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Prepared for:
Southwest Telehealth Resource Center

COVID-19 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.

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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.

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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.

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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

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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 E-Visit codes are allowable	ALLOWABLE **Allowable Codes:** Telehealth Eligible Code **Professional**: POS 02 or 10 & Modifier 95 or GT **Facility:** Modifier GT or 95	CONDITIONAL Check contracted fee schedule to see if virtual check in codes are allowable	ALLOWABLE 99441-99443 98966-98968
CIGNA	NOT ALLOWABLE	ALLOWABLE **Allowable Codes:** Telehealth Eligible Code **Professional:** Modifier 95 or GT & POS used for in-person visit. **Facility**: Not Allowable	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

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AETNA

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

Remote Patient Monitoring:

Allowable Codes: 99453, 99454, 99457, 99458

Telehealth:

Allowable Services: See table below
- **Wellness**: Appropriate E/M codes with a wellness diagnosis for wellness aspects of the visit done via telehealth will be covered. Preventative visit codes should be billed when routine in-office visits can resume, and the remaining parts of the well visit can be completed. Both services will be fully reimbursed, and the patient will not incur a cost share.

HIPAA Compliant Platform: Through the end of the federal COVID-19 PHE, non-HIPAA compliant, non-public facing software can be utilized for telehealth visits, such as Skype & FaceTime.

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

Not Reimbursable:
  - Synchronous telemedicine rendered via an audio only connection.
    - Modifier FQ or 93*

    *Allowable during the COVID-19 PHE
  - Asynchronous Telemedicine Services (services reported w/ GQ modifier).
  - Services that do not include direct patient contact, such as physician standby services.

Provider Location: Aetna will allow physicians to provide care from any location, including the provider's home.

Reimbursement: Reimbursement will be at the same rate as in-person face-to-face visits, refer to your Aetna contract for allowable rates.
- **Capitation**: Telemedicine will be covered within the capitation agreement, similar to an in-office visit

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 during the COVID-19 PHE.

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Cost Share Waiver:

- **Effective March 6th, 2021, through End of PHE:** Aetna will waive cost sharing for COVID-19 testing-related services, which are medical visits that result in an order for, or administration, of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test

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	
90838	90954	90968	96040	98962	99215	99255	99407	G0108	G0427	G0508	G0445	G0437	
90839	90957	90969	96116	99201	99241	99307	G0436	G0109	G0438	G0509	G0514	G0296	
Commercial Codes Effective March 6th, 2020-Unitl Further Notice Due to COVID-19 Pandemic													
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				
92556	92557	92563	92565	92567	92568	92570	92587	92607	92608	92609	92610	92625	92626
92627	96105	96125	97129	97130	94625	94626							

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

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Payor Specific Key Points

E-Visits/Telephone/Virtual Check-In:

Allowable Codes:

- **E-Visits**: Check fee schedule
- **Telephone**: 99441-99443, 98966-98968
  - Allowable only through end of COVID-19 PHE
- **Virtual Check-In**: Check fee schedule

Telehealth:

Allowable Services: See below table for allowable telehealth codes

- **COVID-19 Specific Behavioral Health:** Anthem will allow IOP, PHP, ABA, and psychological testing services to be provided via telehealth. These services will still need to be provided within benefits limits, authorization limits, medical necessity criteria, and within state and federal regulatory requirements and licensure requirements, including HIPAA compliance and the regulations regarding how substance use information is handled. Services must be provided over an audiovisual connection, except for the CPTs that are designated as allowable over an audio only connection.
  - **IOP/PHP:** Bill with applicable revenue code (905, 906, 912, 913) and appropriate behavioral health CPT code. IOP and PHP services delivered telehealth must meet specific requirements, see the detailed list at the following link:
    - https://providernews.anthem.com/colorado/article/information-from-anthem-for-care-providers-that-perform-aba-services-during-covid-19-8
  - **Mental Health and Substance Abuse**:
    - Psychiatric Diagnostic Evaluation: CPT 90791-90792
    - Psychotherapy: 90832-90838, 90839-90840, 90845-90847
    - Medication Management: 90863
    - E&M codes: 99211-99215
  - **ABA Therapy:**
    - Functional Behavior Assessment (FBA): CPT 97151
    - Adaptive Behavioral Treatment by Protocol or Protocol Modification: CPT 97153, 97155
    - Telehealth Caregiver Training: CPT 97156, 97157
  - **Telephonic Only Behavioral Health Codes**:
    - Telephone codes (see above section)
    - Anthem will also recognize telephonic-only services for diagnostic evaluation (90791-90792), psychotherapy (90832-90838, 90839-90840, 90845-90847), and medication management (90863) with place of service (POS) 02 or 10 and modifier 95 or GT
- **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
    - PT/OT codes that require equipment and/or direct physical hands-on interaction and therefore are not appropriate via telehealth include: 97010-97028, 97032-97039, 97113-97124, 97139-97150, 97533, and 97537-97546.
  - 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

HIPAA Compliant Platform: Required

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Modifiers/POS:

- **Professional (1500) Claims**: POS 02 or 10 with modifier 95 or GT
- **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
- **COVID-19 Related**: Append the CS modifier to line items in which COVID-19 evaluation or testing services where performed.

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: The video component has not been waived for telehealth codes, per Anthem if a telephonic-only visit is performed providers should utilize the telephone codes, CPT 99441-99443 and 98966-98968.

<u>**Cost Share Waiver**</u>:

- Effective March 18th, 2020 through End of PHE: Anthem will waive COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test.
- Effective March 19th, 2020-July15th, 2022: Anthem will waive cost sharing for telephonic-only in-network visits.

ANTHEM ELIGIBLE TELEHEALTH CODES												
Standard Telehealth List												
0373T	0362T	90791	90792	9083	90833	90834	90836	90837	90838	90845	90846	90847
90853	90887	92507	92521	92522	92523	92524	96116	96121	96127	96130	96131	96132
96133	96136	96137	96138	96139	96146	96158	96165	96168	96170	97110	97112	97116
97151	9152	97153	97154	97155	97156	97157	97158	97161	97162	97163	97164	97165
97166	97167	97168	97535	97542	97750	97755	97760	97761	98966	98967	98968	99202
99203	99204	99205	99211	99212	99213	99214	99215	99231	99232	99233	99307	99308
99309	99310	99354	99355	99381	9382	99383	99384	99385	99386	99387	99391	99392
99393	99394	99395	99396	99397	99401	99402	99403	99404	99406	99407	99408	99409
99417	99441	99442	99443	99453	99454	99457	99458	99495	99496	H0001	H0004	H0005
H0006	H0015	H0021	H0023	H0031	H0035	H0036	H0038	H0039	H0040	H2021	H2035	G2212
S0201	S9480											
COVID-19												
97530	92526	92606	92609	90839	90840	90863						

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Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: Not Allowable
- **Telephone**: 99441-99443
- **Virtual Check-Ins**: G2010, G2012

E-Consults:

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

Telehealth:

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

- Provided over an interactive audiovisual connection.
  - Services rendered via telephone only are considered interactive and will be reimbursed when the appropriate telephone only code is billed.
- Would be reimbursable if the service were provided face-to face.
- The patient and/or actively involved caregiver must be present and the service must occur in real time.
- A permanent record of online communications is maintained as part of the patient's medical record as if the service were provided as an in-office visit.
  - Must include documentation which identifies the virtual service delivery method. I.e.: audio/video or telephone only.
- Medically appropriate and necessary
- Provided by a health care professional who is licensed, registered, or otherwise acting within the scope of his/her licensure.

Excluded Services:

- Service on the same day as a face-to-face visit, when performed by the same provider and for the same condition.
- Services billed within a post-operative period
- Services performed via asynchronous communications systems (e.g., fax).
- Store and forward telecommunication
- Communications incidental to E/M services, counseling, or medical services included in this policy, including, but not limited to reporting of test results and provision of educational materials.

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- 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.
- Urgent Care centers will not be reimbursed for virtual care*
  *Cigna will reimburse urgent care centers for virtual care services provided on and before March 12, 2022.
- Specific Excluded CPT Codes: 98966, 98967, 98968, 98970, 988971, 98972, 99421, 99422, 99423, G0406, G0407, G0408, G0408, G0425, G0426, G0427, G0459, G0508, G0509, G2025, S0320.

HIPAA Compliant Platform: Through the end of the PHE providers may use nonpublic facing, non-HIPAA compliant platforms, such as FaceTime, Skype, Zoom, etc).

Modifiers/POS:
- **Professional/1500 Claims:**
  - **During the COVID PHE:** POS for in person visit and modifier 95, GT, or GQ
  - **Expiration of COVID PHE:** POS 02 and modifier 95, GT, or GQ
  - **Do not bill POS 10 or other virtual care modifiers until further notice**
- **Facility/UB Claims:** Modifier 95
  - During the COVID-19 PHE, Cigna will temporarily reimburse virtual care services billed on a UB until further notice, when the service is:
    - Reasonable to be provided in a virtual setting; reimbursable per a provider's contract; and synchronous audiovisual technology is utilized (except for CPTs 99441-99443)
  - Note: Intensive outpatient program (IOP) telehealth services were covered prior to the pandemic, and will continue to be covered

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 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
96168	97530	97755	97760	97761	97802	97803	97804	99202	99203	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	G2070	G0296	G0299	G0300
G0396	G0397	G0438	G0439	G0442	G0443	G0444	G0445	G0446	G0447	G0459	G0493	G0513
G0514	G2012	S9123	S9128	S9129	S9131	S9152						

Cost Share Waiver:

- **Effective March 13th, 2020-End of PHE**: Cigna will waive cost sharing for COVID-19 testing-related services, which are medical visits that result in an order for, or administration, of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test.

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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:

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 99391-99397.
  - 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.

HIPAA Compliant Platform: Through the end of the federal COVID-19 PHE, non-HIPAA compliant, non-public facing software can be utilized for telehealth visits, such as Skype & FaceTime.

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

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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										
77427	90957	93268	96168	99201	99234	99305	99354	99498	G0459	G2010
87633	90958	93270	97110	99202	99235	99306	99355	G0108	G0506	G2012
90785	90959	93271	97112	99203	99236	99307	99356	G0109	G0459	G2061
90791	90960	93272	97116	99204	99238	99308	99357	G0270	G0506	G2062
90792	90961	93298	97161	99205	99239	99309	99406	G0296	G0508	G2063
90832	90962	96040	97162	99211	99241	99310	99407	G0396	G0509	99381
90833	90963	96116	97163	99212	99242	99315	99408	G0397	G0513	99382
90834	90964	96130	97164	99213	99243	99316	99409	G0406	G0514	99383
90836	90965	96131	97165	99214	99244	99327	99468	G0407	G2086	99384
90837	90966	96132	97166	99215	99245	99328	99469	G0408	G2088	99385
90838	90967	96133	97167	99217	99251	99334	99471	G0420	Q3014	99386
90839	90968	96136	97168	99218	99252	99335	99472	G0421	98966	99387
90840	90969	96137	97535	99219	99253	99336	99473	G0425	98967	99391
90845	90970	96138	97750	99220	99254	99337	99475	G0426	98968	99392
90846	92227	96139	97755	99221	99255	99341	99476	G0427	98970	99393
90847	92228	96156	97760	99222	99281	99342	99477	G0438	98971	99394
90853	92507	96158	97761	99223	99282	99343	99478	G0439	98972	99395
90863	92521	96159	97802	99224	99283	99344	99479	G0442	99421	99396
90951	92522	96160	97803	99225	99284	99345	99480	G0443	99422	99397
90952	92523	96161	97804	99226	99285	99347	99483	G0444	99423	0373T
90953	92524	96164	98960	99231	99291	99348	99495	G0445	99441	0362T
90954	93228	96165	98961	99232	99292	99349	99496	G0446	99442	90875
90955	93229	96167	98962	99233	99304	99350	99497	G0447	99443	90956
92002	92004	92014	92508	92601	92602	92603	92604	93750	93797	93798
94002	94003	94004	94005	94664	95970	95971	95972	95983	95984	96110
96113	96121	96127	96170	96171	97150	97151	97152	97153	97153	97154
97155	97156	97157	97158	97530	97542	99324	99325	99326	99381	99382
99383	99384	99385	99386	99387	99391	99392	99393	99384	99385	99386
99397	G0410	G0422	G0423	G0424	G0466	G0467	G0468	G0469	G0470	G2087
G9685	S9152	G0071								
Codes Highlighted in Blue -Require an Audiovisual Connection **Codes Highlighted in Green-Can Be Performed via an Audio only (Telephone) or Audiovisual Connection**										

Cost Share Waiver:

Effective March 1st, 2020, through End of PHE: Medica will waive cost-sharing for in-network telehealth visits when related to administration of a COVID-19 test. Utilize the Medica provider portal for details regarding cost-share

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Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:
- **E-Visits**: 99421-99423, G2061-G2063
- **Telephone**: 99441-99443, 98966-98968
- **Virtual Check-In**: G2010, G2012, G2250-G2251, G2252

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

New patients allowable for COVID-19 PHE

Telehealth:

Allowable Codes: See table below for codes allowable via telehealth.
- **Note**-Telehealth rules do not apply when the beneficiary and the practitioner are in the same location and are utilizing telehealth to reduce exposure risks, even if audio/video technology assists in furnishing a service.

HIPAA Compliant Platform: Through the end of the COVID-19 PHE, HHS Office for Civil Rights (OCR) will waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime.

Modifiers/POS:
- **Professional (1500) Claims**: POS that would have been used if the visit were provided in person with modifier 95.
- **Mental Health Claims**: **After PHE Ends**: POS 02 or 10 and modifiers FQ and FR
  - MACs have instructed providers not to use modifier FQ and FR during the PHE
- **CAH Method II (UB) Claims**: Modifier GT
- **CAH & PPS PT/OT/Speech UB Claims**: Modifier 95
- **PPS Facility (UB) Claims**: PN or PO modifier with condition code DR. Appropriate use of the PN and PO modifier is dependent on your specific services and locations. See the "hospital" section for details.
- **COVID-19 Related:** For services relating to the order for or administration of a COVID-19 diagnostic test or for services related to the evaluation of an individual for purposes of determining the need for diagnostic testing, append modifier CS.

Patient Type: Through the end of the PHE, telehealth services can be provided to both new and established patients.

Patient Location: During the COVID-19 PHE, 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

Provider Type: All health care practitioners who are authorized to bill Medicare for their professional services may also furnish and bill for telehealth services. This allows health care professionals who were not previously authorized under the

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statute to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.

- There are no payment restrictions on distant site providers furnishing Medicare telehealth services from their home during the PHE. Report the place of service code that would have been reported had the service been furnished in person.

Reimbursement: Reimbursement will be at the same rate as in-person face-to-face visits, refer to the Medicare fee schedule for allowable rates.

- **Site of Service Differential**: Prior to CMS-1744-IFC, services that had a site differential (facility versus office), were paid on the facility payment rate when services were furnished via telehealth.
    - CMS is maintaining the facility payment rate for services billed using the POS code 02 if providers choose to not change their current billing practices.

Removal of Frequency Limitations on Medicare Telehealth: Per CMS, the following services no longer have limitations on the number of times they can be provided by telehealth:

- A subsequent inpatient visit can be furnished via telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233).
- A subsequent skilled nursing facility visit can be furnished via telehealth every 14 days, previously was 30 days (CPT codes 99307-99310).
  Critical care consult codes may be furnished by telehealth beyond the once per day limitation (CPT codes G0508-G0509).

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.

- Effective April 1st, 2022: Audio only mental health telehealth will be 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

Cost Share Waiver:

March 18, 2020 Through the End of the PHE: Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following categories of HCPCS evaluation and management codes: Office and other outpatient services, hospital observation services, emergency department services, nursing facility services, domiciliary, rest home, or custodial care services, home services, online digital evaluation, and management services.

- **Specific List Applicable HCPCS codes**: Visit https://www.cms.gov/files/document/se20011.pdf, view page 11, and click on the hyperlink as shown below.

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Use these HCPCS codes for billing:

- Physicians and non-physician practitioners
- Outpatient Prospective Payment System (OPPS)
- RHCs and FQHCs
- CAHs: use OPPS codes
- Method II CAHs: use the OPPS list or the physician and non-physician practitioner list, as appropriate.

- Cost-sharing does not apply to the above medical visit services for which payment is made to:
  - Hospital Outpatient Departments paid under the Outpatient Prospective Payment System, Physicians and other professionals under the Physician Fee Schedule, Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs).

2022 MEDICARE ELEGIBLE TELEHEALTH CODES										
2022 Standard Telehealth Codes										
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840
90845	90846	90847	90853	90951	90952	90954	90955	90957	90958	90960
90961	90963	90964	90965	90966	90967	90968	90969	90970	96116	96121
96156	96158	96159	96160	96161	96164	96165	96167	96168	97802	97803
97804	99202	99203	99204	99205	99211	99212	99213	99214	99215	99231
99232	99233	99307	99308	99309	99310	99334	99335	99347	99348	99354
99355	99356	99357	99406	99407	99483	99495	99496	99497	99498	G0108
G0109	G0270	G0296	G0396	G0397	G0406	G0407	G0408	G0420	G0421	G0425
G0426	G0427	G0438	G0439	G0442	G0443	G04444	G0445	G0446	G0447	G0459
G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211	G2212	
Codes Available up Through December 31st, 2023										
90953	90956	90959	90962	92507	92521	92522	92523	92524	93797	93798
96130	96131	96132	96133	96136	96137	96138	96139	97110	97112	97116
97161	97162	97163	97164	97165	97166	97167	97168	97535	97750	97755
97760	97761	99217	99224	99225	99226	99238	99239	99281	99282	99283
99284	99285	99291	99292	99315	99316	99336	99337	99349	99350	99469
99472	99476	99478	99479	99480	G0422	G0423	94625	94626		
Codes Available for the COVID-19 PHE										
0362T	0373T	77427	90875	92002	92004	92012	92014	92508	92526	92550
92552	92553	92555	92556	92557	92563	92565	92567	92568	92570	92587
92588	92601	92602	92603	92604	92607	92608	92609	92610	92625	92626
92627	93750	94002	94003	94004	94005	94664	95970	95971	95972	95983
95984	96105	96110	96112	96113	96125	96127	96170	96171	97129	97130
97150	97151	97152	97153	97154	97155	97156	97157	97158	97530	97542
99218	99219	99220	99221	99222	99223	99234	99235	99236	99304	99305
99306	99324	99325	99326	99327	99328	99341	99342	99343	99344	9345
99441	99442	99443	99468	99471	99473	99475	99477	G0410	G9685	S9152
90901	97537	97763	98960	98961	98962					
Codes Highlighted in Blue -Require an Audiovisual Connection **Codes Highlighted in Green-Can Be Performed via an Audio only (Telephone) or Audiovisual Connection during the COVID-19 PHE ONLY** **Codes Highlighted in Yellow-Have a Medicare Payment Limitation (See Table Below)**										

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Medicare Telehealth Codes Payment Limitations	
CPT/HCPCS	**Medicare Payment Limitation**
90875	Non-covered service
94005	Bundled code
96112	Non-covered service
96170	Non-covered service
96171	Non-covered service
S9152	Not valid for Medicare purposes
G0410	Statutory exclusion

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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
- **Well Child Checks**: Effective November 12, 2020, Health First Colorado will allow well-child check-up visits with procedure codes 99382, 99383, 99384, 99392, 99393, 99394 to be performed via telemedicine for children between the ages of 2 and 18.
  - Providers are encouraged to complete the physical examination the next time the member is seen in person.
  - Fee for Service Providers:
    - If physical examination is performed within 4 months of the telemedicine well-child check-up, void the previously paid claim with the POS 02 or 10 and resubmit for payment of the well-child check-up using the date of service of the physical examination.
  - FQHC/RHCs and IHS/Tribal 638 Providers:
    - Do not void a previous encounter when a physical examination is performed within 4 months of the telemedicine well-child check-up.
    - Indicate the well-child check-up was provided through telemedicine through GT modifier.

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.

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- 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.

COVID Flexibilities: Through End of PHE:

- Telemedicine visits will qualify as billable encounters for FQHCs, RHCs, and HIS'.
- Services allowed under telemedicine may be provided via telephone, live chat, or interactive audiovisual modality for these provider types.
- Expanded list of providers eligible to deliver telemedicine services to include physical therapists, occupational therapists, hospice, home health providers and pediatric behavioral health providers.
  - Home Health Agency services and therapies, Hospice, and Pediatric Behavioral Treatment may be provided via telephone-only.
  - Outpatient Physical, Occupational, and Speech Therapy services must have an interactive audio/visual connection with the member to be provided via telemedicine.

HIPAA Compliant Platform: During the PHE, telehealth visits can be performed via non-compliant HIPAA platforms, such as FaceTime, Facebook Messenger, Skype, Google Hangouts and WhatsApp. After the PHE ends, visits must be performed over a HIPAA compliant platform.

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.

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: COVID-19: Services allowed under telemedicine may be provided via telephone, live chat, or interactive audiovisual modality for these provider types.

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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												

Cost Share Waiver:

Effective March 18th, 2020 through End of PHE: Cost share is waived on COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test

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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 (11, 21, 22, etc) and no modifier

Remote Patient Monitoring Codes:

- **Allowable Codes**: 99091, 99453, 99454, 99457-99458, 99473-99474

POS/Modifier: POS utilized if visit would have in person (11, 21, 22, etc) 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.

HIPAA Compliant Platform: Through the COVID-19 PHE, telehealth visits can be performed via non-compliant HIPAA platforms, such as FaceTime, Facebook Messenger, Skype, Google Hangouts and WhatsApp. After the PHE ends, visits must be performed over a HIPAA compliant platform.

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.

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- 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.

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	90963	90964	90965	90966	90967	90968	90969	90970
92227	92228	92507	92521	92522	92523	92524	93228	93229	93268	93270	93271
93272	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	97535	97750	97755	97760
97761	97802	97803	97804	98960	98961	98962	99202	99203	99204	99205	99211
92212	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	G0425	G0426	G0427	G0438	G0439
G0442	G0443	G0444	G0445	G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514
G2086	G2087	G2088	G9986	G2212	G9481	G9482	G9483	G9484	G9485	G9486	G9487
G9488	G9489	G9978	G9979	G9980	G9981	G9982	G9983	G9984	G9985		
PT/OT/ST											
92507	92521	92522	92523	92524	97110	97112	97116	97161	97162	97163	97164
97165	97166	97167	97168	97535	97750	97755	97760	97761			

<u>**Cost Share Waiver**</u>:

Duration of COVID-19 PHE: UHC is waiving cost sharing for COVID-19-related covered visits (Colorado specific)

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Current cost share waivers:

Payor	Cost Sharing Guidelines
Aetna	**Effective March 6th, 2021, through End of PHE:** Aetna will waive COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test
Anthem BCBS	**Effective March 6th, 2021, through End of PHE:** Anthem will waive COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test **Effective March 19th, 2020-July 15th, 2022,** Anthem will waive cost sharing for telephonic-only in-network visits.
Cigna	**Effective March 13th, 2020 through End of PHE:** Cigna will waive member cost sharing for diagnostic testing and office visits/telehealth visits related to assessment and administration of diagnostic testing.
Medica	**Effective March 1st, 2020 through April 30th, 2021:** Medica will waive cost-sharing for in-network telehealth visits when related to administration of a COVID-19 test.
Medicare	**Effective March 18th, 2020-End of PHE**: Medicare will waive cost sharing for COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in a specified set of HCPCS E/M codes
Medicaid	**Duration of COVID-19 PHE:** First Health Colorado will waive COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test
UHC	**Duration of COVID-19 PHE:** UHC is waiving cost sharing for COVID-19-related covered visits (Colorado specific)

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RURAL HEALTH CLINICS (RHC)
FEDERALY QUALIFIED HEALTH CLINICS (FQHC)

MEDICARE

On March 27th, 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law. As part of the CARES Act, Congress has authorized RHCs to be a “distant site” for telehealth visits, therefore allowing RHC practitioners to provide telehealth services.

Allowable Telehealth Codes: During the COVID-19 PHE, providers can provide any telehealth service that is approved as a Medicare telehealth service under the Medicare Professional Fee Schedule (PFS) (see the Medicare Allowable Telehealth Code Table in the Medicare section).

Billing:

- **HCPCS**: G2025
- **Modifier**: Modifier 95 may be appended but is not required.
- **COIVD-19 Related Care**: Append modifier CS

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”.

Cost Share Waiver: Effective through the end of the COVID-19 PHE, Medicare is waiving cost sharing for specified categories of E/M services if they result in an order for or an administration of a COVID-19 test and relate to the furnishing or administration of such test or to the evaluation of an individual for purposes of determining the need for such test.

- Must waive collection of co-insurance from beneficiaries.
- Apply CS modifier to the service item.

Preventative Services: If an RHC/FQHC performs a preventive service via telehealth that is traditionally subject to a cost share waiver, then the RHC/FQHC should apply a CS modifier to HCPCS G2025, even though the service is unrelated to COVID-19.

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 2022 the rate is $97.24.

Mental Health Services:

- As of January 1st, 2022, CMS will continue to allow mental health telehealth services, performed by an RHC/FQHC even after the PHE ends
- 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.

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- Providers must document the decision

Telephone Services: During the COVID-19 PHE, 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: Medicare will allow RHC/FQHCs to 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.

Reimbursment: Set at the average of the national non-facility PFS payment rates for the 5 E-visits and Virtual Check-In codes. For 2022 the rate is $23.88.

- **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.

MEDICAID

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.

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Allowable Services:

- **Services billed with POS 02 or 10**: Allowable code set below
- **Well Child Checks**: Effective November 12, 2020, Health First Colorado will allow well-child check-up visits with procedure codes 99382, 99383, 99384, 99392, 99393, 99394 to be performed via telemedicine for children between the ages of 2 and 18.
  - Providers are encouraged to complete the physical the next time the member is seen in person.
  - Fee for Service Providers:
    - If physical examination is performed within 4 months of the telemedicine well-child check-up, void the previously paid claim with the POS 02 or 10 and resubmit for payment of the well-child check-up using the date of service of the physical examination.
  - FQHC/RHCs and IHS/Tribal 638 Providers:
    - Do not void a previous encounter when a physical examination is performed within 4 months of the telemedicine well-child check-up.
    - Indicate the well-child check-up was provided through telemedicine through GT modifier.

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.

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.

COVID Flexibilities: Through End of PHE:

- Telemedicine visits will qualify as billable encounters for FQHCs, RHCs, and HIS'.
- Services allowed under telemedicine may be provided via telephone, live chat, or interactive audiovisual modality for these provider types.
- Expanded list of providers eligible to deliver telemedicine services to include physical therapists, occupational therapists, hospice, home health providers and pediatric behavioral health providers.
  - Home Health Agency services and therapies, Hospice, and Pediatric Behavioral Treatment may be provided via telephone-only.
  - Outpatient Physical, Occupational, and Speech Therapy services must have an interactive audio/visual connection with the member to be provided via telemedicine.

HIPAA Compliant Platform: During the PHE, telehealth visits can be performed via non-compliant HIPAA platforms, such as FaceTime, Facebook Messenger, Skype, Google Hangouts and WhatsApp. After the PHE ends, visits must be performed over a HIPAA compliant platform.

Modifiers/POS:

- **Professional (1500) claims**: POS 02 or 10
  - **Modifiers** FQ and FR
    FQ: The service was furnished using audio-only communication technology.

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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.

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: COVID-19: Services allowed under telemedicine may be provided via telephone, live chat, or interactive audiovisual modality for these provider types.

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									
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99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
92507	97532	76801	76802	76805	76810	76811	76812	76813	76814
76815	76816	76817	96116						

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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												

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The following list is a summary of telehealth services that some payors are allowing – see payor's allowable telehealth code list in the payor's section.

- **Professional Fees** such as emergency department visits, initial and subsequent observation and observation discharge day management, initial and subsequent hospital care and hospital discharge day management, critical care services, initial and continuing intensive care services, etc.
- **Diabetes management training** (individual & group) and **individual medical nutritional** (initial and subsequent) are allowed by most payors. CMS, along with many other payors, considers Registered Dietitians and Nutritional Professionals as eligible telehealth clinicians.
- **Facility Fees**: If the patient is not coming into the hospital, you cannot bill your normal facility fee, except for Medicare.
    - Effective April 30th, 2020, Medicare is allowing hospitals to 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.

Commercial Billing:

- **Professional (1500 Form)**: Utilize POS and modifiers as notated in each payor section.
- **Facility (UB Form):** Utilize modifiers, revenue codes, and/or condition codes as notated in each payor section.

Medicare Billing:

- **Professional Services**:
    - **PPS Professional Fees (1500 Form)**: When a physician or nonphysician practitioner who typically furnishes professional services in a hospital outpatient department furnishes telehealth services during the COVID-19 PHE, including when the patient is at home, then bill with a hospital outpatient POS with modifier 95. The physician is paid under the physician fee schedule (PFS) at the facility rate.
    - **Method II CAH (UB Form)**: Utilize modifier GT when a physician performs services within the hospital outpatient department.

- **Facility (UB Form):** CMS-5531-IFC specifically outlines appropriate billing for hospitals during the COVID-19 pandemic.
    - **CAHs:** The extraordinary circumstances policy in CMS-5531-IFC only applies to PPS hospitals and to services paid on OPPS. **It does not apply to CAHs**.
        - **CAH PT/OT/ST:** Append modifier 95 if therapy services are provided via telehealth.

    - **PPS Hospitals:**
        - Hospital OP services reimbursed at the OPPS rate (i.e. diabetic management services, behavioral health, etc.), have the following choices:
            - Utilize the extraordinary circumstances policy, appending a PO modifier reimbursed at the OPPS rate.
            - Not utilize the extraordinary circumstances policy appending a PN modifier and DR condition code which is reimbursed a using the Physician Fee Schedule (PFS).

          For details on the requirements to utilize either option, including notification requirements to CMS, see the following link: https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

            - **Medicare FAQ:**
              Question: *When hospital clinical staff furnish a service using telecommunication technology*
              to the patient who is a registered outpatient of the hospital and the hospital makes the patient's home provider-based to the hospital as a temporary expansion site, should the hospital bill using the telehealth modifier (modifier 95)?
              Answer: *No. In this situation the hospital is furnishing an outpatient hospital service, not a telehealth service, to a patient in a temporarily relocated department of the hospital as*

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discussed at 85 FR 27560. Accordingly, the hospital would bill as it ordinarily would bill and would include the DR condition code or CR condition code (as applicable) on the claim. If the situation involves a relocation of an on-campus or excepted off-campus provider-based department to an off-campus hospital location, the hospital would bill using the PO modifier (service provided at an excepted off-campus provider-based department) only if the hospital requests an extraordinary circumstances relocation request within 120 days of the date the temporary expansion site is made provider-based to the hospital; otherwise, the hospital would append the PN modifier (service provided at a non-excepted off-campus
https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

- OP services already paid on the PFS (i.e. OT, PT, Speech), are billed on a UB with modifier 95 for services on the telehealth list. If the telehealth service performed is NOT on the telehealth list, the PN or PO modifier will apply.

    - **Medicare FAQ:**
      Question: *How do hospitals bill for outpatient therapy services furnished by employed or contracted therapists using telecommunications technology on the UB-04 claim form during the COVID-19 PHE?*
      Answer: *There are two options available to hospitals and their therapists.*

      1.) A hospital could choose to bill for services furnished by employed/contracted PTs, OTs, or SLPs through telehealth, meaning that they would identify furnished services on the telehealth list (https://www.cms.gov/Medicare/Medicare GeneralInformation/Telehealth/Telehealth-Codes), they would bill these services on a UB-04 with a "-95" modifier on each line for which the service was delivered via telehealth. No POS code is required (and there is no location for it on the UB-04).

      2.) A hospital could, instead, use the flexibilities available under the Hospital Without Walls initiative. The hospital would register the patient as a hospital outpatient, where the patient's home acts as a provider-based department of the hospital. The hospital's employed/contracted PT, OT, SLP would furnish the therapy care that the hospital believed could be furnished safely and effectively through telecommunications technology. The hospital is not limited to services included on the telehealth list (since these would not be considered telehealth services), but must ensure the care can be fully furnished remotely using telecommunications technology. The hospital would bill as if the therapy had been furnished in the hospital and the applicable PO/PN modifier would apply for the patient's home since it would be serving as an off-campus department of the hospital. The option to bill for telehealth services, along with the -95 modifier, furnished by employed/contracted PTs, OTs, and SLPs using applicable audio-visual telecommunications technology applies to the following types of hospitals and institutions: Hospital – 12X or 13X (for hospital outpatient therapy services); Skilled Nursing Facility (SNF) – 22X or 23X (SNFs may, in some circumstances, furnish Part B PT/ OT/ SLP services to their own long-term residents); Critical Access Hospital (CAH) – 85X (CAHs may separately provide and bill for PT,OT, and SLP services on 85X bill type); Comprehensive Outpatient Rehabilitation Facility (CORF) – 75X (CORFs provide ambulatory outpatient PT, OT, SLP services); Outpatient Rehabilitation Facility (ORF) – 74X (ORFs, also known as rehabilitation agencies, provide ambulatory outpatient PT and SLP, as well as OT services); and Home Health Agency (HHA) – 34X (agencies may separately provide and bill for outpatient PT/OT/SLP services to persons in their homes only if such patients are not under a home health plan of care)
      https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

- **Originating Site**: During the COVID-19 PHE, if the beneficiary's home or temporary expansion site is considered to be a provider-based department of the hospital, and the beneficiary is registered as an outpatient of the hospital for purposes of receiving telehealth services billed by the physician or practitioner, the hospital may bill under the PFS for the originating site facility fee associated with the telehealth service

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PT/OT/ST

Virtual visits for physical therapy, occupational therapy, and speech therapy have been a point of confusion for many hospitals and stand-alone therapists. The two main points of confusion are:

1.) If physical, occupational, and speech therapists are considered by the payor a provider qualified to perform telehealth services.
2.) If hospital-based physical, occupational, and speech therapists that bill for services on a UB-04 under the hospital NPI can perform virtual visits.

See the below matrix to determine what virtual visit codes therapists can bill. Telephone codes are not represented within the below matrix, as most payors have determined that PT/OT/ST services must be furnished via an audiovisual connection.

Note-Since most major payors allow for PT/OT/ST codes to be performed utilizing telehealth, our recommendation would be to utilize those codes where possible over the E-Visit codes due to reimbursement variances.

Payor	Telehealth Codes	E-Visits
Aetna	**ALLOWABLE**	**1500 FORM-ALLOWABLE** **UB FORM-UNCLEAR**
Anthem BCBS	**ALLOWABLE**	**CONDITIONAL** Check contracted fee schedule to see if E-Visit codes are allowable
Cigna	**CONDITIONAL** **Allowable on 1500 form only**	**NOT ALLOWABLE**
Medica	**ALLOWABLE**	**1500 FORM-ALLOWABLE** **UB FORM-UNCLEAR**
Medicare	**ALLOWABLE**	**1500 FORM-ALLOWABLE** **UB FORM-UNCLEAR**
Medicaid	**ALLOWABLE**	**NOT ALLOWABLE**
UHC	**ALLOWABLE**	**1500 FORM-ALLOWABLE** . **UB FORM-NOT ALLOWABLE** .

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HIPAA COMPLIANT SOFTWARE

The Office of Civil Rights (OCR) has issued the below statement, and therefore Medicare and most other payors are allowing non-HIPAA compliant software to be used for virtual visits. However, some payors have still not waived this as requirement for payment. Refer to the HIPAA compliant statement within each payor section, or if the payor is not listed within this guide, reach out to the payor to verify their telehealth platform requirements.

Please note that public facing platforms are NOT allowed, such as Facebook Live, TikTok, Snapchat, etc.

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, to protect the privacy and security of protected health information, namely the HIPAA Privacy, Security and Breach Notification Rules (the HIPAA Rules).

During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules.

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

REFERENCES & RESOURCES

Aetna:

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

https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/Notifications/R31_Virtual_Care.pdf

CMS:

https://www.cms.gov/newsroom/press-releases/president-trump-expands-telehealth-benefits-medicare-beneficiaries-during-covid-19-outbreak

https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

https://www.cms.gov/files/document/03052020-medicare-covid-19-fact-sheet.pdf

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

https://www.cms.gov/index.php/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

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https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers
https://www.cms.gov/files/document/covid-final-ifc.pdf
https://www.cms.gov/files/document/se20016.pdf
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se
https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf
https://www.cms.gov/files/document/se20011.pdf
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:

https://narhc.org/
https://www.web.narhc.org/News/28271/CARES-Act-Signed-Into-Law

UHC:

https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19.html
https://www.uhc.com/health-and-wellness/health-topics/covid-19
https://www.uhcprovider.com/en/resource-library/news/provider-telehealth-policies.html
https://www.uhcprovider.com/content/provider/en/viewer.html?file=https%3A%2F%2Fwww.uhcprovider.com%2Fcontent%2Fdam%2Fprovider%2Fdocs%2Fpublic%2Fpolicies%2Fcomm-reimbursement%2FCOMM-Telehealth-and-Telemedicine-Policy.pdf
https://www.uhcprovider.com/content/dam/provider/docs/public/resources/news/2020/covid19/telehealth-provisions-west.pdf

Other:

https://www.ahip.org/covid-19-coverage-frequently-asked-questions/

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