020 8:47 AM

- Regarding reimbursement rates: use the Medicare Fee Schedule Calculator on APTA's website. You need to be a member. If you are not a member, you will need to do the legwork and use the CMS Physician Fee Schedule link provided in the intro portion of this communication. These are time based codes. If I spend a total of 25 minutes with a patient during a 7 day period, I can bill one unit of G2063 and will be reimbursed $33.72 (specific to my geographic location). MCR will pay 80% and the balance is either billed

to secondary insurance or to the patient. For example, if I have an established patient who I initially saw in person and established a home exercise program for them and they contact me regarding safety, pain, progression, etc. and I spend 10 minutes reviewing their status and provide guidance on the issues they raised as it relates to my established plan of care. They contact me 2 more times during the 7 day period (which began with the first e-visit) and I spend another 10 minutes on the second e-visit and 5 minutes on the 3rd e-visit. Total time spent during the 7 days = 25 minutes. At the end of the 7 day period (calendar days), I can bill 1 unit of G2063 which is for >21 minutes. (I am not sure if I can then begin another 7 day period) Remember, this is not treatment. You are assessing based on their input or what you observe via a HIPPA compliant video platform and providing your professional advice and guidance. That will vary patient to patient. PTA's cannot do e-visits. They require the skills and training of a PT/OT/SLP. Always check your state practice act. However, this is not telerehab or Telehealth and may not be addressed. If so, ask your state board for clarification specific to service codes G2061-G2063. Non-medicare insurance will need to be confirmed separately. Some have parity clauses which may allow you to actually treat patients via Telehealth and be paid according to their policy. Check and double check. Try to find a written explanation vs a verbal response. Disclaimer: This is my interpretation. Check validation sources, such as CMS.

Posted by Thomas Gangemi -> =JP]B on 3/21/2020 11:00 AM

- Excellent, excellent! However, when it was all said and done your HIPAA section, question 47, implies we can't use Facetime, Skype (nd presumably Zoom,etc) for E visits. Then WHAT mode/platform can we use for E visit?!! Webinar said telephone was ok, but here you say to check with the MAC regarding telephone E -visit.

  Posted by Dennis E on 3/21/2020 3:19 PM

- In the many articles I've gone through, I thought that Medicare guidelines are to bill for a video/telemedicine visit using just the 02 POS and not a modifer. Also that private insurances need the 95 modifier. All this information is confusing as to what codes/modifiers to use & what will actually get paid. Clarity is needed!!

  Posted by Maggie J. on 3/21/2020 4:43 PM

- While billing for E visit by an MD, for office visit, what modifier shall we use against office visits .. For Ex: 99214- ? especially for Medicare, or BCBS..do we have give modifier 95 for both Evisit and Telemedicine visits?

  Posted by Namrata on 3/22/2020 1:18 PM

- Can telehealth be used with IPSIDD clinic services /Article 16 clinics in NYS presently on program?

  Posted by theresa hance on 3/23/2020 11:07 AM

- At present I am told that the e-visit process does not apply to hospital based therapy departments that bill for services on the UB form. Does anyone have information to suggest hospital based services will be able to use this in the future?

  Posted by Ken Berkes on 3/23/2020 11:49 AM

- I too am curious to see how this applies to school based PT in NJ. My school is looking to possibly do e- services (they are saying tell-health) and I want to be able to provide the appropriate care based on these guidelines. Please let me know how this affects school based therapy. Thank you!

Posted by Stephanie Gambino on 3/23/2020 12:17 PM

- The information is scattered. We can only bill for e-visits, so will that require a modifier? CR or 95?Does CR modifier only apply with Medicare or is it for all payers billing as non-institutional? Can we bill e-visits and telehealth codes along with common codes?

  Posted by Amber on 3/23/2020 12:32 PM

- Thank you for the information very helpful appreciate updates as well

  Posted by LYDIA GOMEZ on 3/24/2020 10:02 AM

- What are the rules for e-visits across state lines? We practice on the border of PA/NJ. We have patients in NJ but are licensed in PA only. Can we do e-visits with our NJ residing patients?

  Posted by Billie McDonald on 3/25/2020 10:34 AM

- From approved Assembly Bill No. 415 (3) “Health care provider” means a person who is licensed under this division. Given that PTAs hold a license, I imagine they are not intended to be excluded from providing telehealth services when appropriate? As mentions by others in the forum, E-visits are a different service than telehealth. In this changing landscape, does anyone in this forum or at the APTA have further definitive information regarding the role of PTAs in telehealth?

  Posted by Katherine Sheehan on 3/25/2020 2:48 PM

- Thank you for compiling all of this information. I am concerned about question Nos. 31 & 36. Together, they state that there's a lack of clarity around whether or not a provider can bill for an e-visit more than once in an episode of care, also that these e-visit codes aren't meant to be used for successive 7-day/ weekly appointments. My question is how can this be a viable option for businesses and how is this an ethical solution for patients who need weekly supervised exercise during this coronavirus quarantine?

  Posted by kristen on 3/25/2020 10:56 PM

- I would like clarification on whether or not e-visits are billable by an hospital outpatient therapy department that are billed on a UB-04.

  Posted by Anne Deutschman on 3/26/2020 8:03 AM