

CareOregon Telemedicine COVID-19 Q&A



Updated May 12, 2021

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Telemedicine

General

Q: What does it mean to have a telemedicine visit?

A: CareOregon uses the same definition for telemedicine and telehealth: “the use of telephonic or electronic communications of medical information from one site to another regarding a member’s health status.” These modalities include the use of telephone, e-visits/online services (asynchronous) and two-way audio and visual communications (synchronous). The mode of delivery is indicated by the use of specific modifiers and/or place of service codes specified by the plan.

Q: What is the difference between telehealth and telemedicine?

A: Telehealth and telemedicine are often used interchangeably, but some organizations have different definitions for each. At CareOregon, we define them as the same. Please note that OHA and CMS have different definitions of telehealth.

CMS defines telehealth visit as two-way synchronous audio and video visit in real time.
OHA defines telemedicine/telehealth the same as CareOregon does.

Q: How long will CareOregon continue with expanded telemedicine allowances?

A: CareOregon will allow expanded telehealth services as long as needed for the delivery of such services, in keeping with safe social distancing per state guidance.

Telemedicine care is covered benefit for Medicare and Medicaid members unrelated to COVID-19 and the public health emergency. Telemedicine benefits will remain after the public health emergency but not to the same extent, e.g., some of the state and federal waivers and flexibilities that are set to expire. Telemedicine benefits might change after the public health emergency, but we are unsure to what extent. We intend to keep our provider network updated with new information on telemedicine allowances as we progress through the COVID-19 public health emergency.

Q: Are we allowed to provide telemedicine services intermittently with in-person services?

A: Yes. You can continue to use the interim telemedicine options to help prevent the spread of COVID-19. There is nothing in the Oregon Rules or COVID-19 Guidance for Telehealth that restricts intermittent telemedicine sessions, as long as you are following the recommended safety precautions. We recommend making a note in the clinical documentation of the member’s chart about why you are seeing the member in this manner (e.g., clinically indicated for their situation, mutually decided upon, with precautions taken, etc.). While telehealth is the recommended approach during this pandemic, OHA offers a set of considerations ([found here](#)) to use when weighing the importance of person-centered clinical care and the risk of infection to help with decision-making. It is important to note that OBLPCT issued a rule ([found here](#)) to ensure compliance with the governor’s executive orders, including distancing and safety precautions, and that failure to comply with OHA guidance constitutes gross negligence with violations subject to board sanction.

Technology

Q: Am I required to use a HIPAA-compliant telemedicine platform to provide services?

A: To be eligible for telemedicine reimbursement, the services must be provided using a synchronous audio-video platform. During this public health emergency, the requirement for your platform to be HIPAA-compliant has been waived. A message from the Federal Department of Health and Human Services (HHS) was sent on March 17, 2020, and states, “Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion against health care providers that serve patients in good faith through everyday communications technology, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency.” Additional information can be found [here](#). During the governor’s COVID-19 emergency declaration, OHA will follow federal guidance and not audit this requirement. HIPAA-compliant platforms with appropriate business agreements are preferred.

Q: What platforms are providers using for telemedicine?

A: OHA is following federal guidance regarding HIPAA-compliant platforms. As a result, platforms such as Skype, FaceTime, Zoom and Google Hangouts are being used. However, HIPAA-compliant platforms with appropriate business agreements are preferred. Please reference our Telemedicine Technical Assistance Guide for more information on platforms to use. The guide is located [here](#).

Services

Q: Which members are eligible for telemedicine services?

A: All CareOregon members are eligible to receive services through telemedicine. During this public health emergency, CareOregon encourages members to avoid travel, when possible, to providers’ offices, clinics, hospitals or other health care facilities, where they could risk their own or others’ exposure to further illness.

Q: What is a qualified non-physician health care professional? What roles can submit claims for codes labeled for use by this provider type?

A: Please review the [OHA Telehealth 4/17 Billing Webinar](#) for examples of this provider type on slide 11, Method 2 Coding Chart – “Qualified nonphysician (e.g., nurse practitioner, physician assistant, acupuncturist).”

Q: What services does CareOregon cover for two-way audio-visual visits (a/v)?

A: CareOregon follows the approved services (code sets) set forth by OHA (HERC A5) and CMS (Medicare physician fee schedule via telemedicine) for Medicaid and Medicare beneficiaries, respectively. Sometimes these align and other times they do not. Our guidance documents posted on our provider website contain the updated list of our covered services for all telemedicine modalities for both CMS and OHA. Please refer to these guidance documents for the most updated list of services (codes).

We received questions about whether specific services or provider types are covered via a/v delivery. Please note that while CMS and OHA have approved some provider types and services, providers are expected to use the approved code sets that match the service rendered.

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This is not an exhaustive list of covered services. Please refer to our [posted guidance](#) for the full code set:

Type	Description	Response
Service	Mental health or substance use disorder assessments	Yes
Service	Skills training	Yes
Service	BH group visits	Yes*
Provider	Acupuncturist	Yes
Service	Speech therapy	Yes
Provider	Doulas	Yes
Service	Birth education classes	Yes
Service	Maternity case management	Yes

Q: *Are there any additional consents needed for group sessions allowed under telemedicine codes?

A: It is recommended that a user agreement is provided to group members advising that conversations need to be kept private. Calls should be held in a private space and headphones should be used when possible.

Q: How do I complete consent and other intake documents that normally require signatures if I'm using telemedicine modalities?

A: Per OHA and CMS, verbal, electronic or signed consents are all acceptable. If there is enough time, a copy of the forms can be mailed to the member ahead of time and then any questions can be addressed during the session. Consider including a self-addressed stamped envelope for the member to mail the forms back. Another option is to review the documents verbally with the member. With either option, the member can provide their verbal approval/consent over the phone or electronic signature via a patient portal. This verbal consent must be documented in the member's health record.

Q: How do I complete a Release of Information (ROI) if I'm using telemedicine?

A: Obtaining written consent for ROIs is still required, but during this COVID-19 emergency, a temporary exception is in effect that allows for verbal approval when a bona fide barrier* exists. This verbal consent needs to then be clearly documented in the member's health record. If this option is used, written consent should still be obtained either by mailing the ROI with a self-addressed stamped envelope for the member to return or using member portals. Electronic signatures are also acceptable. [This exception is not applicable to SUD providers subject to 42 CFR Part 2 – x].

**Bona fide barrier: a situation that makes obtaining written consent impractical or overly burdensome. Click [here](#) for more information.*

Q: Can services be provided by telephone instead of two-way audio and visual?

A: In some cases, this is allowed and in others it is not, depending on the member's coverage. OHA has temporarily allowed the use of phone-only communications when a/v are not available or are declined by the member for codes listed on [HERC A5](#). CMS is allowing only a subset of their telemedicine codes to be delivered via phone.

Providers should use the richest, most secure platform that is available to them and the member. A member's medical record must include a note explaining the extenuating circumstances that

prevent the client from accessing services in person. When in-person services resume, update the medical record again to reflect that.

Please use the appropriate modifiers by primary coverage, service and telemedicine modality referenced in our guidelines.

Delivering services via telephone			
	Medicaid	Medicare	Dual members
BH services	It's recommended that the provider complete services by a/v when possible. All approved a/v service codes can be completed by telephone.	Approved phone codes: 99441-99443 98966-98968 In addition to these phone codes, CMS is allowing some a/v codes to be delivered via phone. Please refer to our guidance documents for this set of codes.	Due to the different coverages, we recommend that providers use the method of communication that is best for the member's care. Since the member is dual eligible, Medicaid will process the crossover claim of whatever is left over after Medicare processing.
PH services	Approved phone codes: 99441-99443 98966-98968 99381-99387 99391-99395 <i>In addition to the codes above, OHA has allowed the flexibility to deliver all a/v codes via phone.</i>		

Q: Do I need to use a different billing code when using the phone versus audio/visual?

A: It depends. Providers should use the service code that is most appropriate for the care that was given. (Please refer to our guidance document for code descriptions and the question, “Q. Can services be provided by telephone instead of two-way audio and visual?” for further context.)

Q: Behavioral health members are asking for more services during this crisis. Do we need to update the service plans to include additional services?

A: Under the 410 Oregon Administrative Rules (OARs), providers can document the new services in a note in the medical records. However, the state may have different requirements under the 309 OARs for behavioral health providers who hold a Certificate of Approval.

Q: Can telephone outreach by a QMHP, QMHA or CADC be billed as case management for behavioral health?

A: Yes, if the service they provide fits the description of case management that they would have provided before COVID-19. Per OAR 410-120-0000(39), “case management services means services provided to ensure that CCO members obtain health services necessary to maintain physical, mental and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs, plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency or dental services, referring members to community services and supports that may include referrals to allied agencies.” If you are an agency with a certificate of approval, an additional definition of case management is OAR 309-019-0105 (16): “Case management” means the services provided to assist individuals who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, entitlement and other applicable services.

Q: Does CareOregon allow for G2012 to be billed by QMHPs and SUD programs for brief technology-based check-ins?

A: Yes, CareOregon does allow this code. Additional information regarding this billing code and approved rendering providers can be found on the behavioral health October 2020 DMAP fee schedule [here](#), as well as the [OHA telehealth April 17 billing webinar](#) (slide 12) and the [HERC A5](#).

Billing and Coding

Q: Is there an online reference for billing codes?

A: Yes. Please refer to our provider website and table of covered services.

Q: What is the Place of Service (POS) when I'm using a/v in my home office? What is the POS when I'm using telephone or online services?

A:

Coverage	Physical health and Behavioral health
Medicaid	For a/v services, the POS is 02. For telephone and online services, the POS corresponds to the rendering provider's location. For example, if a provider is working remotely from their own home, the POS is 11.
Medicare	For a/v, phone and online services, use the POS that corresponds to the rendering provider's location. For a/v services please include the GT or 95 modifiers.

Q: Have procedure codes changed since the services have changed from in-person to telehealth?

A: No, procedure codes have not changed for telemedicine services. Please follow the same criteria for billing codes through telemedicine as you did previously for in-person services and groups. A list of approved procedure codes can be found on the CareOregon website [here](#).

Q: How can I bill for phone appointments by Medicaid clients who also have Medicare?

A: When a member has more than one coverage, you should always bill the primary insurance first. The primary plan will process the claim and submit a crossover claim to the secondary insurance for coordination of benefits. The CareOregon guidance for the codes that are covered for Telehealth services, the required modifiers and the POS for telephone or telemedicine can be found [here](#). There is also information available on CMS guidance for Medicare and telemedicine available [here](#).

Q: Are we required to include a GT or 95 modifier when submitting a claim?

A: It depends on the modality and the member's coverage:

	Physical health and Behavioral health
Medicaid	A GT or 95 modifier is not required by CareOregon but is required by DMAP for Open Card clients, and may be required by other CCOs. If the GT modifier is included on a claim sent to CareOregon, the claim will still be accepted and processed like normal.
Medicare	Only for services delivered via two-way audio and visual.

Q: Are we required to include a CR or DR modifier when submitting a claim for telemedicine appointments?

A: The CR or DR modifier should be used if the service you are providing is related to the prevention, identification, assessment or treatment of a COVID-19 exposure (provider or

member). These modifiers should be added after any other modifiers the clinic would have submitted on claims prior to COVID-19. OHA has clarified that all routine services rendered via telemedicine to support social distancing and to prevent exposure to COVID-19 should be billed with modifier CR or DR.

Q: For institutional claims, should the DR condition code be reported for telemedicine services due to the COVID-19 public health emergency?

A: Yes. The provider should submit the DR modifier for any visit related to COVID-19 prevention, identification, diagnosis and treatment. If all services are disaster-related, use DR conditions code to indicate that the entire claim is disaster related. The CR modifier should be used to designate any service line item on a claim that is disaster-related.

Q: Will the COVID-19 modifiers affect claim processing or payment?

A: No, the use of these modifiers will not affect claim payment and processing if the appropriate codes, modifiers and POS are used. We have updated our claims processing systems — including PH Tech — with all the current codes for telemedicine, and we are processing claims. Additional information can be found on the CareOregon website [here](#).

Q: Is it okay if claims contain clinic-specific modifiers to distinguish that visits were telemedicine for their own purposes?

A: When possible, clinics should not submit claims with internal-use codes and modifiers, so these codes do not inadvertently impact claims processing and reimbursement. Our telemedicine guidance describes what modifiers we are requesting on claims to ensure proper reimbursement for COVID-19-related services. These should be added after any modifiers you would add during normal business. If the clinic cannot keep their internal use modifiers from appearing on claims, please reach out to us with a list of the modifiers so we can investigate whether they would impact processing.

Q: Will you accept facility charges for telemedicine services performed by hospital outpatient department staff/clinicians, with claim type 131/UB04 per the recent CMS 1135 waiver?

A: **Medicare can pay for office**, hospital and other visits furnished via telemedicine across the country and including those held in patients' places of residence.

Q: Will we need to add our providers' home addresses as service locations for them to provide telemedicine services from home?

A: Providers are not required to report their home address when providing telemedicine services from their home.

Reimbursement

Q: Has the reimbursement amount for telemedicine changed, and do I need to change my contract?

A: No. The reimbursement amounts are the same. Provider contracts do not need to be updated or amended to allow for reimbursement of telemedicine services.

Q: Will CareOregon reimburse telemedicine visits at the same rate as in-person visits?

A: Yes, please follow the guidance below in order to achieve this payment parity.

Q. How should I submit Telemedicine claims now to achieve this payment parity?

A. Continue to submit claims with the appropriate POS and modifiers for the member's coverage and type of service outlined above and in our telemedicine guidance documents located on our [COVID-19 Provider Resource webpage](#).

Q: Is there a scenario in which I should resubmit a claim?

A: We ask that you only submit a corrected claim if there are changes to any of the claim fields — for example, but not limited to, adding or editing a procedure codes, place or service modifiers.

Q: Are clinics able to submit a corrected claim for telephone calls (e.g., 99441-99443 for the minutes) as 99201-99215 E&Ms if the reason they did not bill those E&Ms in the first place was they did not have the technology to do so yet?

A: Yes. If the clinic feels that there is enough documentation in the member's record to support the use of another service code, they should submit a corrected claim. Please remember that, per OHA, the member's record must meet the same standards as face-to-face visits. The member's medical record must include a note explaining the extenuating circumstances that prevent the member from accessing services in person. When in-person services resume, update the medical record again to reflect that.

Member Support

Q: Does CareOregon have any resources to assist members who need phones, devices, internet access, etc., to participate in telemedicine?

A: Yes. These types of requests may be eligible for flexible services funding through CareOregon as a resource. Additional information, including the forms, eligibility requirements, timelines and process can be found on the CareOregon website [here](#). Scroll down to the "Health-related services" section for additional information.

Q: Does CareOregon have any resources to assist members who need a hotel room because they are at higher risk due to underlying health conditions, have been exposed to COVID-19 or are showing signs of the virus?

A: Yes. CareOregon is attempting to find hotel rooms where members can stay while they await test results or other care that does not meet the criteria for the county's motel sheltering program. The other option is to complete our Health-Related Services Flexible Services Funding Request form. The [form](#) can be found on the CareOregon website [here](#). Scroll down to "Health-related services" section for additional information.

Q: What types of health-related services does CareOregon offer to providers in support of members?

A: CareOregon continues to offer health-related services of many kinds, but in particular we are striving to meet the most immediate member needs: cell phones for telemedicine and hotel rooms for members who are at higher risk due to underlying health conditions, have been exposed to COVID-19 or are showing signs of the virus. Bulk items can be requested to help clinics and providers ensure a constant supply of the most needed items, such as cell phone minutes, transit passes, sleeping bags and more. A Bulk Purchase Request form is required. The [form](#) can be found on the CareOregon website [here](#). Scroll down to the "Health-related services" section for additional information.

Q: Is there any consideration of support for individuals who do not qualify for OHP?

A: CareOregon is following COVID-19-related guidance issued by OHA and CMS in providing benefits for our assigned OHP members. We have not received guidance from OHA on how they are operationalizing coverage for uninsured patients. Provider questions about COVID-19-related coverage for fee-for-service OHP members and OHA policy decisions should be directed to OHA via the COVID-19 inbox: COVID.19@dhs.oha.state.or.us. General fund services for underinsured individuals are managed by the counties. CareOregon recommends that you contact the county where the individual lives to learn more about the potential for support.

Authorization of Services

Q: Does CareOregon require prior authorizations for telemedicine visits during the COVID-19 public health emergency?

A: All authorization procedures remain the same as pre-COVID-19. If a service previously required an authorization, then that will continue for telemedicine services.

Q: Is it ever okay to request a treatment reauthorization without an updated assessment and/or service plan on file? Sometimes members are at their six-month or one-year mark for reauthorization and we are working on reengagement, trying to locate the member and/or providing case management/crisis type services to get the person back in (virtually) for routine services because of complex needs. But the assessment and service plan haven't been updated yet because the person hasn't made it in for their reassessment service.

A: In certain circumstances, you can submit an authorization request without the updated assessment/service plan and continue to provide engagement/crisis services to the member. We recommend that you document this in the member's clinical record and include a note explaining this when you submit the treatment authorization request. Once the member has re-engaged in services and it is clinically indicated, you can resume routine assessment and service plan updates.

Member Records

Q: Where should documents be stored when working remotely?

A: CareOregon is not aware of any unique document storage requirements for telemedicine services. Service notes in the member's record are still required for telemedicine services.

Documentation

Q: Where can I locate Oregon Administrative Rules (OARs) specific to documentation standards during the COVID-19 crisis?

A: OARs for telemedicine medical-surgical services (410-130-0610) can be found on the state website [here](#). OARs specific to telemedicine for behavioral health Medicaid payment (410-172-0850) can be found on the state website [here](#).

Q: Do I need to indicate in a member's chart when services switch to telemedicine?

A: Yes. As part of the process of using telemedicine, providers should document in a member's chart when services switched to telemedicine and should document when telemedicine has officially ended.

Q: For behavioral health providers, what OARs are used for technical assistance and documentation review?

A: CareOregon's behavioral health quality administrators use Oregon Administrative Rules (OAR) 410 to guide in technical assistance and documentation review. The link for the specific OAR 410 rules can be found on the state website [here](#).

COVID-19 Testing

Q: Does CareOregon have any guidance or resources around COVID-19 testing?

A: CareOregon defers to OHA for guidance on testing and specimen collection. Our COVID-19 Provider Resources page lists the codes we have set up in our system for claims related to

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COVID 19 testing. Please review the website for the most appropriate code to use. Reach out to us if you feel these codes do not describe the test you are using and what CPT or HCPC seems most appropriate, and we can investigate reimbursement for that code. The webpage can be found [here](#).

COR-20156798-051521