Codify
BY AAPC

Psychiatry Coding & Reimbursement Alert

CPT® Coding: Master the Path to Successful Telehealth Psychiatry Claims

Hint: Know the HCPCS code to report if your practice is the originating site.

When your clinician provides any psychiatry service for a patient in a remote location through interactive telecommunication systems, you will need to know what codes you can report for the service. You should also be aware of the modifiers you should use to report such a telehealth service.

Background: The Centers for Medicare & Medicaid Services (CMS) will provide Medicare coverage for telehealth services when your clinician performs a telehealth service for patients who are in a rural Health Professional Shortage Area (HPSA) or a county outside of a Metropolitan Statistical Area (MSA). The coverage will be provided for the service only if there is an interactive communication between your clinician and the patient with the help of audio and video telecommunication systems. The patient who is receiving the telehealth service should be present in an eligible facility in order to receive the coverage for the services.

"The telecommunications system must permit real-time communication between the physician at the distant site, and the beneficiary at the originating site," says Kent Moore, senior strategist for physician payment at the American Academy of Family Physicians. "Asynchronous 'store and forward' technology does not qualify except for federal telemedicine demonstration programs in Alaska or Hawaii," Moore adds.

Note: When your clinician is providing the telehealth service, the patient should be face-to-face with your clinician. Any communication that is not face-to-face, such as talking over the phone cannot be considered as telehealth service and will not receive coverage for the service provided.

Know the Difference Between Originating and Distant Site

When telehealth services are provided to patients, they include both an "originating" site and "distant" site. "The originating site is the location of the patient while the distant site is where the physician is located," says **Suzan (Berman) Hauptman, MPM, CPC, CEMC, CEDC**, senior principal of ACE Med, a medical auditing, coding and education organization in Pittsburgh, Pa. The originating site is an eligible facility in a rural Health Professional Shortage Area (HPSA) or a county outside of a Metropolitan Statistical Area (MSA) where the patient receives the telehealth service. The distant site is the location from which your clinician is providing the telehealth service to the patient.

The patient is eligible to receive coverage for telehealth services only if the originating site is one of the following:

- Physician's office
- Hospitals
- Critical access hospitals (CAHs)
- Rural health clinics
- Federally qualified health centers (FQHCs)
- Skilled nursing facilities (SNFs)
- Community mental health centers (CMHCs).

Note: The Health Resources and Services Administration (HRSA), which helps determine HPSAs, includes an eligibility

analyzer on their website. Using the analyzer, you can find out if the originating site at which the patient is present when receiving the telehealth service is an eligible facility or not. You can access this eligibility analyzer at http://datawarehouse.hrsa.gov/telehealthAdvisor/ telehealthEligibility.aspx.

Understand if Your Clinician Can Provide Telehealth Services

In order for your clinician to provide Medicare telehealth services, he/ she should meet the criteria laid down by CMS. The CMS guidance at section 190.6 of chapter 12 of the Medicare Claims Processing Manual states, in part, "As a condition of Medicare Part B payment for telehealth services, the physician or practitioner at the distant site must be licensed to provide the service under state law. When the physician or practitioner at the distant site is licensed under state law to provide a covered telehealth service (i.e., professional consultation, office and other outpatient visits, individual psychotherapy, and pharmacologic management), then he or she may bill for and receive payment for this service when delivered via a telecommunications system."

According to CMS, only the following qualified healthcare professionals can provide telehealth services to patients in eligible originating sites:

- Physician
- Nurse practitioner
- Physician assistant
- Nurse-midwife
- Clinical nurse specialist
- Clinical psychologist
- Clinical social worker
- Registered dietitian or nutrition professional
- Certified registered nurse anesthetist.

According to CMS, your psychiatrist, clinical psychologist, and clinical social worker can provide psychiatry related telehealth services. However, CMS mentions that "clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare." This would include (+90833, Psychotherapy, 30 minuteswith patient and/or family member when performed with an evaluation and management service [List separately in addition to the code for primary procedure]); +90836,(...45 minutes...) and +90838, (...60 minutes...), which are add-on codes for E/M codes. From a Medicare perspective, these providers are not allowed to report E/M codes. "CMS also does not permit clinical psychologists and clinical social workers to bill for psychiatric diagnostic interview examinations with medical services (90792) for the same reason," Moore says.

Learn What Psychiatry Services can Qualify as Telehealth Services

CMS, in its Medicare Learning Network fact sheet on telehealth services, provides a huge list of CPT® and HCPCS codes that you can report for services that are provided through telehealth. Of these, some of the codes that you can report for psychiatry services include the following:

- Psychiatric diagnostic interview examination codes: 90791 and 90792
- Individual psychotherapy codes: 90832-90838
- Psychoanalysis code: 90845
- Family psychotherapy codes: 90846 and 90847
- Neurobehavioral status examination code: 96116
- Behavioral assessment and intervention codes: 96150-96154
- Office and outpatient E/M codes: 99201-99215
- Subsequent hospital care codes: 99231-99233 with the limit of one telehealth visit every three days
- ED or initial inpatient telehealth consultation codes: G0425-G0427
- Follow up telehealth consultation codes for patients in hospitals or skilled nursing facilities: G0406-G0408

- Inpatient pharmacologic management code: G0459.

When your clinician performs any of the above mentioned psychiatry services as a telehealth service to a beneficiary in an eligible originating site, you will have to report the appropriate code to the carrier, which processes the claims for your clinician's service area. "The clinician must document the service as detailed as possible to support the service and medical necessity of the service. This information should be made available to the originating site," Hauptman says.

"Modifier GT (Via interactive audio and video telecommunications systems) would need to be appended to the service code selected," Hauptman adds. In order to let the payer know that your clinician performed a telehealth service, you will have to append modifier GT to the CPT® or HCPCS code that you are reporting for the service.

The originating site where the patient is receiving the service will receive a facility fee. This fee is the lesser of 80 percent of the actual charge or 80 percent of the originating site fee except in CAHs, according to section 190.5 of chapter 12 of the Medicare Claims Processing Manual. "There is only one code for the originating site and it is Q3014," Hauptman says. If you are making the claim for the originating site, you will have to report the telehealth service provided with the HCPCS code, Q3014 (Telehealth originating site facility fee). Deductible and coinsurance rules will apply to Q3014.

Example: Your psychiatrist performs individual psychotherapy for a patient in a physician's office in a HPSA area using interactive video and audio telecommunication systems. The session lasts for 40 minutes. You report 90834 (Psychotherapy, 45 minutes with patient and/or family member) for the psychotherapy session. Since the session is a telehealth service, you report the modifier GT appended to 90834. The physician's office where the patient is located will claim Q3014 for their services.

A Final Word: "These are the rules for Medicare telehealth services as laid down by CMS," Moore says. "Private payers and other public payers like Medicaid may have their own rules related to telehealth. When in doubt, check with the patient's insurance provider for how they handle telehealth services."

Resources: For more information on Medicare telehealth services and reimbursement check the guidance manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf and the MLN matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf.