Questions regarding telehealth? Call us at (602) 875-6042

Telehealth Audit Checklist

#	Telehealth Audit Question	Comments/Notes	Reported Evidence	Opportunities for Improvement
1	In what departments/locations is telehealth happening in the organization?	ER, Clinics, Urgent Care, Inpatient, PT, OT, SNF, Assisted Living, Advanced Care Planning, Mental Health		
2	What technology being used?	Inventory all platforms being used: EMR Telehealth platform, Zoom, FaceTime, Skype,		
3	Do you have a telehealth consent form?	Each consent form should include the following elements: -Patient name and date of birth -Date of service -Rendering provider -Elect services as a telehealth encounter -Instructions regarding the proper location for the -patient during the telehealth encounter -Patient vs. provider responsibilities in case of technical difficulties -Payment considerations -Signature or verbal attestation by the patient		
4	Are you authenticating patient identity before service is rendered?	Require patients to provide a picture of their ID when scheduling the telehealth visit online or ask patients to show their ID during the visit and document this in the note.		
5	Is telehealth consent form used for all payors and patients?			
6	Does your state have Telehealth parity?	When a state passes a telemedicine parity law, it means private payers in the state have to reimburse for telemedicine care in the same way they would for in-person care.		

		Know the rules, and effective dates of any waivers. If the provider did not follow the appropriate rule for each date of service, submit a corrected claim.		
7	What payors are being billed?	Medicare, Medicaid, BC/BS, Aetna, etc		
8	Who in the organization is monitoring telehealth rule changes for all payers?			
9	Who is educating providers of telehealth coding and billing rules?	HIM, Revenue Cycle, CMO, CMIO, COO, Others?		
10	If retroactive changes needed (new dx code or place of service) is there a plan to update previous claims?	Note effective dates for codes and changes in the Telehealth During Certain Emergency Periods Act of 2020		
11	Do you have a report based on CPT and G-codes for telehealth billing to determine your audit population?	See attached code lists of CPT, G-codes and modifiers		
12	What charging methodologies being used?	E&M component vs Time Based		
13	How are time-based encounters documented?	Where in EMR? Note, special field, is this consistent?		
14	Are you maintaining complete HCC capture?			
15	What type of service is being provided Telehealth, Virtual Check-In or E-Visit?	During the public health emergency (PHE) all telehealth services can be performed on New or Established Patients including virtual check-in and e-visits which previously were only for established patients.		
16	How are you avoiding denials on place of service?	The POS code for the place of service where the service would have been performed should be used for telehealth services reported to Medicare during the PHE. The appropriate telehealth modifier should be appended to the CPT code. The most common telehealth modifier for commercial payers is -95.		
17	Are you billing for visits that require audio AND visual when provider only uses audio?	This is applicable for only certain telehealth services but not for all. How to be compliant: Document the specific technology platform used for telehealth. If a provider uses audio-only for a payer that has not relaxed its audio-visual requirements during the current PHE, then		

		bill a CPT code from 99441-99443 range for telephone services		
18	Are you using non-HIPAA compliant telehealth platform if or when waivers are no longer in effect?	During the current PHE, Medicare and some commercial payers permit providers to use non-public facing audio or video communication products. However, these are temporary and that continued use of these platforms after waivers are lifted could subject providers to HIPAA penalties. How to be compliant: Start looking for a HIPAA-compliant telehealth solution now. In the meantime, make a good faith effort to protect patient privacy by enabling all available encryption and privacy settings, and notify patients of the increased risk of using non-HIPAA compliant technologies		
19	Are you monitoring for Upcoding?	How to be compliant: Ensure detailed documentation, especially in the absence of a physical exam. How did the provider spend their time with the patient? What did they discuss and why? What is the patient's level of risk? What data did the provider consider? What tests, if any, did they order?		
20	Are you billing when no services are rendered?	This can occur unintentionally. If an appointment is scheduled, the MA opens record and pre-populates with relevant information. Then the patient forgets to attend the appointment, the claim can generate even though no encounter occurred. How to be compliant: Perform end-of-day charge reconciliation for telehealth visits. Ensure charges include supporting provider note and signature		

MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET (CORRECTED)
March 17, 2020

Medicare coverage and payment of virtual services

Introduction (Summarized):
CMS has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility. These policy changes are granted under the emergency declaration. CMS is expanding this on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

EXPANSION OF TELEHEALTH WITH 1135 WAIVER: Under this new waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's residence starting March 6, 2020. A range of providers, such a doctor, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Additionally, the HHS OIG is providing flexibility for healthcare providers to reduce or waive cost-shring for telehealth visits paid for by federal healthcare programs.

Prior to this waiver Medicare could only pay for telehealth on a limited basis: when the person receiving the service is in a designated rural area and when they leave their home and go to a clinic, hospital, or certain other types of medical facilities for the service.

Even before the availability of this waiver authority, CMS made several related changes to improve access to virtual care. In 2019, Medicare started making payment for brief communications or **Virtual Check-Ins**, which are short patient-initiated communications with a healthcare practitioner. Medicare Part B separately pays clinicians for **E-visits**, which are non-face-to-face patient-initiated communications through an online patient portal.

Medicare beneficiaries will be able to receive a specific set of services through telehealth including evaluation and management visits (common office visits), mental health counseling and preventive health screenings. This will help ensure Medicare beneficiaries, who are at a higher risk for COVID-19, are able to visit with their doctor from their home, without having to go to a doctor's office or hospital which puts themselves and others at risk.

TYPES OF VIRTUAL SERVICES:

There are three main types of virtual services physicians and other professionals can provide to Medicare beneficiaries summarized in this fact sheet: Medicare telehealth visits, virtual check-ins and e-visits.

1. **MEDICARE TELEHEALTH VISITS:** Currently, Medicare patients may use telecommunication technology for office, hospital visits and other services that generally occur in-person
    a. The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home. Distant site practitioners who can furnish and get payment for covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals.
    b. It is imperative during this public health emergency that patients avoid travel, when

possible, to physicians' offices, clinics, hospitals, or other health care facilities where they could risk their own or others' exposure to further illness. Accordingly, the Department of Health and Human Services (HHS) is announcing a policy of enforcement discretion for Medicare telehealth services furnished pursuant to the waiver under section 1135(b)(8) of the Act. To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

KEY TAKEAWAYS:

- *Effective for services starting March 6,* 2020 *and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances*
- *These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.*
- *Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.*
- *While they must generally travel to or be located in certain types of originating sites such as a physician's office, skilled nursing facility, or hospital for the visit, effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.*
- *The Medicare coinsurance and deductible would generally apply to these services. However, the HHS OIG is providing flexibility for providers to reduce or waive cost-sharing for telehealth visits paid for by federal healthcare programs.*
- *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.*

2. **VIRTUAL CHECK-INS:** In all areas (not just rural), established Medicare patients in their home may have a brief communication service with practitioners via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image. We expect that these virtual services will be initiated by the patient; however, practitioners may need to educate beneficiaries on the availability of the service prior to patient initiation
    a. Medicare pays for these "virtual check-ins" (or Brief communication technology-based service) for patients to communicate with their doctors and avoid unnecessary trips to the doctor's office. These virtual check-ins were previously for patients with an established (or existing) relationship with a physician. This requirement has been waived during the PHE allowing providers to use these services for new or established patients. The virtual check-in cannot be related to a medical visit within the previous 7 days and cannot lead to a medical visit within the next 24 hours (or soonest appointment available). The patient must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible would generally apply to these services.
    b. Doctors and certain certain practitioners may bill for these virtual check in services furnished through several communication technology modalities, such as telephone (HCPCS code G2012). The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal. Standard

Part B cost sharing applies to both. In addition, separate from these virtual check-in services, captured video or images can be sent to a physician (HCPCS code G2010).

KEY TAKEAWAYS:

- *This is not limited to only rural settings or certain locations.*
- *Individual services need to be agreed to by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient agreement*
- *HCPCS code 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, 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.*
- *HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by a 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*
- *Virtual check-ins can be conducted with a broader range of communication methods, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication.*

3. **E-VISITS:** In all types of locations including the patient's home, and in all areas (not just rural), Medicare patients may have non-face-to-face patient-initiated communications with their doctors without going to the doctor's office by using online patient portals. For these **E-Visits**, the patient must generate the initial inquiry and communications can occur over a 7-day period. The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. The patient must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible would apply to these services.
    a. Medicare Part B also pays for E-visits or patient-initiated online evaluation and management conducted via a patient portal. Practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) can bill the following codes:
        i. 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
        ii. 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
        iii. 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.
    b. Clinicians who may not not independently bill for evaluation and management visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these e-visits and bill the following codes:
        i. G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes
        ii. G2062: Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes
        iii. G2063: Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative

time during the 7 days; 21 or more minutes.

KEY TAKEAWAYS:

- *This is not limited to only rural settings. There are no geographic or location restrictions for these visits*
- *Patients communicate with their doctors without going to the doctor's office by using online patient portals.*
- *Individual services need to be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation.*
- *The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G206, as applicable*
- *The Medicare coinsurance and deductible would generally apply to these services.*

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA): Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as Face Time or Skype, during the COVID-19 nationwide public health emergency. For more information: : https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

Summary of Medicare Telemedicine Services

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063

CMS Updates: April 30, 2020

FURTHER EXPANSION TELEHEALTH IN MEDICARE:

CMS directed a historic expansion of telehealth services so that doctors and other providers can deliver a wider range of care to Medicare beneficiaries in their homes. Beneficiaries thus don't have to travel to a healthcare facility and risk exposure to COVID-19.

*For the duration of the COVID-19 emergency, CMS is waiving limitations on the types of clinical practitioners that can furnish Medicare telehealth services. Prior to this change, only doctors, nurse practitioners, physician assistants, and certain others could deliver telehealth services. Now, other practitioners are able to provide telehealth services, including physical therapists, occupational therapists, and speech language pathologists.

- Hospitals may bill for services furnished remotely by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is at home when the home is serving as a temporary provider-based department of the hospital. Examples of such services include counseling and educational service as well as therapy services. This change expands the types of healthcare providers that can provide using telehealth technology.

- Hospitals may bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home.

- CMS previously announced that Medicare would pay for certain services conducted by audio-only telephone between beneficiaries and their doctors and other clinicians. Now, CMS is broadening that list to include many behavioral health and patient education services. CMS is also increasing payments for these telephone visits to match payments for similar office and outpatient visits. This would increase payments for these services from a range of about $14-$41 to about $46-$110. The payments are retroactive to March 1, 2020.

- Until now, CMS only added new services to the list of Medicare services that may be furnished via telehealth using its rulemaking process. CMS is changing its process during the emergency, and will add new telehealth services on a sub-regulatory basis, considering requests by practitioners now learning to use telehealth as broadly as possible. This will speed up the process of adding services.

- As mandated by the CARES Act, CMS is paying for the Medicare telehealth services provided by rural health clinics and federal qualified health clinics. Previously, these clinics could not be paid to provide telehealth expertise as "distant sites". Now, Medicare beneficiaries located in rural and other medically underserved areas will have more options to access care from their home without having to travel.

- Since some Medicare beneficiaries don't have access to interactive audio-video technology that is required for Medicare telehealth services, or choose not to use it even if offered by their practitioner, CMS is waiving the video requirement for certain telephone evaluation and management services, and adding them to the list of Medicare telehealth services. As a result, Medicare beneficiaries will be able to use an audio-only telephone to get these services.

Procedure Coding for Telemedicine Visits

Non-Face-to-Face Codes Delivered by Telemedicine

Telephone Consultation

99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to a 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
99442	11-20 minutes of medical discussion
99443	21-30 minutes of medical discussion

Virtual Check-in

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 a 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
G2010	Remote evaluation of recorded video and/or images submitted by a 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

Online Digital Evaluation and Management

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	11-20 minutes
99423	21 or more minutes

Inpatient Services

G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
G0426	Typically 50 minutes communicating with the patient via telehealth
G0427	Typically 50 minutes communicating with the patient via telehealth
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
G0407	Physicians typically spend 25 minutes communicating with the patient via telehealth
G0408	Physicians typically spend 35 minutes communicating with the patient via telehealth
G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth

Interprofessional Telephone / Internet / Electronic Health Record Consultations

99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional, 5-10 minutes of medical consultative discussion and review
99447	11-20 minutes of medical consultative discussion and review
99448	21-30 minutes of medical consultative discussion and review
99449	31 minutes or more of medical consultative discussion and review
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
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes

Face-to-Face Codes Delivered via Telemedicine

Office Outpatient Services: New Patient

99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to- face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

Office Outpatient Services: Established Patient

99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

Inpatient Services: Subsequent Hospital Care

99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

Modifiers for Consideration

GQ	Asynchronous telehealth service.
95	Synchronous telemedicine service rendered via real-time interactive audio and video telecommunication system
GT	Critical Access Hospital (CAH) distant site provider billing under CAH Optional Method II. This goes on an institutional claim and pays 80% of the professional fee schedule rate
G0	(zero) Used to identify telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke
GY	Notice of Liability Not Issued, Not Required Under Payer Policy. Used to report that an Advanced Beneficiary Notice (ABN) was not issued because item or service is statutorily excluded or does not meet definition of any Medicare benefit