

ForwardHealth **UPDATE**

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EXPANDED COVERAGE FOR PERMANENT TELEHEALTH POLICY

This ForwardHealth Update provides details on limited asynchronous and other telehealth services that will be reimbursable under ForwardHealth as part of permanent telehealth policy. As a reminder, permanent telehealth policy goes into effect on the first day of the first month following the end of the federal COVID-19 public health emergency (PHE). For example, if the PHE ends on April 11, 2023, permanent policy would become effective for dates of service on and after May 1, 2023.

To facilitate the transition from temporary to permanent telehealth coverage policy, ForwardHealth will allow providers to submit claims for services identified as permanent telehealth procedure codes under the permanent telehealth billing guidelines listed below. For additional information regarding temporary and permanent policy, providers may refer to the [Telehealth Resources for Providers](#) page of the ForwardHealth Portal.

AFFECTED PROGRAMS

BadgerCare Plus, Medicaid

TO

All Providers, HMOs and Other Managed Care Programs

QUICK LINKS

- [Telehealth topic \(#510\)](#)
- [ForwardHealth Update 2020-15, "Additional Services to Be Provided Via Telehealth"](#)
- [Telehealth Resources for Providers page](#)

Note: Effective January 2023, the Telehealth topic will be restructured and will become its own chapter in the ForwardHealth Online Handbook.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(61).

Asynchronous Telehealth

Effective January 1, 2023, ForwardHealth will begin reimbursing certain asynchronous telehealth services. Asynchronous telehealth services are defined as telehealth that is used to transmit medical data about a patient to a provider when the transmission is **not** a two-way, real-time, interactive communication.

Services that are rendered asynchronously must adhere to the ForwardHealth guidelines for functional equivalency. “Functionally equivalent” means that when a service is provided via telehealth, the transmission of information must be of sufficient quality as to be the same level of service as an in-person visit. Transmission of voices, images, data, or video must be clear and understandable.

Asynchronous delivery is indicated by modifier GQ (Via asynchronous telecommunications system). Modifier GQ must be used for all ForwardHealth-covered asynchronous services including, but not limited to, teleophthalmology, teledermatology, and teleradiology delivered through asynchronous telecommunications systems (for example: through e-consult and remote patient monitoring). Only the service rendered from the distant site must be billed with modifier GQ. The originating site for asynchronous services is not eligible to receive an originating site fee.

“Store and forward” is a term for asynchronous telehealth that involves the transmission of medical information to be reviewed at a later time by a provider at a distant site. The physician or practitioner at the distant site then reviews the case without the member present.

A member’s medical information may include, but is not limited to:

- Video clips
- Still images
- X-rays
- MRIs
- Laboratory results
- Audio clips
- Text documents

The transmission of protected health information must be performed in a manner compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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ForwardHealth will not reimburse for any asynchronous service that does not adhere to the Healthcare Common Procedure Coding System or Current Procedural Terminology code description,

meaning all the components listed in the description need to be present to be reimbursed. For example, if the code

definition specifies “face-to-face” or “hands-on delivery,” this would not allow the service to be performed asynchronously. Providers must adhere to the delivery mode specified in the code description.

“Providers must adhere to the delivery mode specified in the code description.”

Asynchronous Dental Services

For dates of services on and after January 1, 2023, providers should report procedure code D9996 (Teledentistry asynchronous; information stored and forwarded to dentist for subsequent review) along with applicable dental evaluation and diagnostic imaging procedure codes to indicate the service was delivered through store and forward asynchronous teledentistry.

Note: D9996 is informational only and is not separately reimbursable.

When submitting claims for teledentistry, the provider should report all procedures delivered during a virtual evaluation and include the applicable teledentistry code on a separate line in the claim detail.

Telehealth Service Expansion

ForwardHealth is expanding allowable telehealth services to include additional virtual check-in and e-visit options for members to connect with their providers remotely.

A **virtual check-in** is a brief patient-initiated asynchronous or synchronous communication and technology-based service intended to be used to decide whether an office visit or other service is needed. The encounter may involve synchronous discussion over a phone or exchange of information through video or image. A provider may respond to the member’s concern by phone, audio-visual communications, or a secure patient portal. Covered services include both the remote evaluation of a recorded video or image submitted by a member and the interpretation and follow-up by the provider.

An **e-visit** is a communication between a member and their provider through an online HIPAA-compliant patient portal. These patient-initiated asynchronous services involve a member having non-face-to-face

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communications cumulatively over a span of seven days with a provider with whom they have an established relationship. Providers who can bill evaluation and management (E&M) services may utilize online digital E&M codes while other providers may be eligible to bill online assessment and management codes.

Allowable procedure codes for virtual check-in and e-visit services can be found in the [Attachment](#) to this Update.

These services will not require prior authorization and are patient-initiated by established patients of the provider's practice.

Virtual check-in and e-visit telehealth services are not covered or billable if they:

- Take place during an in-person visit.
- Take place within seven days after an in-person visit furnished by the same provider.
- Trigger an in-person visit within 24 hours or the soonest available appointment.
- Do not have sufficient information from the remote evaluation of an image or video (store and forward) for the provider to complete the service.

Only the relevant in-person procedure code that was rendered would be reimbursed if any of the above conditions apply.

Member Consent and Notification

Providers must obtain member consent for telehealth services, including informing the member of any applicable copay or cost sharing that may apply. This includes patient-initiated virtual check-in and e-visit services.

“Providers must obtain member consent for telehealth services, including informing the member of any applicable copay or cost sharing that may apply.”

For more information regarding telehealth consent guidelines, refer to the Telehealth topic ([#510](#)) of the ForwardHealth Online Handbook.

Additionally, providers are responsible for communicating with members how the delivery of a service may potentially vary between an in-person and a telehealth delivery. This includes informing a member of any potential changes they may anticipate in how a service is delivered when the temporary telehealth policy and PHE flexibilities expire and permanent policy is effective.

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Use of Telehealth Modifiers

Providers should include all applicable modifiers to identify the delivery method for telehealth services.

Claims for **synchronous** telehealth services should be indicated by one or more of the following applicable modifiers:

- GT (Via interactive audio and video telecommunication systems)
- 93 (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system)
- FQ (A telehealth service was furnished using audio-only communication technology) Use this modifier when the patient is unable to use audio and video communications. (This modifier is for behavioral health services only.)
- FR (A supervising practitioner was present through a real-time two-way, audio/video communication technology) (This modifier is for behavioral health services only.)

Note: The FQ and FR modifiers are for behavioral health services **only**.

Claims for **asynchronous services** should be indicated using the GQ modifier.

For services that include both asynchronous and synchronous components, claims should indicate that the cumulative services were rendered through both real-time interactions and store-and-forward delivery. For example, in a virtual check-in, if a provider reviews an image submitted by an established patient sent through a secure provider portal and calls the member on the phone to discuss treatment and next steps, the claim should indicate both the 93 and GQ modifiers.

Providers are required to include any additional provider, benefit, or service-specific modifiers that may apply to a service code when delivered through telehealth. For example, when a service is provided by a physical therapist (PT), the codes would need to include the corresponding therapy modifier GP (Services delivered under an outpatient physical therapy plan of care) to signify the telehealth service is furnished as therapy services furnished under a PT plan of care.

Clarifications and Definitions for Existing Telehealth Policy

The following are definitions to clarify the meaning of existing terms that describe different modes of telehealth service delivery in current telehealth policy.

REMINDER

Providers are required to include any additional provider, benefit, or service-specific modifiers that may apply to a service code when delivered through telehealth.

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Under permanent telehealth policy, “direct” refers to face-to-face, in-person contact between a member and a provider. This is a change from how the term “direct” has been used under temporary telehealth policy. Under temporary telehealth policy flexibilities in place during the PHE, direct telehealth services were defined to include delivery through real-time, synchronous telecommunications (such as phone, audio-only, or audio-visual interactions) that do **not** involve face-to-face, in-person patient contact. Refer to ForwardHealth Update [2020-15](#), titled “Additional Services to Be Provided Via Telehealth,” for additional information on temporary policy.

“Face-to-face” refers to requirements that can be met either in-person or through real-time, interactive audio-visual telehealth. Face-to-face equivalence for interactive telehealth services exists when a service is delivered from outside the physical presence of a Medicaid member by using audio, video, or telecommunication technology, and there is no reduction in quality, safety, or effectiveness. ForwardHealth does not consider a “face-to-face” requirement to be met by audio-only or asynchronous delivery of services.

“In-person” refers to when the provider rendering a service and the member receiving that service are located together physically in the same space. In-person services are not considered to be delivered through telehealth, including audio-visual telehealth, unless there are applicable supervision components and requirements that are rendered through telehealth outside of the direct patient contact by the provider.

Documentation Retention

Providers are reminded that they must follow the documentation retention requirements per Wis. Admin. Code § [DHS 106.02\(9\)](#). Providers are required to produce or submit documentation, or both, to the Wisconsin Department of Health Services (DHS) upon request. Per Wis. Stat. § [49.45\(3\)\(f\)](#), providers of services shall maintain records as required by DHS for verification of provider claims for reimbursement. DHS may audit such records to verify actual provision of services and the appropriateness and accuracy of claims. DHS may deny or recoup payment for services that fail to meet these requirements. Refusal to produce documentation may result in denial of submitted claims, recoupment of paid claims, application of intermediate sanctions, or termination from the Medicaid program.

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Information Regarding Managed Care Organizations

This Update applies to telehealth services that members receive on a fee-for-service basis and through BadgerCare Plus, Medicaid SSI, and other managed care programs. For information about managed care implementation of the updated policy, contact the appropriate managed care organization (MCO). MCOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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The ForwardHealth Update is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Medicaid Services within the Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health within DHS.

For questions, call Provider Services at 800-947-9627 or visit our website at www.forwardhealth.wi.gov/.

ATTACHMENT

Allowable Procedure Codes for Virtual Check-In and E-Visit Services

Below are allowable procedure codes for virtual check-in and e-visit services.

VIRTUAL CHECK-IN PROCEDURE CODE	DESCRIPTION
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, 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
G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment
G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report Evaluation and Management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of clinical discussion
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

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VIRTUAL CHECK-IN PROCEDURE CODE	DESCRIPTION
G2252	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; 11–20 minutes of medical discussion

E-VISIT PROCEDURE CODE	DESCRIPTION
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
98971	Qualified nonphysician health care professional online digital assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11–20 minutes
98972	Qualified nonphysician health care professional online digital assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
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

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