In these tumultuous times, it is of the utmost importance that we prioritize the safety of our fellow healthcare workers and patients. That is why many providers are seriously considering changing their business model and reallocating resources to *telehealth*—especially considering that CMS is beginning to reimburse PTs and OTs for certain telehealth services. That said, for those PTs and OTs who decide to bill telehealth in the near future, there are a few crucial facts and processes to understand.

The primary purpose of this informational discussion is to explain how PTs and OTs can bill for telehealth services—not to provide recommendations on technology platforms and services used to deliver telehealth.

### Intro to Telehealth

Telehealth goes by many names. It’s sometimes described as telemedicine or telepractice—or, occasionally, by adding “tele-” to different provider-based services (e.g., telepsychiatry or telerehabilitation).

### Technology

Successful telehealth administration requires the use of a two-way, audio and visual, HIPAA-compliant technology platform. The platform can be real-time and synchronous (e.g., a live call) or asynchronous (e.g., transmission of data—like video files—back and forth over a period of time). Many older telehealth platforms include “store-and-forward” capabilities, but states are phasing out this type of telehealth delivery. Phone calls, texts, emails, and faxes do not qualify as qualified delivery technologies. (For more delivery details, see the [Center for Connected Health Policy’s 2020 billing guide](https://www.chpp相关政策 REPORTS/2020/telehealth-billing-guide.pdf).)

### Legality

Because each state has its own practice act, telehealth laws vary widely across the country, and only some PTs and OTs can legally administer telehealth. It is important that you familiarize yourself with your state laws, regulations, and practice act before you begin incorporating telehealth services into your practice. I recommend starting with the Center for Connected Health Policy’s [2019 review of all 50 states’ telehealth laws](https://www.chpp相关政策 REPORTS/2019/2019-review-of-all-50-states-telehealth-laws.pdf).

### Third-Party Payer Coverage

On March 17, 2020, CMS [changed its policy](https://www.cms.gov/newsroom/press-releases/cms-announces-expansion-of-coverages-for-telehealth-services); Medicare will now cover certain telehealth services—particularly remote assessment and management services that do not require an in-person, face-to-face treatment environment—administered by physical therapists, occupational therapists, and speech-language pathologists. Additionally, some Medicaid programs also provide telehealth coverage. (See the previously referenced [Centers for Connected Health Policy’s billing guide](https://www.chpp相关政策 REPORTS/2019/2019-review-of-all-50-states-telehealth-laws.pdf) for more information.)

At this time, most major commercial payers do not cover telehealth services that are administered by physical rehabilitation providers—and it is not clear if other payers will follow Medicare’s lead. However, a lack of coverage does not necessarily mean you cannot provide telehealth to your patients. You may offer telehealth services on a cash-pay basis if telehealth falls under the scope of practice defined by your state and your payer contracts allow for it. We’ll come back to this.

### Evolving Standards

Until the emergence of the COVID-19 health crisis, there was very limited payer coverage for PT and OT telehealth or remote monitoring. However, the current situation is fluid—and it’s possible that more payers will allow telehealth practice in light of COVID-19’s public health implications. Stay informed about the evolving situation (and consume accurate information) by subscribing to updates from:

- [The Centers for Medicare and Medicaid Services](https://www.cms.gov) (CMS),
- Major commercial payers, and
- Your professional association (e.g., [APTA](https://www.apta.org) and [AOTA](https://www.aota.org)).

For example, on March 17, 2020, the [HHS Office of Inspector General announced](https://www.hhs.gov/ash/newsroom/2020/03/17/office-inspector-general-announces-guidance-telehealth-services) that providers who choose to waive cost sharing (e.g., copays and coinsurance) for Medicare beneficiaries will not be subject to sanctions or penalties. While providers are not obligated to forgo collecting copays and coinsurance, they are now able to waive or reduce cost-sharing obligations during this public health emergency.

### Telehealth Codes and CPT Definitions

It’s essential that you understand how to accurately represent your services when billing CPT codes—and that goes for telehealth services as well.

**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 telehealth, the place of service (POS) is 02: "The location where health services and health-related services are provided or received through a telecommunications system."

**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 American Medical Association (AMA) defined a list of services that, when appended with modifier 95, can be provided and billed as telehealth services. This list is in Appendix P of the CPT® 2020 Professional Edition book. Notably, none of the CPT codes from the Physical Medicine and Rehabilitation section (i.e., the codes used to describe PT and OT services) are on this list. However, the modifier is available for use with the new codes made available to rehab therapists as part of the COVID-19 response, as explained later in this article.

**Modifier GT**

Modifier GT, when applied, designates that the services were delivered synchronously in real-time using a HIPAA-compliant program. Each year, Medicare publishes a list of codes that can be billed with the GT modifier (the same list applies to the GQ modifier, addressed below)—but that list does not contain any codes from the Physical Medicine and Rehabilitation section of the CPT manual. This code was replaced by modifier 95 in 2017—but some commercial payers still use GT for covered telehealth services.

**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.

**Non-Face-to-Face, Non-Physician Services**

Several CPT codes are designated for non-face-to-face, non-physician services. Take a look at the following guidance from the CPT manual, and pay close attention to the highlighted guidance. These guidelines contain specific details regarding the amount and timing of these services. Additionally, please note that while some commercial payers may allow rehab therapists to use the codes covered in this section and receive reimbursement for the associated services, as of the publication date of this article, Medicare does not.

**Telephone Services**

According to the CPT manual—which, by the way, we recommend reviewing in addition to this post—telephone services are “non-face-to-face assessment and management services provided by a qualified health care professional to a patient using the telephone.” Special rules apply to the codes that fall under this classification. If, for example, you and a patient determine during a telephone service that he or she needs to schedule an urgent in-person visit with you within the next 24 hours (or during the next open urgent visit slot), then you would not bill the telephone code. Instead, that session’s time would count as “preservice work” for the office visit that followed.

Additionally, if the subject of the call is in regard to a service that you performed and reported within the past week or within its post-op period, then the telephone service would become part of the previous service—regardless whether you called the patient, or the patient decided to call you.
These codes should be billed with the 95 modifier unless the payer requires the use of the GT and GQ modifiers.

The following are codes that fall under this classification.

- 98966: "Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion"
- 98967: Same service description for "11–20 minutes of medical discussion"
- 98968: Same service description for "21–30 minutes of medical discussion"

Billing Caveats

Note the following caveats when billing these codes:

- Do not report CPT codes 98966 through 98968 if you've reported these same codes during the previous seven days;
- Do not report 98966 through 98968 the same month you report codes 99487 through 99489;
- Do not report 98966 through 98968 if they're performed at the same service time as transitional care management services (99495 and 99496); and
- Do not report codes 98966 through 98968 in conjunction with 93792 or 93793.

Qualified Non-Physician Healthcare Professional Online Digital Evaluation and Management Services

According to the CPT manual, qualified nonphysician healthcare professional online digital evaluation and management services (hereafter referred to as online digital E/M services) are "patient-initiated digital services with qualified nonphysician health care professionals that require qualified nonphysician health care professional patient evaluation and decision making to generate an assessment and subsequent management of the patient.” Non-evaluative test result communication, appointment-scheduling, and other non-E/M communications do not fall under this classification. These patient-initiated services must occur through a HIPAA-compliant, secure platform that allows for digital communication—and while the patient's problem might be new, the patient should be established. Keep in mind that you must keep and permanently store visit documentation (either electronically or as a hard copy). Online digital E/M services are billed once during a seven-day period—which begins upon your initial review of the patient's inquiry—for all the time accumulated therin. The cumulative time for these services encompasses the time you take to:

- review the initial inquiry,
- assess the patient's problem,
- interact with other healthcare professionals regarding the patient’s problem,
- develop management plans (including prescription generation or test ordering), and
- communicate with the patient through HIPAA-supported digital communication.

Qualifying Scenarios

If a patient reaches out within seven days of a prior in-office treatment, E/M service, or procedure—and that outreach relates to the same issue addressed during the prior treatment—then you may not bill this as a separate service. However, if the patient reaches out within seven days of a prior unrelated in-office service, then you may bill this time as its own individual service. And finally, if another, separate E/M service occurred within seven days of your initial review of the patient's inquiry, then you cannot bill codes 98970, 98971, or 98972 again during that time period.

If, during the seven-day period of an online digital E/M service, the same patient exhibits a new, unrelated issue, then the E/M time you spend on the new problem will be added to the cumulative service time of the currently active online digital E/M service time period.

Codes

Do not bill code 98969 for an online digital E/M service, as it's been deleted. Instead, bill one of the following codes:

- 98970: "Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes”
- 98971: Same service description for "11–20 minutes”
- 98972: Same service description for "21 or more minutes”

Modifiers

Providers using these codes should bill Medicare using the 95 modifier. Although rehab therapists cannot currently bill
Medicare using these codes, commercial payers may allow it. However, as of this article’s publication date, it is not clear whether commercial payers will consider these codes or adopt the e-visit codes Medicare has made available to rehab therapists (more on those codes below).

**Billing Caveats**

Note the following caveats when billing these codes:

- Only bill codes 98970 through 98972 once every seven-day period.
- Do not bill digital E/M services that last fewer than five minutes.
- Do not count time associated with 98970, 98971, or 98972 when that time is included (and billed) with other services.
- Do not bill codes 98970 through 98972 for home and outpatient INR monitoring if you’re also billing 93792 or 93793.
- Do not bill codes 98970 through 98972 if you’re billing one of the following codes for the same communication: 99091, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99487, 99489, 99495, or 99496.

**New Telehealth Billing Opportunities for the COVID-19 Response**

As of March 17, 2020, CMS has relaxed its telehealth requirements in response to COVID-19. Per these updates, Medicare will reimburse PTs, OTs, and SLPs for certain telehealth services—as noted by the code list below—that occurred on March 6 or later. This update does not apply to commercial insurance; few other third-party payers currently reimburse rehab therapists for telehealth. (Only some state Medicaid programs do so.) Reach out to your primary commercial payers and verify whether or not they cover telehealth for rehab services. If they do not, you will likely need to look to your patients to pay for these services.

Furthermore, please note that while many large commercial payers (e.g., Anthem, United Healthcare, and Aetna) have gone on to adopt Medicare Part B telehealth policy in the past, we do not yet know if they will follow CMS’s lead and relax their telehealth policies in light of COVID-19.

Only certain CPT codes are eligible for telehealth billing and reimbursement when selectively paired with the 95 or GT modifiers, which we defined in the “Telehealth Codes and CPT Definitions” section above. In other words, you cannot simply add a modifier to any CPT code and bill it as a telehealth service. When billing Medicare for the codes covered in this section, rehab therapists should use modifier 95.

**Updated Coverage of Rehab Therapy Telehealth**

As per CMS’s latest update, PTs, OTs, and SLPs can bill Medicare (and receive payment) for the following telehealth services:

- 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 minutes
- 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.

It’s important to note, though, that these codes apply exclusively to what CMS calls "e-visits." According to the fact sheet for this update, “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. As the fact sheet states, “Distant site practitioners who can furnish and get payment for covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals.”

Here are some other key things to know about e-visits per the waiver release:

- “These services can only be reported when the billing practice has an established relationship with the patient.
- This is not limited to only rural settings. There are no geographic or location restrictions for these visits.
- Patients communicate with their doctors without going to the doctor’s office by using online patient portals.
- Individual services need to be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation.
- The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G206, as applicable.
- The Medicare coinsurance and deductible would generally apply to these services.”

In this news release detailing CMS’s action, Alice Bell, PT, DPT, APTA senior payment specialist, provides this PT-specific example of a situation these codes might cover: “Let’s say that, as a PT, I’ve been seeing a patient for an
orthopedic condition and I am progressing the patient’s exercises,” Bell said. “The patient is unable to come into the clinic but calls me to say she’s having difficulty with one of the exercises and that the other two seem to be too easy. I could arrange an e-visit with the patient and discuss her performance of the exercises. And I could then make a determination—maybe I find that the patient is performing one of the exercises incorrectly—and I could direct the patient on the correct performance. Perhaps I also determine that two of the exercises can be progressed because the patient is improving, so I could instruct the patient in the two new exercises. After that I could advise the patient to contact me for a follow-up e-visit as needed until the patient can return to the clinic.”

The APTA release also directs providers to the CMS Physician Fee Schedule lookup tool to determine the reimbursement rates for G2061-G2063 and notes the Medicare coinsurance and deductible apply to these services.

Additionally, effective immediately during this nationwide public health emergency, the HHS Office for Civil Rights (OCR) will waive HIPAA violation penalties against providers who offer “good faith” services to patients through everyday communication technologies (e.g., Skype or Facetime).

Non-Coverage of Rehab Therapy Telehealth and Patient Cash-Pay

As with all medically necessary services, third-party payer coverage is only part of the patient’s decision process. Consider dry needling: non-coverage in that case creates an opportunity to discuss the benefits of the service. If a service is not covered by a payer for which you are a preferred provider, you may collect payment directly from patients at the time of service. However, before you do this, create a fee schedule for your telehealth services, and create a transparent billing process for your patients. Notify these patients (in writing) that telehealth services are not covered by their payer, and clearly establish the projected cost as well as when you expect payment. If you are not a preferred provider, you are not bound by their noncoverage of your services.

Payer Policies

Be sure to check payers’ medical policies and ensure they do not classify telehealth therapy services as “not medically necessary” or “effectiveness not established.” If either of these classifications apply, then you cannot balance bill the patient for telehealth services. If you proceed and bill these services to that payer, then it will assign the balance to the practice or individual therapist—not the patient. And remember, if you’re a preferred provider for a commercial plan, your contract likely requires you to bill all services to that payer so it can determine the patient’s liability—meaning you cannot simply collect cash from the patient upfront to bypass submitting a claim to the payer. Only Medicare has specific policies that address ABNs and notices of non-coverage.

How do I charge for telehealth within WebPT?

- If you’re a WebPT EMR user, click here to learn more.
- If you’re a RevFlow Standalone EMR user, click here to learn more.
- If you’re a Therabill Standalone EMR user, click here to learn more.

What telehealth services can I use to supplement WebPT? Any suggestions?

While you’ll use the EMR to document and charge out for telehealth as outlined in the previous section, you’ll also need a medium to securely video chat with patients. We have found some free and low-cost options that are cloud-based and easy for patients and providers to use. Please understand that these are suggestions and not affiliated with WebPT.

- Rapid Response from Bluestream (free version available)
- Doxy.me (free version available)

Are the e-visit g-codes available in the app?

Yes. The following codes are available for e-visit use in the WebPT EMR:

- 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 minutes
- 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.”

If other codes are needed, you may use the custom code field.