Billing & coding for virtual first care (V1C)

Virtual First Care Coalition by DIGITAL MEDICINE SOCIETY

Understanding billing and coding is critical to **get paid** for providing V1C services.

As a complement to our **Quickstart Guide**, harness the power of this **Supplemental Guide** to enrich and elevate your knowledge and expertise in the basics of billing and coding.

Recognize the importance of coding

Accurate coding ensures that healthcare providers are appropriately reimbursed for rendered services as evaluated annually by the CPT panel, helping providers maintain cash flow and continue delivering quality care. Furthermore, standardized coding practices allow for more efficient processing of insurance claims, reducing delays and costly administrative errors. Comprehensive coding guidelines are critical to ensuring that providers adhere to legal and regulatory requirements, prevent fraud and promote transparency. Ultimately, effective healthcare coding practices are essential for the effective functioning of the healthcare system, ensuring fair compensation, data accuracy, and overall financial integrity.

How does coding differ for digital health?

Coding for digital health involves selecting the appropriate codes or modifiers that most accurately represent the virtual delivery of services.

A range of technologies, from telemedicine and digital therapeutics to remote patient monitoring and mobile health applications

Various modes of synchronous and asynchronous delivery across apps, video and messaging platforms, devices, etc.

A team-based approach to care delivery incorporating various types of healthcare professionals beyond just physicians

Various reimbursement models, as some services might be covered under telehealth policies or require separate billing codes

Time stipulations that require minutes of interaction with providers versus patient engagement with asynchronous care components

Additionally, compliance with privacy and security regulations, such as HIPAA (Health Insurance Portability and Accountability Act), is crucial when handling electronic health records and transmitting sensitive patient information. As technology advances and the adoption of digital health services continues to grow, medical billing and coding professionals must stay updated with evolving guidelines and regulations, including the CARES Act, CMS reimbursement guidelines, and AMA updates, to code and bill for these digital healthcare services accurately.

Cracking the V1C Codes

Healthcare claims provide a codified view of the patient journey. Each field is critical to ensuring proper reimbursement and yielding valuable healthcare reporting to drive quality standards, reimbursement decisions, and outcomes research. There are many data elements included on a professional claim, but three of the most important for digital health include procedure codes, modifiers, and place of service codes.

Procedure codes

Procedure codes represent specific medical procedures and services provided to patients. These codes help in identifying and categorizing healthcare procedures for various purposes, including billing, reimbursement, and statistical analysis.

In the United States, there are three standard sets of codes that are used in healthcare billing: Current Procedural Terminology (CPT), which falls under the HCPCS (Healthcare Common Procedure Coding System) umbrella, and International Classification of Diseases (ICD-10) diagnosis codes.

HCPCS

HCPCS codes are a set of alphanumeric codes used to identify specific healthcare procedures, services, supplies, and equipment. The HCPCS system consists of two levels of codes: Level I, which includes the Current Procedural Terminology (CPT) codes developed by the American Medical Association (AMA), and Level II, which comprises a broader range of codes for items such as durable medical equipment, drugs (e.g., chemotherapy drugs under J-codes), and supplies.

CPT

CPT stands for Current Procedural Terminology, and this code set was created by the American Medical Association (AMA) to describe the tests, evaluations, services, or procedures performed by healthcare providers. These codes indicate to a payer what specifically a provider is asking to be reimbursed for. They work with other data elements on a healthcare claim to tell the full story of the patient's journey to ensure appropriate payment to the provider.

There are 3 categories of CPT codes:

Category I: Five-digit numeric codes ranging from 00100-99499 that correspond to a procedure or service performed by a provider in either an inpatient or outpatient setting. These codes are divided into six main categories: Evaluation & Management, Anesthesiology, Surgery, Radiology, Pathology & Laboratory, and Medicine.

Category II: Five-digit supplemental alphanumeric codes used for performance measurement. These optional codes are not required for compliant coding practices but provide additional information about the procedures performed.

Category II codes are intended to collect data that supports nationally established performance measures. For example, they are often reported to payers regarding HEDIS measures, reducing the need for burdensome administrative processes such as record abstraction or chart review.

Category III: Temporary alphanumeric codes for new and developing technology, procedures, and services. These codes were created for data collection, assessment, and payment of new services or procedures that aren't Category I codes yet.

The use of these codes allows physicians and other qualified healthcare professionals, insurers, researchers, and policy experts to identify emerging technology, services, and procedures for clinical efficacy, utilization, and outcomes. These codes also provide an avenue for reimbursement for commercial payers.

Category III codes are only valid for 5 years unless renewed.

ICD-10

International Classification of Diseases (ICD) Codes: ICD codes are used to classify and code diagnoses and diseases. These codes provide a standardized language for healthcare providers to document and report patient conditions. They are used internationally to help track disease patterns, manage public health, and provide valuable data for research and analysis. In the United States, they are tied to the procedure codes on a claim to determine accurate coding and correct reimbursement.

Modifiers

Code modifiers are two-digit codes that are billed in conjunction with a procedure code to provide more specific information beyond the code description. For example, a modifier may be used to indicate that a procedure was performed bilaterally (or on both sides) or that a patient's wellness visit was conducted via audio and video. Modifiers are a critical component for virtual care delivery as they are often used to indicate that healthcare services with an existing procedure code were performed digitally rather than creating an entirely new code to describe the service.

Common modifiers for digital health services:

- **93:** Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system
- **95:** Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system
- **GQ:** Via asynchronous telecommunications system
- **GT:** Via interactive audio and video telecommunication systems

Place of service

Place of Service (POS) codes indicate the specific location where a healthcare service was provided. These codes play a significant role in determining the appropriate reimbursement and are used by insurance companies to assess the setting in which the service was rendered. The POS codes categorize various healthcare settings, such as hospitals, clinics, physician offices, ambulatory surgical centers, nursing facilities, and more. Each POS code represents a distinct location or facility type, allowing insurance providers to determine the appropriate payment rates and policies for different settings.

Accurate reporting of POS codes is essential for proper reimbursement, as insurance companies may have specific requirements and payment structures based on the place of service. Therefore, including the correct POS codes on a healthcare claim ensures transparency, facilitates accurate reimbursement and helps to maintain compliance with insurance guidelines.

Two POS codes for digital health:

- **02:** Telehealth Provided Other than in Patient's Home — The location where health services and health-related services are provided or received through telecommunication technology. Patients are not located in their homes when receiving health services or health-related services through telecommunication technology.
- **10:** Telehealth Provided in Patient's Home — The location where health services and health-related services are provided or received through telecommunication technology. The patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health-related services through telecommunication technology.