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Prepared for:
Southwest Telehealth Resource Center

Virtual Visit & Reimbursement Guide Colorado

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TELEHEALTH

Definition: There are three types of telehealth services:

- **Asynchronous Telehealth (Store & Forward)** is the transfer of digital images, sounds, or previously recorded video from one location to another to allow a consulting practitioner (usually a specialist) to obtain information, analyze it, and report back to the referring practitioner. This is a non-interactive telecommunication because the physician or health care practitioner views the medical information without the patient being present.
- **Synchronous Telehealth** is real-time interactive video teleconferencing that involves communication between the patient and a distant practitioner who is performing the medical service. The practitioner sees the patient throughout the communication, so that two-way communication (sight and sound) can take place.
- **Remote Patient Monitoring** is use of digital technologies to collect health data from individuals in one location and electronically transmit that information to providers in a different location for assessment.

For the purposes of this document, the guidelines below are specific to synchronous telehealth with the originating site being the patient's home, as that will be the most applicable during the COVID-19 pandemic.

CPT/HCPCS Codes:

Telehealth eligible CPT/HCPCs codes vary by payor (refer to payor guidelines section).

Place of Service Codes

POS 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. Patient is not located in their home when receiving health services or health related services through telecommunication technology.

POS 10: Telehealth Provider in Patient's Home-Effective January 1st, 2022

- The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care

*Note-Renamed on January 1st, 2022, previously was only called "Telehealth

During the COVID-19 PHE, many payors are allowing the POS that would have been used if the visit was performed in person to allow for a site of service payment differential

Reporting Criteria:

- Report the appropriate E/M code for the professional service provided.
- Communication must be performed via live two-way interaction with both video and audio.
    - During the COVID-19 pandemic, some payors have waived the video requirement.
- All payors had previously required that communications be performed over a HIPAA compliant platform. However, during the COVID-19 pandemic, several payors, including Medicare, have waived this requirement.
    - Refer to the HIPAA Compliant section for more details.

Documentation Requirements: Telehealth services have the same documentation requirements as a face-to-face encounter. The information of the visit, history, review of systems, consultative notes, or any information used to make a medical decision about the patient should be documented. In addition, the documentation should note that the service was provided through telehealth, both the location of the patient and the provider, and the names and roles of any other persons participating in the telehealth visit. Obtain verbal consent at the start of the visit and ensure consent is documented. Maintain a permanent record of the telehealth visit in the patient's medical record.

Definition: Online Digital Evaluation and Management Services (E-Visits) are an E/M service provided by a Qualified Healthcare Professional or an assessment provided by a Qualified Nonphysician Healthcare Professional to a patient using an audio and visual software-based communication, such as a patient portal.

CPT/HCPCS Codes:
Reportable by a Qualified Healthcare Professionals:

- **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.

Reportable by Qualified Nonphysician Healthcare Professionals (Physical Therapists, Occupational Therapists, Speech Language Pathologists, Clinical Psychologists Registered Dietitian, etc.):

- **G2061/98970**: Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes.
- **G2062/98971**: Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes.
- **G2063/98972**: Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.

Reporting Criteria:

- Online visits must be initiated by the patient. However, practitioners can educate beneficiaries on the availability of e-visits prior to patient initiation.
- The patient must be established. However, during the COVID-19 pandemic Medicare and some other payors have waived this requirement.
- E-Visit codes can only be reported once in a 7-day period.
- Cannot report when service originates from a related E/M service performed/reported within the previous 7 days, or for a related problem within a postoperative period.
- E-Visits are reimbursed based on time.
    - The 7-day period begins when the physician personally reviews the patient's inquiry.
    - Time counted is spent in evaluation, professional decision making, assessment and subsequent management.
    - Time is accumulated over the 7 days and includes time spent by the original physician and any other physicians or other qualified health professionals in the same group practice who may contribute to the cumulative service time.
    - Does not include time spent on non-evaluative electronic communications (scheduling, referral notifications, test result notifications, etc.). Clinical staff time is also not included.

Documentation Requirements: These are time-based codes, and documentation must support what the physician did and for how long. Time is documented and calculated over the 7-day duration and must meet the CPTs time requirement. Obtain verbal consent at the start of the visit and ensure the consent is documented. Maintain a permanent record of the telehealth visit in the patient's medical record.

Definition: A brief check in between a practitioner and a patient via telephone or other audiovisual device to decide whether an office visit or other service is needed. A remote evaluation is recorded video and/or images submitted by an established patient.

CPT/HCPCS Codes:

- **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.
- **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.
- **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
- **G0071:** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only.

Reporting Criteria:

- The patient must be established. However, during the COVID-19 pandemic Medicare and some other payors have waived this requirement.
- Communication must be a direct interaction between the patient and the practitioner. Not billable if performed by clinical staff.
- If the virtual check-in originates from a related E/M provided within the previous 7 days, then the service is considered bundled into that previous E/M and would not be separately billable.
- If the virtual check-in leads to an E/M within the next 24 hours or soonest available appointment, then the service is considered bundled into the pre-visit time of the associated E/M and would not be separately billable.

Documentation Requirements:

Documentation should include medical decisions made, names and roles of any persons participating in the evaluation, and the communication method (telephone, video/audio software, etc.). Obtain verbal consent at the start of the visit and ensure the consent is documented. Maintain a permanent record of the telehealth visit in the patient's medical record.

Definition: A telephone visit is an evaluation and management service provided by a qualified healthcare professional or an assessment and management service provided by a qualified nonphysician health care professional via audio telecommunication.

CPT/HCPCS Codes:
Reportable by Qualified Healthcare Professionals:

- **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.
- **99442**: 11-20 minutes of medical discussion.
- **99443**: 21-30 minutes of medical discussion.

Reportable by Qualified Nonphysician Healthcare Professionals (Physical Therapists, Occupational Therapists, Speech Language Pathologists, Clinical Psychologists Registered Dietitian, etc.):

- **98966:** Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- **98967:** 11-20 minutes of medical discussion.
- **98969:** 21-30 minutes of medical discussion.

Reporting Criteria:

- Call must be initiated by the patient.
- The patient must be established. However, during the COVID-19 pandemic Medicare and some other payors have waived this requirement.
- Communication must be a direct interaction between the patient and the healthcare professional.
- If the call originates from a related E/M or assessment provided within the previous 7 days, then the service is considered bundled into that previous E/M or assessment and would not be separately billable.
- If the call leads to an E/M or assessment within the next 24 hours or soonest available appointment, then the service is considered bundled into the pre-visit time of the associated E/M or assessment and would not be separately billable.

Documentation Requirements:

Documentation should include medical decisions made, the names and roles of any persons participating in the call, and the length of call. Obtain verbal consent at the start of the visit and ensure the consent is documented. Maintain a permanent record of the telehealth visit in the patient's medical record

PAYOR MATRIX

PAYOR	E-VISIT	TELEHEALTH	VIRTUAL CHECK-IN	TELEPHONE
AETNA	ALLOWABLE 99421-99423 98970 -98972 G2061-G2063	ALLOWABLE **Allowable Codes:** Telehealth Eligible Code **Professional:** Modifier GT, 95, FR, 93 or FQ w/ POS 02. **Facility**: Modifier GT, 95, FR, 93 or FQ	ALLOWABLE G2010 G2012	ALLOWABLE 99441-99443 98966-98968
ANTHEM BCBS	CONDITIONAL Check contracted fee schedule to see if allowable	ALLOWABLE **Allowable Codes:** Telehealth Eligible Code **Professional**: POS 02 or 10 & Modifier 95, GT, 93, FQ **Facility:** Modifier GT, 95, 93, FQ	CONDITIONAL Check contracted fee schedule to see if allowable	CONDITIONAL Check contracted fee schedule to see if allowable
CIGNA	NOT ALLOWABLE	ALLOWABLE **Allowable Codes:** Telehealth Eligible Code **Professional:** Modifier 95, GT, 93 FQ & POS 02 **Facility**: Modifier 95, GT, 93, FQ	ALLOWABLE G2012	ALLOWABLE 99441-99443
MEDICA* *Excludes MHCP Members	ALLOWABLE 99421-99423 98970 -98972 G2061-G2063	ALLOWABLE **Allowable Codes:** Telehealth Eligible Code **Professional:** POS 02 or 10 w/ modifier 95, GT, FQ or 93 **Facility**: Modifier GT, 95, 93, or FQ	ALLOWABLE G2010 G2012	ALLOWABLE 99441-99443 98966-98968
MEDICARE	ALLOWABLE 99421-99423 G2061-G2063 **RHC**: G0071	ALLOWABLE **Allowable Codes:** Telehealth Eligible Code **Professional**: Modifier 95 w/ POS used for in-person visit. **Facility:** PN or PO modifier w/ DR condition code. **Method II**: Modifier GT. **RHC**: G2025. **Facility PT/OT/ST**: Modifier 95	ALLOWABLE G2010 G2012 G2250-G2252 **RHC**: G0071	ALLOWABLE 99441-99443 98966-98968 Modifier 95 **RHC**: G2025
MEDICAID	NOT ALLOWABLE	ALLOWABLE **Allowable Codes:** Telehealth Eligible Code **Professional**: POS 02 or 10 w/ FQ or FR modifier. **Facility:** Modifier GT	NOT ALLOWABLE	ALLOWABLE 99441-99443 98966-98968 **Modifier**: FQ
UHC COMMERICAL	ALLOWABLE 99421-99423 98970 -98972	ALLOWABLE **Allowable Codes:** Telehealth Eligible Code **Professional:** 02 or 10 **Facility:** Modifier 95 or GT	ALLOWABLE G2010 G2012 G2250-G2252	ALLOWABLE 99441-99443

Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 99421-99423, 98970-98972, G2061-G2063
- **Telephone**: 99441-99443, 98966-98968
- **Virtual Check-Ins**: G2010, G2012, G2250-G2252

Remote Patient Monitoring:

Allowable Codes: 99453, 99454, 99457, 99458

Telehealth:

Allowable Services: See table below

Modifiers/POS:

- **Commercial**:
  - **1500:** POS 02 with modifier GT, 95, or FR
    - If audio only allowable code, POS 02 with modifier FQ or 93
  - **UB**: Modifier GT, 95, or FR
    - If audio only allowable code, modifier FQ or 93

Not Reimbursable:

- Synchronous telemedicine codes rendered via an audio only connection.
- Asynchronous Telemedicine Services (services reported w/ GQ modifier).
- Services that do not include direct patient contact, such as physician standby services.

Patient Location: Patient can be located at any location, including their home

Transmission & Originating Site Fees: T1014 and Q3014 are not eligible for payment, Aetna considers these services as incidental to the charges associated with the E/M.

Video Component: The telehealth video component is required, except on codes indicated below that can be provided over audio only.

AETNA ELIGIBLE TELEHEALTH CODES													
Telehealth Allowable Codes													
90791	90845	90960	92227	96161	99203	99243	99309	99408	G0396	G0442	G2086	90840	G0439
90792	90846	90961	93228	97802	99204	99244	99310	99409	G0397	G0443	G2087	90958	G0513
90832	90847	90963	93229	97803	99205	99245	99354	99495	G0406	G0444	G2088	90970	99453
90833	90853	90964	93268	97804	99211	99231	99355	99496	G0407	G0446	90955	96160	99454
90834	90863	90965	93270	G0270	99212	99232	99356	99497	G0408	G0447	99252	99202	99457
90836	90951	90966	93271	98960	99213	99233	99357	99498	G0425	G0459	99253	99242	99458
90837	90952	90967	93272	98961	99214	99251	99406	97085	G0426	G0506	99254	99308	99418
90838	90954	90968	96040	98962	99215	99255	99407	G0108	G0427	G0508	G0445	G0437	G0316
90839	90957	90969	96116	99201	99241	99307	G0436	G0109	G0438	G0509	G0514	G0296	G0317
G0318	G3002	G3003	96105	97750	C7900	C7901	C7902						

Temporary Commercial Codes Effective Until Further Notice													
G0410	92002	96170	97164	99217	99235	99307	99344	99476	G0408	G2010	90839	96121	96161
G2061	92012	96171	97165	99218	99236	99308	99345	99477	G0425	G2012	90840	96127	96164
G2062	92065	97110	97166	99219	99238	99309	99347	99478	G0426	G2086	90845	96130	96165
G2063	92526	97112	97167	99220	99239	99310	99348	99479	G0427	G2087	90846	96131	96167
H0015	92601	97116	97168	99221	99281	99315	99349	99480	G0442	G2088	90847	96132	96168
H0035	92602	97150	97530	99222	99282	99316	99350	99483	G0443	97085	90853	96133	97535
H2012	92603	97151	97542	99223	99283	99327	99421	G0108	G0444	90791	90863	96136	97802
H2036	92604	97153	S9443	99224	99284	99328	99422	G0109	G0445	90792	92507	96137	97803
S9480	92606	97155	97755	99225	99285	99334	99423	G0270	G0446	90832	92508	96138	97804
77427	92609	97156	97760	99226	99291	99335	99468	G0296	G0447	90833	92521	96139	G0270
90953	94664	97157	97761	99231	99292	99336	99469	G0396	G0459	90834	92522	96156	98966
90956	96110	97161	98970	99232	99304	99337	99471	G0397	G0506	90836	92523	96158	98967
90959	96112	97162	98971	99233	99305	99341	99472	G0406	G0513	90837	92524	96159	98968
90962	96113	97163	98972	99234	99306	99343	99475	G0407	G0514	90838	96116	96160	99451
99354	99355	99356	99357	99406	99407	G0436	G0437	99441	99442	99443	99446	99447	99448
99449	99497	99498	99452	H0038	G0422	G0423	G0424	99342	90875	93750	93798	95970	95791
95972	95983	95984	90849	96125	97129	97130	92228	94625	94626	96105	96125	97129	97130
92556	92557	92563	92565	92567	92568	92570	92587	92607	92608	92609	92610	92625	92626
92627	90901	97763											

Codes in Blue Require an Audiovisual Connection
Codes in Green Can be Performed Over a Telephone or Audiovisual Connection
Cells Highlighted in Yellow do **NOT** Require Modifier GT,95, or FR

Payor Specific Key Points

E-Visits/Telephone/Virtual Check-In:

Allowable Codes:

- **E-Visits**: Check fee schedule
- **Telephone**: Check fee schedule
- **Virtual Check-In**: Check fee schedule

Telehealth:

Allowable Services:

Professional: Professional Virtual Visits rendered at the distant site, via live video through a secure and private data connection, and must be submitted with the appropriate CPT/HCPCS code and applicable modifier and POS.

Facility: Facility Virtual Visits rendered at the distant site, via live video through a secure and private data connection, must be submitted with appropriate, CPT/HCPCS, revenue code, and applicable modifier

- **Not Covered:**
  - Non-direct member services other than Remote Patient Monitoring
  - Services that require equipment and/or direct physical hands-on care that cannot be provided remotely
  - Services rendered virtually that are not eligible for reimbursement when rendered in-person
  - Services rendered by facsimile, e-mail, instant messaging, electronic chart, or other electronic communication
  - Services that do not represent real-time interaction between a member located at the originating site and a provider located at a distant site.
  - PT/OT/ST services provided without live audio/visual communication

Modifiers/POS:

- **Professional (1500) Claims**: POS 02 or 10 with modifier 95, GT, FQ, 93
- **Facility (UB) Claims**:
  Rendered At Distant Site: Appropriate revenue code for the service rendered with modifier 95 or GT
  Rendered at Originating Site: POS for provider rendering in-person services to the member and originating site HCPCS

Patient Location: Patient can be located at home or at an allowable originating site facility.

Provider Type: Licensed providers performing services within their scope.

- Providers do not need to notify Anthem of a temporary address for providing health care services. Providers should continue to submit claims with their primary service address, not their temporary address.

Reimbursement: POS 02 and 10 will be eligible for office-based reimbursement.

Transmission & Originating Site Fees: Originating site fee (Q3014) is allowable for originating site facilities. Transmission fees are not allowed

Video Component: Required

Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: Not Allowable
- **Telephone**: 99441-99443
- **Virtual Check-Ins**: G2012

Interprofessional Consultations:

Cigna recognizes E-Consult codes, which occurs when a treating health provider seeks guidance from a specialist physician through electronic means (phone, internet, EHR consultation, etc.)

- **Allowable Codes**: 99446-99452
- **Non-Billable**:
  - If the consultation to a transfer of care or other face-to-face service (e.g., a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes should not be billed.
  - If the consultation lasted less than 5 minutes.
  - If the consultation was for the sole purpose to arrange transfer of care or a face-to-face visit.

Remote Patient Monitoring:

Cigna recognizes remote patient monitoring, which is the use of digital technologies to monitor and capture medical data from patients and electronically transmit this information to healthcare providers for assessment:

- Allowable codes: 99091, 99453, 99454, 99457, 99458, 99473, 99474, S9110
- Deatlied Medical Policy for Conditions Allowed via RPM

Telehealth Medical:

Allowable Services: See below table for allowable medical telehealth codes.
All of the following must also be met:

- Services must be interactive and use both audio and video internet-based technologies, and would be reimbursed if the service was provided face-to-face
- The patient or involved caregiver must be present on the receiving end and the service must occur in real time
- All technology used must be secure and meet or exceed federal and state privacy requirements
- A permanent record of online communications relevant to the ongoing medical care and follow-up is maintained as part of the record as if the service were provided as an in-office visit
- The permanent record must include documentation which identifies the virtual service delivery method. i.e.: audio/video or telephone only
- All services provided are medically appropriate and necessary
- The evaluation and management services (E/M) provided virtually must meet E/M criteria
- The patient's clinical condition is of low to moderate complexity, and while it may be an urgent encounter, it should not be an emergent clinical condition
- Virtual care services must be provided by a health care professional who is licensed, registered, or otherwise acting within the scope of his/her licensure.

Excluded Services:

- The virtual care service occurs on the same day as a face to face visit, when performed by the same provider and for the same condition.
- Transmission of digitalized data is considered integral to the procedure performed and is not separately reimbursable.

- Virtual care services billed within the post-operative period of a previously surgical procedure will be considered part of the global payment for the procedure.
- Services were performed via asynchronous communications systems (e.g., fax).
- Store and forward telecommunication, whether an appropriate virtual care modifier is appended to the procedure code or not.
- Patient communications are incidental to E/M services, counseling, or medical services, including, but not limited to reporting of test results and provision of educational materials.
- Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.
- No reimbursement will be made for any equipment used for virtual care communications.

Telehealth Behavioral Health:

Allowable Services: See below table for allowable medical telehealth codes.
All of the following must also be met:

- Services must be interactive and use audio and/or video internet-based technologies (synchronous communication), and would be reimbursed as if the service was provided face-to- face
- The patient and/or actively involved caregiver must be present on the receiving end
- All technology used must be secure and meet or exceed federal and state privacy requirements.
- A permanent record of online communications relevant to the ongoing care and follow- up is maintained as part of the medical record as if the service were provided as an in-office visit
- The permanent record must include documentation which identifies the virtual service delivery method. I.E.: audio/video or telephone only
- All services provided are medically appropriate and necessary
- The evaluation and management services (E/M) provided virtually must meet E/M criteria
- While some aspects of care in an acute setting may be rendered virtually, exclusively virtual services should be limited to situations when the clinical condition is low to moderate complexity and not the primary intervention for an emergent clinical condition.
- Virtual care services must be provided by a health care professional who is licensed, registered, or otherwise acting within the scope of his/her licensure.

Excluded Services:

- The virtual care service occurs on the same day as a face to face visit, when performed by the same provider and for the same condition.
- Transmission of digitalized data is considered integral to the procedure performed and is not separately reimbursable.
- Patient communications are incidental to E/M services, counseling, or medical services, including, but not limited to reporting of test results and provision of educational materials
- Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.
- No reimbursement will be made for the originating site of service fee or facility fee, unless otherwise mandated by state or federal law
- No reimbursement will be made for any equipment used for virtual care communications.

Modifiers/POS:

- **Professional/1500 Claims:** POS 02 and modifier 95, GT, GQ, 93 or FQ
  - **Do not bill POS 10 until further notice**
- **Facility/UB Claims:** Modifier 95, GT, GQ, 93 or FQ
  - Announced May 11th, 2023: *Virtual care billed by facilities on a UB-04 claim form continues to be reimbursable until further notice, with an expectation that it will move to permanently reimbursable for*

certain services as part of our R31 Virtual Care Reimbursement Policy later this year. Additional information about this update will be communicated soon.

Provider Type: Providers who are licensed, registered, or otherwise acting within the scope of their licensure may provide telehealth services.

Reimbursement: Reimbursement will be at the same rate as in-person face-to-face visits, refer to your Cigna contract for allowable rates.

Video Component: An audiovisual connection is required except for telephone codes.

Transmission & Originating Site Fees: Cigna will not reimburse an originating site of service fee/facility fee for telehealth visits (HCPCS Q3014). Cigna will also not reimburse transmission fees; transmission of digitalized data is considered integral to the procedure performed and is not separately reimbursable.

CIGNA MEDICAL ELIGIBLE VIRTUAL CODES												
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962	90963
90964	90965	90966	90967	90968	90969	90970	92507	92508	92521	92522	92523	92524
92601	92602	92603	92604	96040	96112	96113	96116	96156	96158	96159	96160	96161
96164	96165	96167	96168	97110	97112	97161	97162	97163	97164	97165	97166	97167
97168	97530	97755	97760	97761	97802	97803	97804	92202	92203	99204	99205	99211
99212	99213	99214	99215	99406	99407	99408	99409	99441	99442	99443	99495	99496
99497	99498	G0108	G0151	G0152	G0153	G0155	G0157	G0158	G0270	G0296	G0299	G0300
G0396	G0397	G0438	G0439	G0442	G0443	G0444	G0445	G0446	G0447	G0493	G0513	G0514
G2012	S9123	S9128	S9129	S9131	S9152	99446	99447	99448	99449	99451	99452	99091
99453	99454	99457	99458	99473	99474	99381	99382	99833	99384	99385	99386	99387
99391	99392	99393	99394	99395	99396	99397						

Non-Reimbursable Codes Regardless of Modifier												
98966	98967	98968	98970	98971	98972	99421	99422	99423	G0406	G0407	G0408	G0425
G0426	G0427	G0459	G0508	G0509	G2025	Q3014	S0320	T1014				

CIGNA BEHAVIORHAL HEALTH ELIGIBLE VIRTUAL CODES												
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845	0846
90847	90849	90853	90863	90875	90876	90880	96110	96127	916156	96158	96159	96164
96165	96167	96168	96170	96171	97151	97152	97153	97154	97155	97156	97157	97158
99058	99078	99202	99203	99204	99205	99211	99212	99213	99214	99215	99217	99218
99219	99220	99221	99222	99223	99224	99225	99226	99231	99232	99233	99234	99235
99236	99238	99239	99281	99282	99283	99284	99285	99304	99305	99306	99307	99308
99309	99310	99315	99316	99318	99324	99325	99326	99327	99328	99334	99335	99336
99337	99354	99335	99336	99337	93354	99355	99356	99357	99404	99408	99409	99415
99416	99417	99441	99442	99443	99446	99447	99448	99449	99456	994484	99495	99496
0591T	0592T	G0410	H0015	H0035	H0038	H2011	S0201	S9480				

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 99421-99423, 98970-98972, G2061-G2063
- **Telephone**: 98966-98968, 99441-99443
- **Virtual Check-In**: G2010, G2012

E-Visit Exclusions:

- See below "Telehealth Coverage Limitations"

Telehealth:

Medica's emergency telehealth policy was set to end when the federal PHE ended (May 11th, 2023). However, Medica has not updated its standard telehealth policy yet, and therefore, upon inquiry, a Medica representative stated that the emergency policy will be in effective until further notice.

Allowable Codes: See table below for specific codes.

- **Wellness Visits:** During the COVID-19 PHE Medica will allow preventive visits to be provided via telehealth utilizing CPTs 99381-99387 and 9930799391-99397.
    - Providers may perform all or portions of a preventive visit that can be done appropriately via telehealth.
    - Services that require face-to-face interaction may be provided later, however, providers may only bill one preventive medicine code to cover both portions.

Modifiers/POS:

- **Professional (1500) Claims**: POS 02 or 10 with modifier GT or 95
- **Facility (UB) Claims**: GT or 95
- **Audio Only**: 93 or FQ
- **COVID-19 Related**: For services relating to the order for or administration of a COVID-19 test or for services related to the evaluation for purposes of determining the need for diagnostic testing, append modifier CS.

Provider Type: Audiologist, Certified Genetic Counselor, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist, Licensed Drug & Alcohol Counselor, Dentist, Nurse Midwife, Nurse Practitioner, Occupational Therapist, Physical Therapist, Physician, Physician Assistant, podiatrist, Registered Dietitian or Nutrition Professional, and Speech Therapist.

Reimbursement: Reimbursement will be at the same rate as in-person face-to-face visits, refer to your Medica contract for allowable rates.

Store and Forward Telehealth: Medica allows both synchronous (interactive audiovisual communication) and asynchronous (store and forward). Utilize modifier GQ.

Originating Sites:

- Allowable originating sites: Office of physician or practitioner; hospital (inpatient or outpatient); home; critical-access hospital (CAH); rural health clinic (RHC) and federally qualified health center (FQHC); hospital-based or CAH-based renal dialysis center (including satellites); skilled nursing facility (SNF); end-stage renal disease (ESRD) facilities; community mental health center; Residential Substance Abuse Treatment Facility; and other eligible medical facilities.

Transmission & Originating Site Fees: Transmission fees (HCPCS T1014) are not eligible for payment, however Medica will allow an originating site fee (HCPCS Q3014) to be billed by an originating site facility.

Telehealth Coverage Limitations: The following are not covered under telemedicine:

- Provider initiated e-mail, refilling or renewing existing prescriptions, scheduling a diagnostic test or appointment, clarification of simple instructions or issues from a previous visit, reporting test results, reminders of scheduled office visits, requests for a referral, non-clinical communication, educational materials, brief follow-up of a medical procedure without indication of complication or new condition including, but not limited to, routine global surgical follow-up, brief discussion to confirm stability of the patient's without change in current treatment, when information is exchanged and the patient is subsequently asked to come in for an office visit, a service that would similarly not be charged for in a regular office visit, consultative message exchanges with an individual who is seen in the provider's office immediately afterward, communication between two licensed health care providers that consists solely of a telephone conversation, email or facsimile, communications between a licensed health care provider and a patient that consists solely of an e-mail or facsimile.

Video Component: See below matrix for codes that can be performed over an audio only connection.

MEDICA ALLOWABLE TELEHEALTH CODES-COVID-19 PHE									
0362T	90961	92567	95984	96139*	97166	99233	99350	G0396*	G2212*
0373T	90962	92568	96105	96156*	97167	99234	99406*	G0397*	G3002
77427	90963	92570	96112	96158*	97168	99235	99407*	G0406*	G3003
90785*	90964	92587	96113	96159*	97530	99236	99441*	G0407*	G9685
90791*	90965	92588	96116*	96160*	97535*	99238	99442*	G0408*	G2212*
90792*	90966	92601	96121*	96161*	97537	99239	99443*	G0420*	
90832*	90967	92602	96125	96164*	97542	99281	99468	G0421*	
90833*	90968	92603	96127*	96165*	97750	99282	99469	G0422	
90834*	90969	92604	96130*	96167*	97755	99283	99471	G0423	
90836*	90970	92607	96131*	96168*	97760	99284	99472	G0425*	
90837*	92002	92608	96132*	97110	97761	99285	99473	G0426*	
90838*	92004	92609	96133*	97112	97763	99291	99475	G0427*	
90839*	92012	92610	96136*	97116	97802*	99292	99476	G0438*	
90840*	92014	92625	96137*	97129	97803*	99304	99477	G0439*	
90845*	92507*	92626	95984	97130	97804*	99305	99478	G0442*	
90846*	92508*	92627	96105	97150	99202	99306	99479	G0443*	
90847*	92521*	93750	96112	97151	99203	99307	99480	G0444*	
90853*	92522*	93797	96113	97152	99204	99308	99483	G0445*	
90901	92523*	93798	96116*	97153	99205	99309	99495	G0446*	
90951	92524*	94002	96121*	97154	99211	99310	99496	G0447*	
90952	92526	94003	96125	97155	99212	99315	99497*	G0459*	
90953	92550	94004	96127*	97156	99213	99316	99498*	G0506*	
90954	92552	94625	96130*	97157	99214	99341	G0108*	G0508	
90955	92553	94626	96131*	97158	99215	99342	G0109*	G0509	
90956	92555	94664	96132*	97161	99221	99344	G0270*	G0513*	
90957	92556	95970	96133*	97162	99222	99345	G0296*	G0514*	
90958	92557	95971	96136*	97163	99223	99347	G0316	G2086*	
90959	92563	95972	96137*	97164	99231	99348	G0317	G2087*	
90960	92565	95983	96138*	97165	99232	99349	G0318	G2088*	
Codes With An * Can Be Performed via an Audio only (Telephone) or Audiovisual Connection									

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 99421-99423, G2061-G2063
- **Telephone**: 99441-99443, 98966-98968
  - Allowed through December 31st, 2024
- **Virtual Check-In**: G2010, G2012, G2250-G2251, G2252

Modifiers:

- **E-Visits & Virtual Check-Ins**: None
- **Telephone**: Modifier 95

Telehealth:

Consolidated Appropriations Act: Extends certain telehealth flexibilities for Medicare patients through December 31st, 2024:

- Originating site restriction waiver
- Expanded list of allowable telehealth practitioners
- Audio only telehealth services
- In person requirement for mental health services via telehealth
- Extension of FQHC/RHC to serve as originating site for non-behavioral/mental telehealth services

Allowable Codes: See table below for codes allowable via telehealth

Modifiers/POS:

- **Professional (1500) Claims**:
  - **Through December 31st, 2023**: POS that would have been used if the visit were provided in person with modifier 95
    - **Modifier**: FR if applicable
- **Mental Health Claims**: POS 02 or 10
  - **Modifier** 93 if performed over audio only
  - **RHC/FQHC**: Modifier FQ
- **CAH Method II (UB) Claims**: Modifier GT
- **CAH & PPS PT/OT/Speech UB Claims**: Modifier 95

Patient Location: Through December 31st, 2024, Medicare will pay for office, hospital, and other visits furnished via telehealth across the country, whether urban or rural, and in all settings, including in patients' homes.

- **Mental Health**: CMS permanently added a patient's home as an originating site for patients receiving mental health services via telehealth. "Home" includes temporary lodging. Must meet the following requirements:
  - The provider (or another provider in the same practice and subspecialty) has conducted an in-person (non-telehealth) visit within 6 months
  - After the initial tele-mental health visit, the provider must conduct an in-person visit at least once every 12 months
    - However, this visit is not required if the patient and provider consider the risks of an in-person visit and agree that the risks outweigh the benefits
    - Provider should document decision in the patient's medical record
  - Through December 31st, 2024, the initial 6 month visit and the in person visit every 12 month requirement is waived

Provider Type: Through December 31st, 2024, physical therapists, occupational therapists, speech language pathologists, and audiologists, to receive payment for Medicare telehealth services.

- **January 1st, 2025:** Allowable provider types will revert back to only physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals

Reimbursement: In the 2023 Physician Fee Schedule Final Rule, CMS extended payment parity for telehealth in non-facility settings through the end of 2023

- Absent further rulemaking, beginning Jan. 1, 2024, distant-site practitioners would again be reimbursed based only on facility rates, resulting in reimbursement for some telehealth services reverting to lower pre-PHE levels.

Rural Health Clinics & Federally Qualified Health Centers: See the RHC and FQHC section for specific billing regulations.

Transmission/ Originating Site Fees: Medicare does not reimburse for transmission fees. If applicable, Medicare will reimburse an originating site fee (HCPCS Q3014).

- 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.

Video Component: When providers are providing an E/M service that would otherwise be reported as an in-person or telehealth visit, using audio-only technology, providers should utilize the appropriate telephone E/M code (99441-99443), not the in person or telehealth visit code.

- Telephone Codes only available for use through December 31st, 2024
- Audio only mental health telehealth will be permanently reimbursable if:
    - The provider has the technical capability, at the time of the service, to use an interactive telecommunications system
    - The patient is incapable of, or fails to consent to, the use of video technology for the service
    - The beneficiary is located at his or her home
    - The practitioner documents the reason for using audio-only technology uses the appropriate service level modifier

2023 MEDICARE ELEGIBLE TELEHEALTH CODES											
2023 Telehealth Codes											
0362T	0373T	77427	90785	90791	90792	90832	90833	90834	90836	90837	90838
90839	90840	90845	90846	90847	90853	90875	90901	90951	90952	90953	90954
90955	90956	90957	90958	90959	90960	90961	90962	90963	90964	90965	90966
90967	90968	90969	90970	92002	92004	92012	92014	92507	92508	92521	92522
92523	92524	92526	92550	92552	92553	92555	92556	92257	92563	92565	92567
92563	92565	92567	92568	92570	92587	92588	92601	92602	92603	92604	92607
92608	92609	92610	92625	92626	92627	93750	93797	93798	94002	94003	94004
94005	94625	94626	94664	95970	95971	95972	95983	95984	96105	96110	96112
96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138
96139	96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171
97110	97112	97116	97129	97130	97150	97151	97152	97153	97154	97155	97156
97157	97158	97161	97162	97163	97164	97165	97166	97167	97168	97530	97535
97537	97542	97750	97755	97760	97761	97763	97802	97803	97804	98960	98961
98962	98966	98967	98968	99202	99203	99204	99205	99211	99212	99213	99214
99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238	99239
99281	99282	99283	99284	99285	99291	99292	99304	99305	99306	99307	99308
99309	99310	99315	99316	99341	99342	99344	99345	99347	99348	99349	99350
99406	99407	99441	99442	99443	99468	99469	99471	99472	99473	99475	99476

99477	99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0270
G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0420	G0421
G0422	G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445	G0446
G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211	G2212
G3003	G9685	S9152									
Codes Highlighted in Green-Can Be Performed via an Audio only											

Medicare Telehealth Codes Payment Limitations	
CPT/HCPCS	**Medicare Payment Limitation**
90875	Non-covered service
94005	Bundled code
96110	Non-covered service
96170	Non-covered service
96171	Non-covered service
98960	Bundled code
98961	Bundled code
98962	Bundled code
S9152	Not valid for Medicare purposes
G0410	Statutory exclusion
G2211	Bundled code

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: Not Allowable
- **Telephone**: 98966-98968, 99441-99443
- **Virtual Check-In**: Not Allowable

Modifier/POS: None
Patient Type: Established

Telehealth:

Telehealth Definition:

- Health First Colorado defines telemedicine as services provided under either of the below arrangements:
    - A member receives services via a live audio/visual connection from a single provider.
    - A member and a provider are physically in the same location and additional services are provided by a second (distant) provider via a live audio/visual connection.
        - The provider who is present with the member is called the originating provider
        - The provider located at a different site is called the distant provider.

Telehealth Requirements:

- Providers may only bill procedure codes which they are already eligible to bill.
- Services must meet the same standard of care as in-person care.
- Providers must document the member's consent, either verbal or written.
- Contact with the provider must be initiated by the member.
- Does not alter the scope of practice of any health care provider, nor does it authorize the delivery of services in a setting or manner not otherwise authorized by law.
- Services not otherwise covered by Health First Colorado are not covered when delivered via telemedicine.
- The use of telemedicine does not change prior authorization requirements.

Allowable Services:

- **Services billed with POS 02 or 10**: Allowable code set below

Non-covered Services:

- Services not otherwise covered by Health First Colorado are not covered when delivered via telemedicine
- Telemedicine does not include consultations provided by telephone (interactive audio), email or facsimile machines.
    - Services appropriately billed to managed care should continue to be billed to managed care. All managed care requirements must be met for services billed to managed care. Managed care may or may not reimburse telemedicine costs.

Face to Face Requirement:

- The Health First Colorado requirement for an initial face-to-face contact between provider and member may be waived when treating the member through telemedicine
- Prior to treating the member through telemedicine for the first time, the provider must furnish each member with all the following written statements, which must be signed (electronic signatures will be accepted) by the member or the member's legal representative:
    - The member retains the option to refuse the delivery of health care services via telemedicine at any time without affecting the member's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the member would otherwise be entitled.
    - All applicable confidentiality protections shall apply to the services.

- The members shall have access to all medical information resulting from the telemedicine services as provided by applicable law for member access to his or her medical records.
- Note: These above requirements do not apply in an emergency.

Modifiers/POS:

- **Professional (1500) claims**: POS 02 or 10
  - **Modifiers** FQ and FR
    FQ: The service was furnished using audio-only communication technology.
    FR: The supervising practitioner was present through two-way, audio/video communication technology.
- **Facility (UB) claims:** Modifier GT

Patient Location: If no originating provider is present, then the location of the originating site is at the member's discretion and can include the member's home.

Provider Type: Physician, Clinic, Osteopath, FQHC, Doctorate Psychologist, MA psychologist, Physician Assistant, Nurse Practitioner, RHC

- COVID-19: Health First Colorado has expanded the list of providers eligible to deliver telemedicine services to include physical therapists, occupational therapists, hospice, home health providers and pediatric behavioral health providers.
- As of October 30th, 2022, there is a provider specialty type for Clinic and Non-Physician Practitioner groups that meet the following definition:
  - An eHealth entity is defined as a group practice that delivers services exclusively through telemedicine and is enrolled in a provider type that has an eHealth specialty.
  - Refer to the Code of Colorado Regulations (1- CCR 2505-10, Section 8.095) for more information.
  - Providers who meet this definition must update their enrollment to this provider specialty type. Guidance on how to enroll can be found on our Provider Enrollment page. Services are restricted to those currently allowed for telemedicine

Reimbursement: The reimbursement rate for a telemedicine service shall, as a minimum, be set at the same rate as comparable in-person service.

Video Component: Required

Transmission & Originating Site Fees:

- The following procedure codes, when billed with modifier GT by appropriate providers (not FQHC,RHC, or HIS) , pay the telemedicine transmission fee (an additional $5.00 to the fee listed in the most recent Health First Colorado Fee Schedule).
  - When providing Family Planning via Telemedicine, appropriate providers may use the combination modifier codes of FP/GT (in this order).
  -

Transmission Fees-Modifier GT									
90791	90832	90833	90834	90836	90837	90838	90863	90846	90847
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
92507	97532	76801	76802	76805	76810	76811	76812	76813	76814
76815	76816	76817	96116						

MEDICAID ELIGIBLE TELEHEALTH CODES												
76801	76802	76805	76811	76812	76813	76814	76815	76816	76817	90791	90792	90832
90833	9083	90836	90837	90838	90839	90840	90846	90847	90849	90853	90863	92507

92508	92521	92522	92523	92524	92526	92606	92607	92608	92609	92610	92630	92633
96040	96101	96102	96110	96111	96112	96113	96116	96118	96119	96121	96125	96130
96131	96132	96133	96136	96137	96138	96139	96146	97110	97112	97129	97130	97140
97150	97151	97153	97154	97155	97158	97161	97162	97163	97164	97165	97166	97167
97168	97530	97533	97535	97537	97542	97755	97760	97761	97763	97802	97803	97804
98966	98967	98968	99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
99382	99383	99384	99392	99393	99394	99401	99402	99403	99404	99406	99407	99408
99409	99417	99411	99442	99443	G0108	G0109	G8431	G8510	G9006	H0001	H0002	H0004
H0006	H0025	H0031	H0032	H0049	H1005	H2000	H2011	H2015	H2016	S9445	S9485	T1017
V5011												
Allowed for Outpatient Hospital Telemedicine Billing												

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 99421-99423, 98970-98972
- **Interprofessional Consultation**: 99446-99449, 99451, 99452
- **Telephone**: 99441-99443
- **Virtual Check-In**: G2010, G2012, G2250-G2252

POS/Modifier: POS utilized if visit would have in person and no modifier

Remote Patient Monitoring Codes:

- **Allowable Codes**: 99091, 99453, 99454, 99457-99458, 99473-99474, 98975-98977, 98980-98981,

POS/Modifier: POS utilized if visit would have in person and no modifier

Interprofessional Assessment Codes:

- **Allowable Codes**: 99446-99449, 99451-99452

POS/Modifier: POS utilized if visit would have in person and no modifier

Telehealth:

Allowable Codes: UHC will allow any services on the below lists:

- Services recognized by the Centers for Medicare and Medicaid Services (CMS)
- Services recognized by the American Medical Association (AMA) included in Appendix P of the CPT code set
- Additional services identified by UnitedHealthcare that can be effectively performed via Telehealth
    - See Telehealth Allowable Codes table below for UHC specified codes

PT/OT/ST Services: All PT/OT/ST Telehealth visits must be performed using live, interactive video conferencing that involves the presence of both parties at the same time and a communication link between them that allows a real-time audio and visual interaction to take place. E-mailing "stored" exercise videos and discussing or reviewing by phone is not reimbursable.

Modifiers/POS:

- **Professional (1500) claims**: POS 02 or 10. Modifiers 95, GT, GQ, and G0 are not required to identify telehealth services but are accepted as information if reported on claims.
- **Facility (UB) claims:** Revenue code 780 (allowable during the PHE only)

Provider Type: Physician, nurse practitioner, physician assistant, nurse-midwife, clinical nurse specialist, registered dietitian or nutrition professional, clinical psychologist, clinical social worker, certified registered nurse anesthetists, physical therapists, occupational therapists, and speech therapists.

Reimbursement: Reimbursement will be at the same rate as in-person face-to-face visits, refer to your UHC contract for allowable rates.

Patient Location: UHC will recognize CMS designated originating sites considered eligible for furnishing telehealth services to a patient located in an originating site.

- Examples of CMS originating sites with a telpresenter: the office of a physician or practitioner, hospital, critical access hospital (CAH), rural health clinic (RHC), federally qualified health center (FQHC), hospital

based renal dialysis center, skilled nursing facility (SNF), community mental health center (CMHC), mobile stroke unit, patient home-for monthly end stage renal, ESRD-related clinical assessments, for purposes of treatment of a substance use disorder or a co-occurring mental health disorder.

- UHC will also recognize home as an originating site for telehealth services (no telepresenter present)

Transmission & Originating Site Fees: UHC will allow the originating site to submit a claim for services of the telepresenter using HCPS Q3014. T1014 is not eligible for payment, UHC considers these services as incidental to the charges associated with the E/M.

Video Component: Telehealth services must be performed over an audiovisual connection, unless audio only allowable code is utilized

- UHC will align with the AMA and will consider for reimbursement the services included in Appendix T of the CPT code set, which are appropriate for reporting real-time, interactive audio-only telehealth, when appended with modifier 93, and reported with POS 02 or 10
- All PT/OT/ST Telehealth visits must be performed using live, interactive video conferencing that involves the presence of both parties at the same time and a communication link between them that allows a real-time audio and visual interaction to take place. E-mailing “stored” exercise videos and discussing or reviewing by phone is not reimbursable

UHC ELEGIBLE TELEHEALTH CODES											
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845
90846	90847	90853	90863	90951	90952	90953	90954	90955	90956	90957	90958
90959	90960	90961	90962	90964	90965	90966	90967	90968	90969	90970	92227
92228	92507	92521	92522	92523	92524	93228	93229	93268	93270	93271	93272
93797	93798	94625	94626	96040	96116	96121	96130	96131	96132	96133	96136
96137	96138	96139	96156	96158	96159	96160	96161	96164	96165	96167	96168
97110	97112	97116	97161	97162	97163	97164	97165	97166	97167	97168	97530
97535	97750	97755	97760	97761	97802	97803	97804	98960	98961	98962	99202
99203	99204	99205	99211	99212	99213	99214	99215	99217	99224	99225	99226
99231	99232	99233	99238	99239	99281	99282	99283	99284	99285	99291	99292
99307	99308	99309	99310	99315	99316	99334	99335	99336	99337	99347	99348
99349	99350	99354	99355	99356	99357	99395	99396	99397	99406	99407	99408
99409	99469	99472	99476	99478	99479	99480	99483	99495	99496	99497	99498
G0108	G0109	G0270	G0296	G0396	G0397	G0406	G0407	G0408	G0420	G0421	G0422
G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445	G0446	G0447
G0459	G0506	G508	G0509	G0513	G0514	G2086	G2087	G2088	G2211	G2212	G9481
G9482	G9483	G9484	G9485	G9486	G9487	G9488	G9489	G9978	G9979	G9980	G9981
G9982	G9983	G9984	G9985	G9986							
PT/OT/ST											
92507	92521	92522	92523	92524	97110	97112	97116	97161	97162	97163	97164
97165	97166	97167	97168	97535	97750	97755	97760	97761			
AUDIO ONLY CODES											
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845
90846	90847	92507	92508	92521	92522	92523	92524	96040	96110	96116	96121
96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171	97802
97803	97804	99406	99407	99408	99409	99497	99498				

COST SHARING WAIVER (CO-PAY/CO-INSURANCE/DEDUCTIBLE)

The Families First Coronavirus Response Act, section 6001 (a)(2) required payors to waive cost sharing for office visits (including in-person visits and telehealth visits), urgent care center visits, and emergency room visits that resulted in an order for or administration of a COVID-19 test, or an evaluation to determine if a COVID-19 test was required. With the end of the federal COVID-19 PHE on May 11th, 2023, the Families First Coronavirus Response Act also expired, resulting in the expiration of the required cost share waiver.

Payor Specific Key Points:

As part of the CARES Act, Congress has authorized RHCs and FQHCs to be a "distant site" for telehealth visits, therefore allowing RHC and FQHCs practitioners to provide telehealth services.

- RHCs & FQHCs will continue to be allowed to act as a distant site until December 31st, 2024, under the Consolidated Appropriations Act.

Telehealth:
Consolidated Appropriations Act: Extends certain telehealth flexibilities for Medicare patients until December 31st, 2024, including:

- Originating site restriction waiver
- Expanded list of allowable telehealth practitioners
- Audio only telehealth services
- In person requirement for mental health services via telehealth
- Extension of FQHC/RHC to serve as originating site

Cost Report:

- **RHC:** Costs for furnishing distant site telehealth services will not be used to determine the RHC AIR rate but must be reported on the appropriate cost report form. RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled "Cost Other Than RHC Services."
- **FQHC**: Costs for furnishing distant site telehealth services will not be used to determine the FQHC PPS rate but must be reported on the appropriate cost report form. FQHCs must report both originating and distant site telehealth costs on Form CMS-224-14, the Federally Qualified Health Center Cost Report, on line 66 of the Worksheet A, in the section titled "Other FQHC Services".

Allowable Codes: See table below for codes allowable via telehealth.

Billing:

- **HCPCS**: G2025
- **Professional (1500) Claims**:
  - **Through December 31st, 2023**: POS that would have been used if the visit were provided in person with modifier 95
  - **Modifier**: FR if applicable
- **Mental Health Claims**: POS 02 or 10 and modifier FQ if performed via audio only

Mental Health Services:

- CMS will permanently allow mental health telehealth services performed by an RHC/FQHC
- The service must be either audio visual OR
- Audio-only if the following are present:
  - The patient is incapable of, or fails to consent to, the use of video technology for the service
  - The provider has conducted an in-person visit within the last 6 months of the initial tele-mental service
  - The services are medical necessary
  - After the initial telehealth visit, the provider conducts an in-person visit at least once every 12 months of each tele-mental visit.
    - However, if the patient and provider consider the risks of an in person service and agree that these risks outweigh the benefits, then the annual visit may be skipped.

        - Providers must document the decision
    - Until December 31st, 2024, the initial 6 month visit and the in person visit every 12 month requirement is waived

Provider Type: Through December 31st, 2024, physical therapists, occupational therapists, speech language pathologists, and audiologists, to receive payment for Medicare telehealth services.

- **January 1st, 2025:** Allowable provider types will revert back to only physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals

Reimbursement: The RHC/FQHC telehealth payment rate is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS. For 2023 the rate is $95.88.

Transmission/ Originating Site Fees: Medicare does not reimburse transmission fees. If applicable, Medicare will reimburse an originating site fee (HCPCS Q3014).

- 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.

Video Component: When providers are providing an E/M service that would otherwise be reported as an in-person or telehealth visit, using audio-only technology, providers should utilize the appropriate telephone E/M code (99441-99443), not the in person or telehealth visit code.

- Audio only mental health telehealth will be permanently reimbursable if:
    - The provider has the technical capability, at the time of the service, to use an interactive telecommunications system
    - The patient is incapable of, or fails to consent to, the use of video technology for the service
    - The beneficiary is located at his or her home
    - The practitioner documents the reason for using audio-only technology uses the appropriate service level modifier

Telephone Services: Until December 31st, 2024, RHC/FQHCs can perform audio only telephone E/M services utilizing CPT codes 99441, 99442, and 99443.

- RHCs can furnish and bill for these services using HCPCS code G2025.
- At least 5 minutes of telephone E/M by physician or other qualified health care professional who may report E/M services must be provided to an established patient, parent, or guardian.
- Cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

Virtual Check-Ins & E-Visits: Until December 31st, 2024, RHC/FQHCs can perform E-Visits (CPT codes 99421-99423), which are online digital E/M services that utilize a secure patient portal. Medicare will also allow RHC/FQHCs to perform Virtual Check Ins (HCPCS G2012 and G2010).

- RHCs should bill HCPCS G0071 if E-Visit or Virtual Check-In services are performed.
- **Reimbursement:** is set at the average of the national non-facility PFS payment rates for the 5 E-visits and Virtual Check-In codes. For 2023 the rate is set at $ $23.14
- **G0071:** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between RHC or FQHC practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC.

2023 MEDICARE ELEGIBLE TELEHEALTH CODES											
2023 Telehealth Codes											
0362T	0373T	77427	90785	90791	90792	90832	90833	90834	90836	90837	90838
90839	90840	90845	90846	90847	90853	90875	90901	90951	90952	90953	90954
90955	90956	90957	90958	90959	90960	90961	90962	90963	90964	90965	90966
90967	90968	90969	90970	92002	92004	92012	92014	92507	92508	92521	92522
92523	92524	92526	92550	92552	92553	92555	92556	92257	92563	92565	92567
92563	92565	92567	92568	92570	92587	92588	92601	92602	92603	92604	92607
92608	92609	92610	92625	92626	92627	93750	93797	93798	94002	94003	94004
94005	94625	94626	94664	95970	95971	95972	95983	95984	96105	96110	96112
96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138
96139	96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171
97110	97112	97116	97129	97130	97150	97151	97152	97153	97154	97155	97156
97157	97158	97161	97162	97163	97164	97165	97166	97167	97168	97530	97535
97537	97542	97750	97755	97760	97761	97763	97802	97803	97804	98960	98961
98962	98966	98967	98968	99202	99203	99204	99205	99211	99212	99213	99214
99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238	99239
99281	99282	99283	99284	99285	99291	99292	99304	99305	99306	99307	99308
99309	99310	99315	99316	99341	99342	99344	99345	99347	99348	99349	99350
99406	99407	99441	99442	99443	99468	99469	99471	99472	99473	99475	99476
99477	99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0270
G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0420	G0421
G0422	G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445	G0446
G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211	G2212
G3003	G9685	S9152									
Codes Highlighted in Green-Can Be Performed via an Audio only											

Medicare Telehealth Codes Payment Limitations	
CPT/HCPCS	**Medicare Payment Limitation**
90875	Non-covered service
94005	Bundled code
96110	Non-covered service
96170	Non-covered service
96171	Non-covered service
98960	Bundled code
98961	Bundled code
98962	Bundled code
S9152	Not valid for Medicare purposes
G0410	Statutory exclusion
G2211	Bundled code

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: Not Allowable
- **Telephone**: 98966-98968, 99441-99443
- **Virtual Check-In**: Not Allowable

Modifier/POS: None
Patient Type: Established

Telehealth:

Telehealth Definition:

- Health First Colorado defines telemedicine as services provided under either of the below arrangements:
    - A member receives services via a live audio/visual connection from a single provider.
    - A member and a provider are physically in the same location and additional services are provided by a second (distant) provider via a live audio/visual connection.
        - The provider who is present with the member is called the originating provider
        - The provider located at a different site is called the distant provider.

Telehealth Requirements:

- Providers may only bill procedure codes which they are already eligible to bill.
- Services must meet the same standard of care as in-person care.
- Providers must document the member's consent, either verbal or written.
- Contact with the provider must be initiated by the member.
- Does not alter the scope of practice of any health care provider, nor does it authorize the delivery of services in a setting or manner not otherwise authorized by law.
- Services not otherwise covered by Health First Colorado are not covered when delivered via telemedicine.
- The use of telemedicine does not change prior authorization requirements.

Allowable Services:

- **Services billed with POS 02 or 10**: Allowable code set below

Non-covered Services:

- Services not otherwise covered by Health First Colorado are not covered when delivered via telemedicine
- Telemedicine does not include consultations provided by telephone (interactive audio), email or facsimile machines.
    - Services appropriately billed to managed care should continue to be billed to managed care. All managed care requirements must be met for services billed to managed care. Managed care may or may not reimburse telemedicine costs.

Face to Face Requirement:

- The Health First Colorado requirement for an initial face-to-face contact between provider and member may be waived when treating the member through telemedicine
- Prior to treating the member through telemedicine for the first time, the provider must furnish each member with all the following written statements, which must be signed (electronic signatures will be accepted) by the member or the member's legal representative:
    - The member retains the option to refuse the delivery of health care services via telemedicine at any time without affecting the member's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the member would otherwise be entitled.
    - All applicable confidentiality protections shall apply to the services.
    - The members shall have access to all medical information resulting from the telemedicine services as provided by applicable law for member access to his or her medical records.

- Note: These above requirements do not apply in an emergency.

Modifiers/POS:

- **Professional (1500) claims**: POS 02 or 10
  - **Modifiers** FQ and FR
    FQ: The service was furnished using audio-only communication technology.
    FR: The supervising practitioner was present through two-way, audio/video communication technology.
- **Facility (UB) claims:** Modifier GT

Patient Location: If no originating provider is present, then the location of the originating site is at the member's discretion and can include the member's home.

Provider Type: Physician, Clinic, Osteopath, FQHC, Doctorate Psychologist, MA psychologist, Physician Assistant, Nurse Practitioner, RHC

- COVID-19: Health First Colorado has expanded the list of providers eligible to deliver telemedicine services to include physical therapists, occupational therapists, hospice, home health providers and pediatric behavioral health providers.
- As of October 30th, 2022, there is a provider specialty type for Clinic and Non-Physician Practitioner groups that meet the following definition:
  - An eHealth entity is defined as a group practice that delivers services exclusively through telemedicine and is enrolled in a provider type that has an eHealth specialty.
  - Refer to the Code of Colorado Regulations (1- CCR 2505-10, Section 8.095) for more information.
  - Providers who meet this definition must update their enrollment to this provider specialty type. Guidance on how to enroll can be found on our Provider Enrollment page. Services are restricted to those currently allowed for telemedicine

Reimbursement: The reimbursement rate for a telemedicine service shall, as a minimum, be set at the same rate as comparable in-person service.

Video Component: Required

Transmission & Originating Site Fees:

- The following procedure codes, when billed with modifier GT by appropriate providers (not FQHC,RHC, or HIS) , pay the telemedicine transmission fee (an additional $5.00 to the fee listed in the most recent Health First Colorado Fee Schedule).
  - When providing Family Planning via Telemedicine, appropriate providers may use the combination modifier codes of FP/GT (in this order).
  -

Transmission Fees-Modifier GT									
90791	90832	90833	90834	90836	90837	90838	90863	90846	90847
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
92507	97532	76801	76802	76805	76810	76811	76812	76813	76814
76815	76816	76817	96116						

MEDICAID ELIGIBLE TELEHEALTH CODES												
76801	76802	76805	76811	76812	76813	76814	76815	76816	76817	90791	90792	90832
90833	9083	90836	90837	90838	90839	90840	90846	90847	90849	90853	90863	92507
92508	92521	92522	92523	92524	92526	92606	92607	92608	92609	92610	92630	92633
96040	96101	96102	96110	96111	96112	96113	96116	96118	96119	96121	96125	96130

96131	96132	96133	96136	96137	96138	96139	96146	97110	97112	97129	97130	97140
97150	97151	97153	97154	97155	97158	97161	97162	97163	97164	97165	97166	97167
97168	97530	97533	97535	97537	97542	97755	97760	97761	97763	97802	97803	97804
98966	98967	98968	99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
99382	99383	99384	99392	99393	99394	99401	99402	99403	99404	99406	99407	99408
99409	99417	99411	99442	99443	G0108	G0109	G8431	G8510	G9006	H0001	H0002	H0004
H0006	H0025	H0031	H0032	H0049	H1005	H2000	H2011	H2015	H2016	S9445	S9485	T1017
V5011												
Allowed for Outpatient Hospital Telemedicine Billing												

HIPAA COMPLIANT SOFTWARE

On April 11, 2023, OCR announced that the HIPPA compliant software enforcement discretion will expire at 11:59 p.m. on May 11, 2023, due the expiration of the COVID-19 PHE. OCR will continue to support the use of telehealth after the PHE by providing a 90-calendar day transition period for covered health care providers to make any changes to their operations that are needed to provide telehealth in a private and secure manner in compliance with the HIPAA Rules. During this transition period, OCR will continue to exercise its enforcement discretion and will not impose penalties on covered health care providers for noncompliance with the HIPAA Rules in connection with the good faith provision of telehealth. The transition period will be in effect beginning on May 12, 2023, and will expire at 11:59 p.m. on August 9, 2023.

REFERENCES & RESOURCES

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https://apps.availity.com/availity/web/public.elegant.login

https://www.aetna.com/individuals-families/member-rights-resources/covid19.html

Anthem BCBS:

https://providernews.anthem.com/colorado/article/information-from-anthem-for-care-providers-about-covid-19-updated-march-20-2020

https://www.anthem.com/docs/public/inline/Telehealth_Allowed_Services-CO.pdf

https://providernews.anthem.com/colorado/article/information-from-anthem-for-care-providers-that-perform-aba-services-during-covid-19-8

Colorado Medicaid:

https://hcpf.colorado.gov/provider-telemedicine

https://hcpf.colorado.gov/health-first-colorado-announces-telemedicine-changes

https://hcpf.colorado.gov/telemedicine-manual

HHS

https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

Cigna:

https://static.cigna.com/assets/chcp/resourceLibrary/medicalResourcesList/medicalDoingBusinessWithCigna/medicalDbwcCOVID-19.html

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https://www.cms.gov/files/document/covid-final-ifc.pdf

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https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1#:~:text=In%20the%20CY%202021%20PFS%20proposed%20rule%2C%20CMS%20proposed%20to,ends%20or%20December%2031%2C%202021.

Medica:

https://www.medica.com/providers

https://www.medica.com/-/media/documents/provider/emergency-telemedicine-policy-excluding-mhcp.pdf?la=en&hash=D154D75363E094EB8C24010607883665

https://www.medica.com/-/media/documents/provider/covid-19-preparedness-provider-faq.pdf?la=en&hash=71B81851C5046B016DD910711E6D18F4

NARHC:

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UHC:

https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19.html

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Document Prepared By: Hayley Prosser, ruralMED Director of Revenue Cycle Services, hprosser@ruralmed.net