Telemental Health Services Reimbursement Policy - Medicare

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the procedure code or codes that correctly describe the health care services provided to individuals whose behavioral health benefits are administered by Optum, including but not limited to UnitedHealthcare members. This reimbursement policy is also applicable to behavioral health benefit plans administered by OptumHealth Behavioral Solutions of California.

Our behavioral health reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other procedure coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to services billed on the UB-04 claim form and to electronic claim submissions (i.e., 837p and 837i) and for claims submitted online through provider portals. Coding methodology, clinical rationale, industry standard reimbursement logic, regulatory issues, business issues and other input in developing reimbursement policy may apply.*

This information is intended to serve only as a general reference resource regarding our reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to behavioral health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for behavioral health care services provided to members. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: member's benefit coverage, provider contracts and/or legislative mandates. It is expected that all participating providers will only bill services included within their existing contract provisions as it relates to procedure coding. Finally, this policy may not be implemented exactly the same way on the different electronic claim processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this website. However, the information presented in this policy is accurate and current as of the date of publication.

Optum uses a customized version of the Claim Editing System known as iCES Clearinghouse to process claims in accordance with our reimbursement policies.

**CPT® is a registered trademark of the American Medical Association*

Applicability

This reimbursement policy applies to all health care services billed on CMS 1500 forms and to services billed on the UB-04 claim form and to electronic claim submissions (i.e., 837p and 837i) and for claims submitted online through provider portals. This policy applies to Medicare only, all products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy Overview

This policy describes Optum reimbursement for Telehealth/Telemedicine behavioral health services. For the purpose of understanding the terms in this policy, Telehealth/Telemedicine occurs when the Physician or Other Qualified Health Care Professional and the patient are not at the same site. Telehealth/Telemedicine services only include live, Interactive Audio and Visual Transmissions of an encounter from one site to another using telecommunications technology. The terms Telemental, Telehealth and Telemedicine are used interchangeably in this policy.

United Behavioral Health operating under the brand Optum
U.S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Solutions of California

Reimbursement Guidelines – Telemental/Telehealth/Telemedicine

The Centers for Medicare and Medicaid Services (CMS) have 2 POS codes dedicated to Telehealth Services.

POS Code 02: The location where health services and health related services are provided or health related services through telecommunication technology. Patient is not located in their home when receiving health services or health related service through telecommunication technology.

POS Code 10: The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.

Optum will reimburse for CMS approved Telehealth Services with the use of the telehealth POS code 02 or POS 10, which certifies that the service meets the telehealth requirements or one of the telehealth-associated modifiers (95 or GQ).

These Telehealth POS codes do not apply to Originating Site facilities billing a facility fee.

Several conditions must be met for Medicare to make payments for Telemental health services under the Medicare Physician Fee Schedule (MPFS). The service must be on the list of Medicare Telehealth services and meet all of the following additional requirements:

- The service must be furnished via an interactive telecommunications system
- The service must be furnished by a physician or authorized practitioner
- The service must be furnished to an eligible Telehealth individual
- The individual receiving the service must be located in a Telehealth originating site.

NOTE: The above Guidelines do not apply to Medicare plans that have been granted health services as part of their Basic Benefit.

In accordance with CMS the eligible Originating Sites are listed below:

- The office of a physician or practitioner
- A Hospitals (inpatient or outpatient)
- A Critical Access hospital (CAH)
- A Rural Health Clinic (RHC)
- A Federally Qualified Health Center (FQHC)
- A hospital-based or critical access hospital-based renal dialysis center (including satellites); NOTE: Independent renal dialysis facilities are not eligible Originating Sites
- A Skilled nursing facility (SNF)
- A Community Mental Health Center (CMHC)
- Patient home* – Drug treatment and mental health services

NOTE: CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. They cannot bill or be reimbursed for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.

Optum behavioral health considers an eligible provider to deliver Telehealth services as:

• Be legally authorized and hold a valid license to provide mental health and/or substance abuse services in the State where the member is receiving services; and

• Perform services within the scope of his/her license as defined by CMS guidelines and enrolled in the Medicare program.

Modifiers
The Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes that describe a Telehealth service (a provider-patient encounter from one site to another) are generally the same codes that describe an encounter when the provider and patient are at the same site.

Telephone Services
Optum follows CMS guidelines and does not reimburse for telephone charges when billed with POS 02 or 10 because they do not involve direct, face to face patient contact and are considered an integral part of other services provided.

Opioid Use Disorder Treatment
Optum follows CMS guidelines effective for services rendered on or after January 1, 2020, and considers office-based treatment for opioid use disorders, G2086-G2088, eligible for reimbursement according to the CMS Physician Fee Schedule (PFS). Please refer to the Opioid Treatment Program Reimbursement Policy.

Definitions	
Asynchronous Telecommunication	Medical information is stored and forwarded to be reviewed at a later time by a physician or health care practitioner at a distant site. The medical information is reviewed without the patient being present. Also referred to as store-and-forward telehealth or non-interactive telecommunication.
Interactive Audio and Video Telecommunication or Interactive Audio and Visual Transmissions or Audio-Visual Communication Technology	Medical information is communicated in real-time with the use of Interactive Audio and Video Communications equipment. The real-time communication is between the patient and a distant physician or health care specialist who is performing the service reported. The patient must be present and participating throughout the communication.
Originating Site	The location of a patient at the time the service being furnished via a telecommunications system occurs.
Telehealth/Telemedicine	Telehealth services are live, Interactive Audio and Visual Transmissions of a physician-patient encounter from one site to another using telecommunications technologies. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

Questions and Answers	
1	**Q:** What are the documentation requirements for Telehealth visits? **A.** For documentation requirements please visit the link Behavioral Health Services Documentation
2	**Q:** How does Optum reimburse for phone calls to patients that are not associated with any other service? For example, a provider receives a call from a patient at 2 A.M. The provider is able to handle the situation over the phone without requiring Additional services. On what basis will the visit be denied? **A:** Optum will not reimburse for this service since it did not require direct, in-person patient contact. This service is considered included in the overall management of the patient.

	Note: For Telehealth services rendered in response to the COVID-19 public health emergency, providers should visit COVID-19 information page on Optum Provider Express COVID-19 Provider Information for additional resources.
3	**Q:** A provider makes daily telephone calls to check on the status of a patient's condition. These services are in lieu of clinic visits. Will Optum reimburse the physician for these telephone services? **A: No**, Optum will not reimburse telephone services.
4	**Q:** Does Optum reimburse website charges for provider groups if their website provides patient education material? **A:** No, Optum will not reimburse for Internet charges since there is no direct, in-person patient contact.
5	**Q:** What is the difference between Telehealth services and telephone calls? **A:** Telehealth services are live Interactive Audio and Visual Transmissions of a provider-patient encounter from one site to another using telecommunications technologies. Telephone calls are non-face-to-face medical discussions, between a physician or other healthcare professional and a patient, that do not require direct, in-person contact.
6	**Q:** Will Optum reimburse Telemental Health Services if billed with POS 02 or POS 10 along with a GT Modifier? A: No. Optum will only reimburse for Telemental Health Services if a provider bills with the appropriate POS 02 or 10 along with the appropriate modifier (95 or GQ).

Covered Telehealth Services CPT Codes listed below are not intended as exhaustive of all relevant codes	
CPT Codes	**Description**
90785	Interactive complexity (list separately in addition to the code for primary psychiatric procedure)
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service(list separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)
90845	Psychoanalysis
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with the patient present), 50 minutes
90853	Group psychotherapy (other than of a multiple-family group)
99202	Office/outpatient visit new patient
99203	Office/outpatient visit new patient
99204	Office/outpatient visit new patient
99205	Office/outpatient visit new patient
99211	Office/outpatient visit establish patient
99212	Office/outpatient visit establish patient

99213	Office/outpatient visit establish patient
99214	Office/outpatient visit establish patient
99215	Office/outpatient visit establish patient
G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month
G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; ; each additional 30 minutes beyond the first 120 minutes

Resources
www.cms.gov American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

History / Updates	
January , 2023	Anniversary Review Remove GT modifier from Reimbursement Guidelines Section and added Q&A 6
September, 2022	Updated Q&A 1 & 2
August, 2022	Updated Reimbursement Guidelines Section
January, 2022	2022 Annual Review Overview section updated Reimbursement Guidelines Section: added POS 10, updated modifier list new codes FQ and FR Definitions Updated
May, 2021	Anniversary Review; No Updates
January, 2021	Reimbursement Overview & Guidelines Section revised; POS 02 is required for telehealth services Definitions Section revised Q&A 1 2 & 3 Section updated Supplemental Waiver List 2021 Update
December, 2020	Updated On-Line Digital Evaluation and Management Services section; removed deleted codes 98969 and 99444
April, 2020	Annual Anniversary Date Reimbursement Guidelines Section: added Patient Home for originating site, added Opioid codes and language, Updated Optum Supplemental Benefit Waiver list Updated Telehealth Covered Code List
November, 2019	Updated Title to policy from Virtual Visits Medicare & Retirement Reimbursement Policy to Telemental Health Services Reimbursement Policy - Medicare
August, 2019	Annual Anniversary Date
January, 2019	Removal of the GT modifier as an acceptable billing practice
August, 2018	New