# MEDICARE & MEDICAID COVID-19 TELEMEDICINE PAYMENT WAIVERS FREQUENTLY ASKED QUESTIONS (FAQS)

**Updated 5-12-2020 Q1. During the declared public health emergency (PHE) may a provider temporarily provide Telehealth services from their home?**
*A1. Yes, the provider may provide this service temporarily out of their home. The professional fee out of their clinic department would be billed. If the clinic is provider-based, then the facility charge is billed as well. Modifier PO would be reported on the facility charge to identify the provider's home as an off-campus department of the hospital.*

**Q2. Does Medicaid follow Medicare's guidance for reporting Telehealth services, i.e. Place of Service (POS) and modifier?**
*A2. No, the GT modifier is reported for facility services reported on UB-04 claim and POS 02 with no modifier should be reported when billing professional services on a CMS-1500 claim.*

**Q3. If a provider conducts a visit via telephone with audio only, can a code from 99201-99205 or 99211-99215 be billed?**
*A3. No, these codes require a face-to-face visit and may not be billed if the visit is conducted via telephone with audio only. The appropriate telephone evaluation codes would be utilized, e.g. 99441,99442,99443 and 98966,98967,98968.*

**Q4. Can telephone evaluation codes be reported with more than one unit?**
*A4. Only one unit may be reported for these codes.*

**Q5. How and when is Q3014 billed?**
*A5. Q3014 is the CPT code billed by the originating site for reimbursement related to the use of a room and telecommunication equipment. The provider who is supplying the room and equipment would bill Q3014. Note - when the patient's home is the originating site, no one can bill Q3014.*

**Updated 5-12-2020 Q6. The Medicare and Medicaid Telehealth guidance states that they have expanded the coverage to include telephone visits, does mean that a provider may bill an evaluation and management (E&M) code, e.g. 99213, when the visit was conducted by telephone audio-only?**
*A6. No, the guidance indicates that the coverage has been expanded to cover telephone visits with audio-only, not that an E&M service may be reported if the visit was conducted by telephone with audio only. Audio-only Telephone E&M services conducted by a physician or APC are now recognized by Medicare as Telehealth services and will be paid at the office E&M rate. Medicare also expanded their list to identify Telehealth services that may be provided by audio-only, such as Annual Wellness Visits (AWVs).*

**Q7. How long will the Telehealth COVID-19 payment waivers be in effect? Do payment waivers apply to Commercial Payers?**
*A7. The payment waivers will be in effect until the declared PHE ends. The waivers apply to Medicare and state Medicaid programs. Separate conversations will need to occur with the Commercial payers to determine what they are adopting.*

**Q8. Should on-site visits conducted via video or through a window in the clinic be reported as Telehealth services?**
*A8. No, Telehealth services can only be reported when the patient and the provider are located in different locations and conducted via an audio and video telecommunication system.*

**Q9. What place of service (POS) should be reported for Medicare professional claims?**
*A9. Report the POS that would have applied if the visit were conducted in-person, e.g. Big Sky Medical Center Clinic reports POS 11.*

**Q10. Can I charge a telephone visit if a Telehealth visit transitioned to telephone due to connectivity issues?**
*A10. You may choose to report the appropriate E&M service based on what was conducted prior to the transition to the telephone visit or one of the Telephone E&M codes.*

**New 5-12-2020 Q11. If a provider is unable to provide an Annual Wellness Visit (AWV) using audio & video, e.g. due to connectivity issues, is it appropriate to conduct and bill for an AWV by audio-only?**
*A11. Yes, a provider may provide and charge for an AWV if it was conducted with audio-only.*

**New 5-12-2020 Q12. Is modifier 95 reported for audio-only Telehealth Services?**
*A12. Yes, if recognized as a Telehealth service report modifier 95.*

**New 5-12-2020 Q13. How is time counted to determine an E&M level of service?**
*A13. Time is defined as the total time personally spent on the day of the visit, which includes face-to-face and non face-to-face time. Typical times spent for each level of service can be found in the CPT Manual for Office/Outpatient E&M Services. Please note that the counseling statement of 50% is not applicable during the PHE for Telehealth services.*

**New 5-12-2020 Q14. If Medicare has waived the out of state licensing requirements, does this mean that a provider may use their Montana license to practice medicine out of state?**
*A14. CMS has waived the federal requirements to allow providers to see patients out of state, however individual state requirements may still apply. Before a physician can provide Telehealth services in a state where he or she does not hold a license, the physician must ensure that the state has adopted waived requirements. Refer to Table 9, "Out of State Telehealth Visits" for further guidance.*

**New 5-12-2020 Q15. Did Arizona adopt the out-of-state licensure waiver?**
*A15. No, Arizona has established an expedited process and a provider may not practice medicine without completing the process to be recognized to practice medicine in AZ, including telehealth visits. For further questions, please contact Sarah Compton, Telehealth Program Coordinator.*

**New 5-12-2020 Q16. Can Deaconess Hospital Clinics bill for a nurse-only visit provided via telehealth?**
*A16. Yes, a nurse only visit is recognized as a therapeutic service. The patient is required to have an established relationship with the provider. The established process would be followed, the only change is instead of a face-to-face visit the patient can be located in their home and all other processes should be followed.*

**New 5-12-2020 Q17. Can Remote Physiologic Monitoring provided for 10 days be reported?**
*A17. Depends on the condition being monitored. For patients with suspected or confirmed COVID-19, the minimum monitoring days has been reduced from 16 to 2. For all other acute or chronic conditions, a minimum of 16 days is required.*