Apple Health (Medicaid) clinical policy and billing for COVID-19

In this time of the COVID-19 pandemic, the Health Care Authority is aware that usual and customary ways of providing and billing/reporting services may not be feasible. It is also understood that different providers will have different capabilities. Therefore, in the interest of public health, HCA's Apple Health (Medicaid) program is trying to be as flexible as possible and is creating new policies that will allow you to provide medically necessary services and bill or report the encounter with the most appropriate code you determine applicable, using the guidance below.

This FAQ reinforces the agency's current policies regarding telemedicine as defined in [WAC 182-531-1730](#) and covers the new telehealth policies that will only be in effect during this health care crisis. We will update this FAQ as necessary to respond to new information as it develops.

The FAQ below was revised after new information was released Friday, March 20, by the Centers for Medicare & Medicaid Services (CMS) in an all-state call about the use of telehealth in Medicaid.   Note: Medicaid is not subject to the same policies as Medicare.

Contents

Frequently Asked Questions

Part 1- General Information

Q: What are the requirements for providing services via telemedicine/telehealth to a Washington State Apple Health (Medicaid) client residing in Washington?

You must be licensed in Washington State to bill for a~~a~~ telemedicine or telehealth services. Out-of- state practitioners can apply to be emergency volunteer health practitioners and register to practice in Washington state, or apply for Washington State licensure that may result in a temporary practice permit. Service(s) must be rendered consistent with the scope of professional licensure or certification. Please see [Washington State Department of Health](#) website for further information and details related to each option. This rule does not pertain to providers in a Direct IHS Clinic, Tribal Clinic or Tribal FQHC as those providers may be licensed in any state per Federal law.

If the Washington Apple Health (Medicaid) client is receiving services outside of Washington State by a Washington State provider, the provider must follow the applicable laws of the state in which the client is located

Q: Are you following Medicare's guidance and allowing the provider to select the E&M code level based just on the Medical Decision Making (MDM), or the time, with time defined as all of the time associated with the E/M on the day of the encounter?

Yes, Apple Health (Medicaid) is allowing the provider to code the E&M based on this CMS guidance. *The MCO's will follow this policy.

Q: Is Medicaid removing any requirements regarding documentation of history and/or physical exam in the medical record?

Yes, Medicaid is removing requirements regarding documentation of the history and/or physical exam in the medical record when providing services via telemedicine or telehealth. *The MCO's will follow this policy.

Q: What if I am providing telemedicine or telehealth services outside of office hours?

The following codes are available as add on codes for services provided by primary care providers via telemedicine/telehealth outside of Monday- Friday, 8-5 workday hours.

See [COVID-19 fee schedule for rates](#). *The MCO's will follow this policy as well.

Code	Definition	Modifier
99050	Services provided at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service	CR
99051	Service(s) provided during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	CR

Q: Is there any more information regarding telemedicine and telehealth that I can review?

Yes, You will find more information in the [Apple Health (Medicaid) telemedicine and telehealth brief for COVID-19](#) and [Apple Health (Medicaid) telehealth policy recorded webinar](#).

Part 2- Telemedicine using usual E/M codes, CPT or HCPC codes, store and forward

Q: What telemedicine services are covered?

All Apple Health programs (FFS and MCOs) cover telemedicine when:

- Delivered via HIPAA compliant interactive, audio and video telecommunications (including web-based applications), and
- The provider works within their scope of practice to provide a covered service to an Apple Health eligible client.

FFS AND MCOs will reimburse for professional services provided via telemedicine, in the following settings:

- Inpatient hospital, including ICU and CCU
- Outpatient Hospital, including ER, hospital- based clinics
- Free standing clinic and office services

Please see HCA's brief on telehealth services for instructions on how to bill for telemedicine.

Telemedicine services are paid at the same rate as if the services were provided face-to-face.

*Please confer with the client's MCO regarding billing requirements.

Q: How do I bill for services provided via telemedicine?

For services provided via telemedicine, bill the code you would usually that denotes the service rendered (including E/M codes) with POS 02 (telemedicine). If you should receive the non-facility rate, you need to add modifier 95. Please see physician's billing guide for detailed instructions on how to bill for telemedicine services or appropriate MCO billing instructions.

Q: Can an Outpatient Hospital facility bill for the originating site facility fee when the client is at home?

Yes, when the facility is providing administrative and clinical support services for a client receiving services via telemedicine from a provider associated with that facility/clinic. To receive payment for the originating site facility fee when the client is at home, providers must bill only the Q3014 with the CR modifier. Do not bill the G0463 for the same date of service. This policy is effective as of 3/1/20. See the COVID- 19 fee schedule.

*The MCOs will follow this policy as well.

Q: Is store and forward a covered telemedicine modality?

Yes, but only if you are providing dermatology services. Please see the Physician-related/professional services billing guide.

Q: What if telemedicine is used to provide services when the client and the provider are within the same facility?

Yes. During this time, HCA wants Apple Health providers to be able to use telemedicine services to provide patient care even if it is within the same facility. When providing telemedicine services within the same facility, do not submit a claim for the originating site. *The MCOs will follow this same policy.

Part 3- telehealth using usual E/M codes, CPT or HCPC codes
Q: What modes of technology can I use to provide services to my patients?

Under the circumstances, Apple Health is covering a variety of technology modalities in lieu of in person visits to support evaluation, assessment and treatment of clients. These modalities include:

Other forms of telehealth, such as on-line digital exchange through a patient portal; telephone calls, Face-Time; Skype; or email.

Texting may also be used, but the agency cautions as to the extent this should be used for doing assessments and providing treatment. (See section on G2012 below.). *The MCOs are adopting these policies as well.

Q: How do I bill if I am using another telehealth technology to provide medical services, e.g. on-line digital exchange through a patient portal; telephone calls, Face-Time; Skype; or email? This includes regular E/M codes as well as other CPT/HCPC codes.

Apple Health is aware that there are instances when telemedicine is not an option and providers need to use other methods to provide care.[1] Apple Health is *temporarily* allowing other modalities to be used when current practice for providing services is not an option (face to face, telemedicine). Report the service modality code (CPT or HCPC code) as you would if the encounter was in person. In these cases, Apple Health is temporarily allowing services using a telephone or other means of electronic transaction, as described above, to conduct an office visit. Report the code (CPT or HCPC) as you would if the encounter was in person. Always document the modality used for delivery in the health care record. Remember to:

Use the CR modifier

Use the POS indicator that best describes where the client is, for example "12" is home; "31" is skilled nursing facility, "13" is assisted living facility, etc. Do not bill with the providers location as the place of service. *The MCOs are adopting these policies as well.

Q: Do I need to take any measures to inform the client about technologies that may not be HIPAA compliant?

Yes, clients must be informed when using a non-HIPAA compliant technology. This can be done in the following ways:

- Using mail to obtain written consent
- Use of an electronic signature
- Verbal - but the information provided and the verbal consent must be documented and dated.

Once in-person visits are resumed, the client must sign a consent form that communicates in writing that the client provided consent to use a platform that could not protect their personal health information.

Part 4- Other telehealth codes and policies

Q: What other codes could be used if the other options above are not applicable to the care provided?

If you are a licensed provider who can bill an E&M code and using the usual procedure code with one of the options described in Parts 1, 2, or 3 isn't applicable, below is a matrix of other available codes. *The MCOs are adopting these policies as well.

Please see the COVID-19 fee schedule for rates.

Code	Description
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

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[1] The provider is quarantined at home, the clinic is closed, the client lives remotely and doesn't have access to the internet or the internet does not support HIPPA compliance, or the circumstances require the provider to utilize a different technology modality to provide healthcare services.

99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

Q: How do I bill these modalities?

Bill the CPT code provided using the CR (catastrophe/disaster) modifier at the line level.   *The MCOs are adopting these policies as well.

Q: Can telephone calls be initiated by the provider?

Yes, during this pandemic, we are allowing providers to initiate phone calls. The MCOs will follow this policy as well.

Q: What if I am trying to serve a new client, since the codes listed above are for established patients?

Apple Health is allowing use of codes 99441-99443, 99421-99423 for new or established patients during this crisis. *The MCOs will follow this policy as well.

Q: What will I be paid for providing services using these modalities?

When you bill for 99441-99443 or 99421-99423 using a CR modifier, you will be paid the rates identified on the COVID-19 fee schedule. Due to system constraints, the system will not pay the pediatric enhanced rate for these codes. If you are a provider that receives an enhanced rate for E/M services provided to children/youth under the age of 18, please follow the instructions in Part 2 or 3 for billing a telemedicine or a telehealth E/M code to receive the pediatric enhanced rate.

*Depending on your contract with the MCOs their reimbursement may be different - for example if you are reimbursed at a capitated rate, or another non fee for service methodology.

Q: If I am making the call from my house to the client that is at home, what POS do I use?

Place of Service (POS) is where the client received the medical service. For example, if the client is at home, then use POS 12. *The MCOs will follow this policy as well.

Q: What if I need to consult with another provider regarding treatment of my patient?

99446 is already a covered code. See Physician-related/professional services fee schedule. *MCOs will follow this policy as well.

Q: What about e-consults?

During this crisis we are *temporarily* allowing the following code to be utilized when consultation between other specialties occurs. See the [COVID-19 fee schedule](#).

Code	Description
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time

You must bill with the CR modifier. *The MCOs will follow this policy as well.

Q: Medicare has given guidance to use G2012. Is Apple Health covering that code?

Yes. This code is covered and must be billed with modifier CR. Apple Health considers texting a virtual check-in. If billing for texting to complete a telehealth visit with a client, bill the G2012 code for payment of this service. *The MCOs will follow this policy as well.

Code	Description
G2012	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

Q: Is Z11.59 a covered diagnosis code?

Yes, Z11.59 is a covered code with a retroactive date of March 1, 2020. If you have received a denial due to diagnosis code Z11.59, please resubmit your claim.

Part 5 – Telemedicine and Telehealth in the FQHC/RHC setting

Q: What medical services described above are encounter eligible for federally qualified health centers (FQHCs), rural health clinics (RHCs), and Tribal Facilities (Direct IHS Clinics, Tribal Clinics and Tribal FQHCs)?

The following CPT Codes are encounter eligible when billed with modifier CR: 99441-43, 99421-23, G2012, 99429.

Fee For Service (FFS) Claims:

As with all FFS encounter eligible claims, the above listed CPT codes should be billed directly to ProviderOne with a T1015.

Managed Care Claims:

FQHCs, RHCs, and Tribes should bill MCOs with these codes for managed care clients. For all FQHCs and those RHCs who reconcile directly with HCA, these claims will be included in the annual reconciliation.

For those RHCs who receive the full encounter rate, MCOs will ensure these clinics receive their full encounter rate for the above listed services. As with all encounter eligible services, RHCs are required to bill a T1015 in addition the above listed CPT codes in order to get the full encounter rate through MCOs.

For Tribal Facilities (Direct IHS Clinics, Tribal Clinics, and Tribal FQHCs) – the MCO payment of the encounter rate is scheduled to begin on 04/01/2020 (AI/AN clients) and 07/01/2020 (nonAI/AN clients). Until MCO payment of the encounter rate begins – the balance of the encounter rate may be billed to P1 for Medical services

*MCOs will follow this policy as well.

Q: Are FQHC's or RHC's eligible to be an originating site?

Yes, both FQHC's and RHC's are approved originating sites. Apple Health (Medicaid) only pays an originating site facility fee for services provided via telemedicine. The MCOs will follow this policy as well.*

Part 6 - Provider/program specific information including the following: EPSDT, Office Based Opioid Treatment, Medical Nutritional Therapy, Residents, Maternity

EPSDT
Q: What about EPSDT visits that were provided via telemedicine or telehealth?

Apple Health is aware that there are components of an EPSDT visit that cannot be completed via telemedicine or telehealth. As those components are critical to the well-being of children/youth, there will be a need for a follow-up appointment to complete those components. Apple Health is approving the following plan to address this concern.

For an EPSDT appointment via telemedicine/telehealth, follow the guidance below:
- services provided via a telehealth modality choose the appropriate EPSDT visit code, with modifier CR and the POS indicator that best describes where the client is, for example "12" (home)
- services provided via telemedicine modality, choose the appropriate EPSDT visit code, with modifier CR, POS 02
    - Note: remember to add any of the additional procedure codes that are applicable to other services/screenings provided (see EPSDT billing guide and Physician-related/healthcare services billing guide)

    *The MCO's will follow this policy as well. However, providers should check with the MCO about the modifier code requirements.

For the in-person follow-up appointment to complete EPSDT components, bill the following on an EPSDT claim:
- 99429 with modifier CR (see COVID-19 fee schedule)
    - Note: remember to add any of the additional procedure codes that are applicable to other services/screenings provided (see EPSDT billing guide and Physician-related/healthcare services billing guide)

    *The MCO's will follow this policy as well. However, providers should check with the MCO about the modifier code requirements.

Code	Description
99429	Unlisted preventive medicine service

Office Based Opioid Treatment
Q: How can I provide support to my patients receiving Office Based Opioid Treatment (OBOT) services when patient contact has been limited during the COVID-19 crisis?

During COVID-19, 99211 can be billed when a nurse phone call is utilized to provide contact and support to assist in accomplishing treatment goals. This is a separate E/M billed by the provider to be used in lieu of a face to face E/M. Bill with modifier CR.   If the nurse providing the service is funded through a current contract with Health Care Authority (such as SOR/OTN/Hub and Spokes/ Nurse Care Manager Projects), they are excluded from billing this service at this time. *The MCOs will follow this policy as well.

Medical Nutrition Therapy
Q: Can dieticians bill for medical nutrition therapy provided via telemedicine or telehealth?

Yes, dieticians can bill for medical nutrition therapy services that are provided via telemedicine or telehealth. Please follow guidance for those policies. * The MCOs are adopting these policies as well.

Residents

Q: Can residents provide care allowed under the primary care exception (PCE) via telemedicine/telehealth?

Yes, as long as the appropriate level of supervision is in place for all residents based on each resident's level of education/training and ability, as well as patient complexity and acuity. Apple Health (Medicaid) is aligning with Medicare policy to allow office/outpatient E/M services provided in a primary care center under direct supervision of the teaching physician either in person or by interactive telecommunications technology. * The MCOs will follow this policy as well.

Maternity

Q: Will the agency continue to pay for OB services under pre-COVID 19 reimbursement policies (bundled/unbundled payment)? How will services rendered using telemedicine/telehealth modalities be reimbursed?

Yes, HCA will continue to reimburse for OB services under pre-COVID-19 reimbursement policies using the bundled or unbundled approach, as applicable. Prenatal and postnatal services rendered using a telemedicine/telehealth modality and conducted as an OB visit will be reimbursed as it would if the visit was in person under the agency's OB bundled/unbundled reimbursement policy. *The MCO's will follow this policy.

Q: How do I bill the antepartum care place of service (POS) if some of those services were provided via telemedicine or telehealth?

HCA recommends you choose the usual procedure code you would have for billing the service and use the POS of that is relevant to the service provided on the date of the last visit. For example,

- If the service was provided via telehealth (such as FaceTime, Skype etc.), then use the CR modifier and the POS that denotes the location of client, e.g. 12 (at home)
- If the service was via telemedicine, use POS 02 (telemedicine)
- If the service was provided in person in an office setting , use POS 11 (office)

Just like pre- COVID 19 OB billing policies and procedures, for any service provided that falls outside of the CPT guidelines for global OB care, follow the telemedicine/ telehealth guidance for all medical providers. Problem-oriented services provided outside of the standard of care can be provided via telemedicine or telehealth. Please see the guidance above regarding how to bill for those services. *The MCO's will follow this policy.

Part 7 - Billing for LAB, Specimen collection and facility fees

Q: Which COVID-19 diagnostic lab tests are covered?

Below is a matrix of the codes that are covered. You must include modifier CR on the line level. Limit one per day. The MCOs will follow this policy as well.*

Code	Description	Professional claims	Facility claims
U0001	Cdc 2019 novel coronavirus (2019-ncov) real-time rt-pcr diagnostic panel	Modifier CR	Modifier CR and Condition code DR
U0002	2019-ncov coronavirus, sars-cov-2/2019-ncov (covid-19), any technique, multiple types or subtypes (includes all targets), non-cdc	Modifier CR	Modifier CR and Condition code DR
U0003	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe	Modifier CR	Modifier CR and

			Condition code DR
U0004:	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R.	Modifier CR	Modifier CR and Condition code DR
87635	Infectious agent detection by nucleic acid (DNA or RNA): severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique	Modifier CR	Modifier CR and Condition code DR
87426	severe acute respiratory syndromecoronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19])	Modifier CR	Modifier CR and Condition code DR

(top partial row continues: "technique, making use of high throughput technologies as described by CMS-2020-01-R")

You must include the CR modifier on the line level. The Apple Health fee-for-service (FFS) program (see COVID-19 fee schedule) and the Managed Care Organizations (MCOs) have adopted these codes.

Q: When does Medicaid deem it medically necessary to order antibody testing?

Clinical Policy: Medical Necessity Criteria for Antibody Testing for SARS-CoV-2 Policy

Antibody testing currently has clinical applicability only in specific circumstances and is not recommended for the general public on a broad scale. Per CDC Interim Guidelines for COVID-19 antibody testing should not be used to determine immune status in individuals until the presence, durability, and duration of immunity is established.

Based on this information, WA Health Care Authority requires the following criteria be met for payment of COVID-19 antibody tests:

- Must be performed by a CLIA certified Lab
- Meet medical necessity criteria, specifically that the results from the antibody test will be used by a clinician to initiate or change the management of a client's care.
  - A representative example of this occurs in cases where a client has late complications of COVID-19 illness, such as multisystem inflammatory syndrome in children

Please note, this policy may be updated as new information becomes available. This policy has a retroactive date of 4/10/20. The agency may perform a post-pay review on any claim and supporting physician's documentation to ensure compliance with this policy.

Codes:

- 86328 — Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single-step method (e.g., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19
- 86769 — Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]).
- Apple Health (Medicaid) is aware that there are other non-specific codes that could be used to gain the same information, if those codes are billed to Apple Health (Medicaid) the same criteria listed above will be applied.

Modifier:

- CR Modifier on the line level

Limitations:

- Limited to 1 antibody test per calendar year per client. If additional test are needed, providers can submit a limitation extension request to HCA. Please see the Physician-related/professional services guide for information regarding limitation extension.

Rates:

- Please see the COVID-19 fee schedule

Q: If we set up a drive up/ drive through COVID-19 testing site, how can we bill for those services?

When collecting a specimen to test for COVID-19 that is not associated with an E/M visit, HCA is allowing CPT code 99001 to be billed.

Code	Description
99001	Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)

Patient cars located in the parking lot of a clinic in which clinic staff provides COVID testing will be considered extensions of the clinic. Patient cars located in the parking lot of a hospital in which ER staff provide COVID testing will be considered extensions of the ER. If these examples do not apply to your situation, bill POS 15 (mobile unit).

You must bill with the CR modifier. Please see the COVID-19 fee schedule. The MCOs will follow this policy as well.*

Q: If I need to test a client for COVID-19, will I get paid for collecting the specimen?

If you are a provider that can bill for an E/M service, the testing is part of the E/M service. If the client comes in to the provider's office just for the specimen collection, then you can bill 99211 for the service. *The MCOs will follow this policy as well.

Q: What if we are submitting a facility claim that is related to COVID-19?

Consistent with Medicare policy, add condition code DR (Disaster Related). *The MCOs will follow this policy as well.

Q: What if care is provided in a tent outside the ED?

If services are provided in a tent located in close proximity to the ED and the ED staff provides COVID care or non-COVID care, it will be considered an extension of the ED (POS 23). For professional services, use the CR modifier. For facility fees, use condition code DR. *The MCOs will follow this policy as well.

Part 8 - Examples for preparing claims that utilized telemedicine or telehealth modalities to provide services

EPSDT/Well-Child Exam Scenarios

Scenario #1

Practitioner conducts an EPSDT telehealth visit with child and parent(s), who are in their home. No health care concerns are identified, but child is due for a vaccine, which is delivered in the office.

- Bill the appropriate EPSDT visit code and modifier CR and POS "12" (home); (if the service is rendered using telemedicine modality, see the Clinical FAQ for billing instructions regarding modifiers and use of POS code "02")
- Bill appropriate vaccine administration code on the same claim, if this service is done the same day as the EPSDT visit code. If not on the same day, bill on a separate claim

- If in the FQHC or Indian Health Service or tribal clinic setting and both procedures are performed the same day, FQHC or Indian Health Care Provider (IHCP) should receive one encounter rate. If the procedures are completed on different days, the FQHC or IHCP should receive an encounter rate for the telehealth visit and a fee for service level of reimbursement for the vaccination administration

Scenario #2

Practitioner conducts an EPSDT telehealth visit with child and parent(s) who are in their home. Practitioner determines an in-person visit is needed to do the physical assessment/exam of the well child visit.

- Bill the appropriate EPSDT visit code with modifier CR and POS "12" (home); (if the service is rendered using telemedicine modality, see the FAQ for billing instructions regarding modifiers and use of POS code "02")
- Bill the in-person visit to complete the EPSDT exam using CPT code 99429 with modifier CR and POS, as indicated by the setting of the exam
    - Note: If both of these services are performed on the same day bill the in person visit as a completed EPSDT visit only.
- If in the FQHC setting and both procedures are performed the same day, FQHC or IHCP should receive one encounter rate. If performed on different days, both the telehealth visit and the in-person appointment would qualify for the FQHC or IHS encounter rate

Scenario #3

Practitioner conducts a telemedicine EPSDT visit with child and family, noting the child is exerting effort to breathe, increased respiratory rate. Practitioner asks family to bring the child into the office for an in-person exam.

- Bill the in-person visit using the appropriate EPSDT visit code with POS of the visit, e.g. "11" (clinic); or
- Bill the appropriate E/M code, as indicated, if child is sick, and that reflects the level of care provided to address the medical concern, as well as any of the well child services provided
- FQHCs should receive one encounter rate for each visit, if one of the conditions is true: the second procedure is provided by a provider with a different specialty or the second procedure has an unrelated diagnosis, as outlined in WAC 182-548-1450(1).   Direct IHS Clinics, Tribal Clinics and Tribal FQHCs may receive one encounter rate for each visit if the visits are distinctly separate visits and otherwise eligible for the IHS encounter rate per the Tribal Health Billing Guide.

General Medical Scenarios

Scenario #1

Practitioner initiates a telehealth visit with patient during which the practitioner determines a separate in-person visit is necessary for a physical exam to make a diagnosis and establish a treatment plan, for the same problem.

- Bill the appropriate E/M code for the in-person visit with POS "11" (clinic), as indicated, that reflects the level of care provided to address the medical concern. You may include the time spent in the telehealth visit
- If in the FQHC or Indian Health Service or tribal clinic setting and both the telehealth visit and the in-person visit are conducted on the same day, by the same provider and under the same diagnosis, only one FQHC or IHS encounter payment will be made.

Scenario #2

Practitioner conducts a telemedicine (HIPAA compliant audio-visual modality) visit with client (at home) to address concerns regarding recent increased wheezing when client goes on a walk. Practitioner collects clinical data and information; adjusts therapy; and educates client about the use of new medications and changes in symptoms that may warrant follow-up.

- Bill appropriate E/M code with POS "02"
- FQHCs and IHCPs should receive one encounter rate for this visit

Maternity Scenarios

We do allow a combination of in-person and telemedicine/telehealth visits. FQHCs will bill their managed care plan as any other provider and will be reimbursed according to the contractual arrangements between the FQHC and the MCO. As prenatal visits are eligible for the FQHC encounter rate, HCA will include these services in the managed care reconciliation for CY 2020.   Direct IHS Clinics, Tribal Clinics and Tribal FQHCs are eligible for the IHS encounter rate for both Managed Care and FFS clients, contract the HCA Tribal Affairs office for more information

Scenario #1

Practitioner has a total of 5 antepartum visits (does not do delivery) with client; the first three were in-person and the last two were via telehealth.

- Bill 59425 with CR modifier and POS that denotes the location of client on the last visit, e.g. "12", if at home

Scenario #2

Practitioner has telephone call with client. Gravida 1/para 0 client at 9 weeks gestation reported concern about being tired all the time. Client denies any other issues.

- Bill appropriate E/M for service provided via telehealth with modifier CR and POS that denotes the location of client, e.g. "12", if at home; or
- If the service provided does not warrant a E&M level of care, bill the appropriate telephone code (99441-43) with modifier CR and POS that denotes the location of client, e.g. "12", if at home

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