How to get paid for virtual first care (V1C)

IMPACT
Virtual First Care V1C Initiative

While establishing a contract is the critical first step to getting reimbursed for virtual care, healthcare providers must ensure they're in compliance with both **coding standards** and **contractual obligations** in order for their claims to be **processed** and **paid**.

This guide describes 5 essential ways for checking your claims to ensure:

- Correct reimbursement
- Compliance with payor-specific guidelines.

Use this guide as a quick, efficient, and reliable resource to ensure your V1C claims are primed for reimbursement. Access easy-to-follow explanations on what each step to reimbursement entails, detailed actions for checking your claims, and scenarios to demonstrate the process.

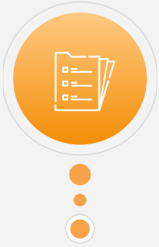
By mastering these tasks, you can ensure accurate billing, proper reimbursement, and compliance with payor guidelines. Explore our Coding Library for more guidance on the procedure codes, modifiers, and place of service codes that are approved for virtual care services.

Looking for additional information regarding the terms and concepts mentioned in this guide? Check out our Supplemental Guide: Billing & Coding Basics for an overview of common coding elements, including procedure codes, modifiers, and place of service codes and the unique considerations for virtual-first care.

Double-check claims to ensure all data elements are populated, including member demographics (i.e., Member ID)

Ensure the appropriate modifiers or place of service code is used based on procedure codes or coverage agreements

Check new patient vs. established patient billing restrictions



Confirm CPT and ICD-10 code combinations are reimbursable and not subject to payer-specific billing edits

Confirm QHP billing and incident-to rules where applicable

Double-check claims to ensure all data elements are populated, including member demographics (i.e., member ID)

What does this mean?

- Review each field on the claim to ensure all data elements are populated and accurately reflect the services provided.
- Pay special attention to member demographics, including the Member ID, to avoid processing errors that delay payment.

How do I check?

1. Verify that all required fields, such as patient name, date of birth, and insurance information, are complete and correct.
2. Cross-reference the Member ID with the patient's insurance records to ensure accuracy.
3. Review any diagnosis or procedure-specific codes to ensure they reflect the services rendered and include all required elements as outlined in coding guidelines or payor contracts (i.e., a modifier).

How it works in the real world

Emily woke up with a persistent sore throat, congestion, and fever. Unable to obtain a last-minute appointment at her regular physician's office, she downloaded a new primary care app she'd read about in the news and scheduled a virtual appointment from her phone. In a quick 15-minute video visit, a primary care physician (PCP) thoroughly assessed her symptoms and prescribed appropriate medication for her to pick up at her nearest pharmacy.

The claim submitted for Emily's visit must include the correct demographic and member information as well as the codes that most accurately describe her condition and services rendered. Since the visit was conducted virtually, additional modifiers or place of service codes are required as well.

Insured's I.D. number: ABC123456789
Patient's name: Doe, Emily
Patient's birth date: 11/13/1983
Sex: F
Insured's name: Doe, Emily
Patient relationship to insured: Self
Date of service: 10/15/2023
Diagnosis: J06.9 (Acute upper respiratory infection)
Procedure: 99202 (Office or other outpatient visit for the evaluation and management of a new patient, 15-29 minutes)
Modifier: 95
Place of service: 02

Note: These are only a few of the elements included in a healthcare claim. It is critical that all elements on the claim form are verified to ensure claims are paid correctly.

Ensure the appropriate modifiers and place of service codes are used based on procedure codes and coverage agreements

What does this mean?

- The modifiers for virtual care are 93, 95, GQ, and GT. The appropriate code depends on whether the care was delivered synchronously via audio-only, included a video component, or was rendered asynchronously.
- The place of service codes for virtual care are 02 and 10. The appropriate code depends on whether the virtual appointment was rendered while the patient was in their home or at another location.
- Acceptable modifiers and place of service codes may vary depending on the specific payor and coverage agreements outlined in the contract.

How do I check?

1. Review the procedure codes listed on each claim and determine if any modifiers are required based on coding requirements for the specific service provided or any contractual agreements with payors.
2. Confirm that the place of service code accurately reflects the location where the digital care service was rendered and is accepted by the specific payor.

How it works in the real world

Let's revisit Emily. Since her appointment was conducted virtually, additional modifiers are required for processing by her insurance company. Additionally, her insurer requires a place of service of 02 to indicate virtual care.

The claim for Emily's visit should include the following:

- **Procedure:** 99202 (Office or other outpatient visit for the evaluation and management of a new patient, 15-29 minutes)
- **Modifier:** 95
- **Place of service:** 02

Check new patient vs. established patient billing restrictions

What does this mean?

- Some payors restrict how frequently a patient can be billed as a "new" patient. Procedure codes may seem to describe the same service but vary slightly by specifying whether the patient was new or established at the time of service.

How do I check?

1. Determine whether the patient is considered new or established based on each payor's guidelines.
2. Use the procedure code that accurately describes both the service rendered *and* the patient's status.

How it works in the real world

Joey has been experiencing difficulty sleeping due to sleep apnea. His PCP refers him to Dreem's digital sleep clinic for an assessment and potential treatment. As a new patient, Joey receives an online questionnaire and is scheduled for an initial virtual consultation with a Dreem clinician. The sleep specialist prescribes an at-home sleep test, and Joey receives the equipment he needs to complete the test from the comfort of his home.

Joey's insurance plan has the following guidelines for defining a new patient vs. an established patient:

- A *new* patient has not received services in the last three years.
- An *established* patient has received services within the last three years.

Based on these guidelines, Joey is considered a *new* patient, which requires a specific procedure code.

The claim for Joey's visit should bill procedure code **99203** to indicate an office or other outpatient visit to evaluate and manage a *new* patient lasting 15-29 minutes.

Read this full case study.

Confirm CPT and ICD-10 code combinations are reimbursable and not subject to payor-specific billing edits

What does this mean?

- CPT codes describe the specific healthcare service or procedure performed, while the ICD-10 code explains the reason for the visit or the patient's medical condition.
- To ensure proper reimbursement, it's crucial for healthcare providers to confirm that the CPT and ICD-10 code combinations used in the claims are reimbursable and comply with payor-specific billing edits.

How do I check?

1. Verify that each CPT code is appropriately linked to the correct corresponding ICD-10 code.
2. Review payor-specific billing edits and medical necessity requirements to ensure the combination is eligible for reimbursement.

How it works in the real world

At Mark's annual physical, his PCP diagnoses him with diabetes and high cholesterol. Mark decides to enroll in Omada's cardiometabolic program, which offers personalized support and guidance for individuals with diabetes and cardiovascular disease risk factors. He logs into the Omada app, which tracks his meals, exercise, and weight and connects him with a personal health coach to set achievable goals and provide accountability.

Mark's claim would need to include the following:

Procedure Code: 98970 (Qualified nonphysician health care professional online digital evaluation and management service)

ICD-10 Codes:

- **E11.9** (Type 2 diabetes mellitus without complications) - Explains the reason for Mark's participation in Omada's cardiometabolic program related to his diabetes.

Procedure Code **98970** represents the specific healthcare service the personal health coach provides in the Omada cardiometabolic program. ICD-10 code **E11.9** provides information about Mark's medical conditions to explain the reasons for his participation in a program designed to support him in managing his diabetes effectively.

Prior to launch, Omada reviews billing edits with each payor to ensure their claims system can accept and process these CPT code and ICD-10 code combinations.

Read this full case study.

Confirm Qualified Healthcare Professional (QHP) billing and incident-to rules

What does this mean?

- Incident-to-billing allows non-physician practitioners (e.g., nurse practitioners, physician assistants) to provide services under the direct supervision of a QHP, usually a physician. The non-physician practitioner provides services on behalf of the QHP, and the QHP must initiate the treatment plan.
- QHP billing rules ensure that the services provided by healthcare professionals meet specific qualifications and high standards set by the government or insurance companies. QHPs must comply with these rules to receive reimbursement for their services.
- Incident-to and QHP billing rules work together to allow non-physician practitioners to collaborate with QHPs to provide high-quality patient care.

How do I check?

1. Some insurers only allow incident-to billing if it's required by State Medicaid or federal regulations. It is critical to first confirm if the patient's insurance plan allows incident-to-billing.
2. If allowed, verify that the procedure code is eligible for incident-to billing and that the service was provided by a non-physician practitioner (e.g., nurse) under the direct supervision of the QHP who initiated the treatment plan
3. Direct supervision for virtual care is met if the supervising physician is immediately available to engage via interactive audio-video. Audio-only technology is *not* sufficient to fulfill direct supervision requirements.

How it works in the real world

Mary is enrolled in a program to manage her Type 2 Diabetes. In addition to health coaching and educational resources, the program uses digital tools to track and monitor physiological data, including her glucose levels, remotely. Her care team includes a nurse, Sarah, who is designated to monitor her health data under the general supervision of the program's physician. Sarah actively reviews Mary's health data, makes necessary adjustments to her care plan, and conducts virtual sessions to communicate updates on Mary's progress or answer questions and connect with the physician if needed.

Mary's health plan allows incident-to-billing for remote patient monitoring codes. Since the nurse was designated to work under the supervision of the program's physician, her time may be billed incident-to.

The program may bill procedure code **99457** (remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month: first 20 minutes) to be reimbursed for Sarah's time spent with Mary.