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Prepared for:
Southwest Telehealth Resource Center

COVID-19 Virtual Visit & Reimbursement Guide Nevada

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Definition: There are three types of telehealth services:

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

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

CPT/HCPCS Codes:

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

Place of Service Codes

POS 02: Telehealth Provided Other than in Patient's Home*

- The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.

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

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

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

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

Reporting Criteria:

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

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

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

CPT/HCPCS Codes:

Reportable by a Qualified Healthcare Professionals:

- **99421:** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes.
- **99422:** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes.
- **99423:** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

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

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

Reporting Criteria:

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

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

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

CPT/HCPCS Codes:

- **G2012:** Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- **G2010:** Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
- **G2250:** Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.
- **G2251:** Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion.
- **G2252:** Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
- **G0071:** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only.

Reporting Criteria:

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

Documentation Requirements:

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

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

CPT/HCPCS Codes:

Reportable by Qualified Healthcare Professionals:

- **99441:** Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- **99442:** 11-20 minutes of medical discussion.
- **99443:** 21-30 minutes of medical discussion.

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

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

Reporting Criteria:

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

Documentation Requirements:

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

PAYOR MATRIX

PAYOR	E-VISIT	SYNCHRONOUS 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: Appropriate Code From Provider's Fee Schedule Professional: POS 02 or 10 w/ modifier 93, 95, GT, GQ Facility: Modifier GT, 93, or 95	NOT ALLOWABLE	NOT ALLOWABLE
UHC COMMERCIAL	ALLOWABLE 99421-99423 98970 -98972	ALLOWABLE Allowable Codes: Telehealth Eligible Code Professional: 02 or 10	ALLOWABLE G2010 G2012 G2250-G2252	ALLOWABLE 99441-99443

PAYOR GUIDELINES

FEDERAL COVID-19 PHE

Numerous flexibilities listed in the below payor sections, as noted, will end when the COVID Federal PHE Ends. The official end of the COVID-19 PHE will occur May 11th, 2023.

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

*Allowable during the COVID-19 PHE

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.

Cost Share Waiver:

- **Effective March 6th, 2020 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	99418
90838	90954	90968	96040	98962	99215	99255	99407	G0108	G0427	G0508	G0445	G0437	G0316
90839	90957	90969	96116	99201	99241	99307	G0436	G0109	G0438	G0509	G0514	G0296	G0317
G0318	G3002	G3003	96105	97750	C7900	C7901	C7902						
Commercial Codes Effective March 6th, 2020-End of PHE													
G0410	92002	96170	97164	99217	99235	99307	99344	99476	G0408	G2010	90839	96121	96161
G2061	92012	96171	97165	99218	99236	99308	99345	99477	G0425	G2012	90840	96127	96164
G2062	92065	97110	97166	99219	99238	99309	99347	99478	G0426	G2086	90845	96130	96165
G2063	92526	97112	97167	99220	99239	99310	99348	99479	G0427	G2087	90846	96131	96167
H0015	92601	97116	97168	99221	99281	99315	99349	99480	G0442	G2088	90847	96132	96168
H0035	92602	97150	97530	99222	99282	99316	99350	99483	G0443	97085	90853	96133	97535
H2012	92603	97151	97542	99223	99283	99327	99421	G0108	G0444	90791	90863	96136	97802
H2036	92604	97153	S9443	99224	99284	99328	99422	G0109	G0445	90792	92507	96137	97803
S9480	92606	97155	97755	99225	99285	99334	99423	G0270	G0446	90832	92508	96138	97804
77427	92609	97156	97760	99226	99291	99335	99468	G0296	G0447	90833	92521	96139	G0270
90953	94664	97157	97761	99231	99292	99336	99469	G0396	G0459	90834	92522	96156	98966
90956	96110	97161	98970	99232	99304	99337	99471	G0397	G0506	90836	92523	96158	98967
90959	96112	97162	98971	99233	99305	99341	99472	G0406	G0513	90837	92524	96159	98968
90962	96113	97163	98972	99234	99306	99343	99475	G0407	G0514	90838	96116	96160	99451
99354	99355	99356	99357	99406	99407	G0436	G0437	99441	99442	99443	99446	99447	99448
99449	99497	99498	99452	H0038	G0422	G0423	G0424	99342	90875	93750	93798	95970	95791
95972	95983	95984	90849	96125	97129	97130	92228	94625	94626	96105	96125	97129	97130
92556	92557	92563	92565	92567	92568	92570	92587	92607	92608	92609	92610	92625	92626
92627	90901	97763											

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



Payor Specific Key Points

E-Visits/Telephone/Virtual Check-In:

Allowable Codes:

- **E-Visits:** Check fee schedule
- **Telephone:** 99441-99443, 98966-98968
- **Virtual Check-In:** Check fee schedule

Telehealth:

Allowable Services:

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

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

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

HIPAA Compliant Platform: Required

Modifiers/POS:

- **Professional (1500) Claims:** POS 02 or 10 with modifier 95, GT, FQ, 93
- **Facility (UB) Claims:**
Rendered At Distant Site: Appropriate revenue code for the service rendered with modifier 95 or GT
Rendered at Originating Site: POS for provider rendering in-person services to the member and originating site
HCPCS
- **COVID-19 Related:** Append the CS modifier to line items in which COVID-19 evaluation or testing services were 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.

Cost Share Waiver:

- 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-April 11th, 2023: Anthem will waive cost sharing for telephonic-only in-network visits.

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 Medical:

Allowable Services: See below table for allowable medical telehealth codes.

All of the following must also be met:

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

Excluded Services:

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

Telehealth Behavioral Health:

Allowable Services: See below table for allowable medical telehealth codes.

All of the following must also be met:

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

Excluded Services:

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

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

Modifiers/POS:

- **Professional/1500 Claims:**
 - **During the COVID PHE:** POS for in person visit and modifier 95, GT, or GQ
 - **After COVID PHE:** POS 02 and modifier 95, GT, or GQ, 93 or FQ
 - **Do not bill POS 10 until further notice**
- **Facility/UB Claims:** Modifier 95
 - During the COVID-19 PHE, Cigna will temporarily reimburse virtual care services billed on a UB, 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 MEDICAL ELIGIBLE VIRTUAL CODES												
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962	90963
90964	90965	90966	90967	90968	90969	90970	92507	92508	92521	92522	92523	92524
92601	92602	92603	92604	96040	96112	96113	96116	96156	96158	96159	96160	96161
96164	96165	96167	96168	97110	97112	97161	97162	97163	97164	97165	97166	97167
97168	97530	97755	97760	97761	97802	97803	97804	92202	92203	99204	99205	99211
99212	99213	99214	99215	99406	99407	99408	99409	99441	99442	99443	99495	99496
99497	99498	G0108	G0151	G0152	G0153	G0155	G0157	G0158	G0270	G0296	G0299	G0300
G0396	G0397	G0438	G0439	G0442	G0443	G0444	G0445	G0446	G0447	G0493	G0513	G0514
G2012	S9123	S9128	S9129	S9131	S9152	99446	99447	99448	99449	99451	99452	99091
99453	99454	99457	99458	99473	99474	G2010	S9110					

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

CIGNA BEHAVIORAL HEALTH ELIGIBLE VIRTUAL CODES												
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845	0846
90847	90849	90853	90863	90875	90876	90880	96110	96127	916156	96158	96159	96164
96165	96167	96168	96170	96171	97151	97152	97153	97154	97155	97156	97157	97158
99058	99078	99202	99203	99204	99205	99211	99212	99213	99214	99215	99217	99218
99219	99220	99221	99222	99223	99224	99225	99226	99231	99232	99233	99234	99235
99236	99238	99239	99281	99282	99283	99284	99285	99304	99305	99306	99307	99308
99309	99310	99315	99316	99318	99324	99325	99326	99327	99328	99334	99335	99336

99337	99354	99335	99336	99337	93354	99355	99356	99357	99404	99408	99409	99415
99416	99417	99441	99442	99443	99446	99447	99448	99449	99456	994484	99495	99496
0591T	0592T	G0410	H0015	H0035	H0038	H2011	S0201	S9480				

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 or to the evaluation of an individual for purposes of determining the need for such a test.

MEDICA

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

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

E-Visit Exclusions:

- See below “Telehealth Coverage Limitations”

Telehealth:

Medica’s emergency telehealth policy is set to end when the COVID-19 PHE ends

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

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

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

Cost Share Waiver:



MEDICARE

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

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

Modifiers:

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

New patients allowable for COVID-19 PHE

Telehealth:

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

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

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

- Temporary telehealth code coverage will be removed once the PHE expires +151 days
- Category 3 codes will be available through the end of 2023
- **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:**
 - **During PHE:** POS that would have been used if the visit were provided in person with modifier 95
 - **After PHE:** POS 02 or 10
 - **Modifier:** FR if applicable
- **Mental Health Claims: After PHE Ends:** POS 02 or 10 and modifier 93 if performed over audio only
 - **RHC/FQHC:** Modifier FQ
 - MACs have instructed providers not to use modifier FQ, 93, or 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 During PHE:** 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: Through December 31st, 2024, Medicare will pay for office, hospital, and other visits furnished via telehealth across the country, whether urban or rural, and in all settings, including in patients' homes.

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

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

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

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

Removal of Frequency Limitations on Medicare Telehealth: During the PHE, 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.

- Telephone Codes only available for use through December 31st, 2024
- Effective April 1st, 2022: Audio only mental health telehealth will be permanently reimbursable if:
 - The provider has the technical capability, at the time of the service, to use an interactive telecommunications system

- The patient is incapable of, or fails to consent to, the use of video technology for the service
- The beneficiary is located at his or her home
- The practitioner documents the reason for using audio-only technology uses the appropriate service level modifier

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.

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).

2023 MEDICARE ELEGIBLE TELEHEALTH CODES											
2023 Telehealth Codes											
0362T	90956	92508	92602	95970	96139	97153	97760	99223	99308	99471	G0318
0373T	90957	92521	92603	95971	96156	97154	97761	99231	99309	99472	G0396
77427	90958	92522	92604	95972	96158	97155	97763	99232	99310	99473	G0397
90785	90959	92523	92607	95983	96159	97156	97802	99233	99315	99475	G0406
90791	90960	92524	92608	95984	96160	97157	97803	99234	99316	99476	G0407
90792	90961	92526	92609	96105	96161	97158	97804	99235	99341	99477	G0408
90832	90962	92550	92610	96110	96164	97161	98960	99236	99342	99478	G0410
90833	90963	92552	92625	96112	96165	97162	98961	99238	99344	99479	G0420
90834	90964	92553	92626	96113	96167	97163	98962	99239	99345	99480	G0421
90836	90965	92555	92627	96116	96168	97164	99202	99281	99347	99483	G0422
90837	90966	92556	93750	96121	96170	97165	99203	99282	99348	99495	G0423
90838	90967	92557	93797	96125	96171	97166	99204	99283	99349	99496	G0425
90839	90968	92563	93798	96127	97110	97167	99205	99284	99350	99497	G0426
90840	90969	92565	94002	96130	97112	97168	99211	99285	99406	99498	G0427
90845	90970	92567	94003	96131	97116	97530	99212	99291	99407	G0108	G0438
90846	92002	92568	94004	96132	97129	97535	99213	99292	99441	G0109	G0439
90847	92004	92570	94005	96133	97130	97537	99214	99304	99442	G0270	G0442
90853	92012	92587	94625	96136	97150	97542	99215	99305	99443	G0296	G0443
90954	92014	92588	94626	96137	97151	97750	99221	99306	99468	G0316	G0444
90955	92507	92601	94664	96138	97152	97755	99222	99307	99469	G0317	G0445
G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211
G2212	G3002	G3003	G9685	S9152							



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

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits:** Not Allowable
- **Telephone:** Not Allowable
 - During the COVID-19 PHE, the telephonic restriction is lifted temporarily. Utilize the CPT that would have been utilized if visit was performed in person.
- **Virtual Check-In:** Not Allowable

Telehealth:

Telehealth Definition: DHCFP defines telehealth as the delivery of service from a provider of health care to a patient at a different location through the use of telecommunication technologies, not including facsimile or electronic mail.

Allowable Services: Any service within the scope of practice of the rendering provider and is clinically appropriate may be provided via telehealth.

Asynchronous Telehealth DHCFP reimburses for services delivered via asynchronous telehealth, however, these services are not eligible for originating site facility fees.

Allowable Services Through The COVID-19 PHE: The below services are allowable during the COVID-19 PHE. Services must be within scope of practice and be appropriate to be delivered via a telehealth platform. Additionally, Providers are required to maintain visual sight of the recipient while providing services.

- Physical therapy/occupational therapy/speech therapy (PT/OT/ST)
- Applied Behavior Analysis (ABA):
 - One-on-one Adaptive Behavior Treatment
 - Supervision, assessments and parent training
- Group therapy
 - Restrictions are still in effect for Private Duty Nursing (PDN), Day and Residential Habilitation, Adult Day Health and Home Health.
- Psychosocial Rehabilitation (PSR) for individuals under the age of 18 These services are prior authorized and require existing treatment plans and established provider relationships.
- Initial and recertification assessments to determine patients' homebound status remotely or by record review for home health agencies
- Initial and recertification assessments for hospice agencies
- DME equipment evaluation, setup, and use training, that not multifaceted or complex, can be performed via telehealth while ensuring damage, warranty negotiation, and safety is not a risk.

Non-Covered Services:

- Telephone calls, images transmitted via facsimile machines (faxes); text messages; and e-mail.
- The following services must be provided in-person and are not considered appropriate services to be provided via telehealth:
 - Basic Skills Training and Psychosocial Rehabilitation services, whether authorized, provided, and billed as stand-alone services or as components of Intensive Outpatient Program, Partial Hospitalization, and Day Treatment must be provided in person.
 - Personal care services provided by a Personal Care Attendant (PCA) as identified in provider qualifications found in MSM Chapter 2600, Intermediary Service Organization and MSM Chapter 3500, Personal Care Services.
 - Home Health Services provided by a Registered Nurse (RN), Physical Therapist (PT), Occupational Therapist, Speech Therapist, Respiratory Therapist, Dietician or Home Health Aide as identified in provider qualifications found in MSM Chapter 1400, Home Health Agency (HHA)

- Private Duty Nursing services provided by an RN as identified in provider qualifications found in MSM Chapter 900, Private Duty Nursing

HIPAA Compliant Platform: Required

Modifiers/POS:

- **Professional (1500) claims:** POS 02 or 10 w/ modifier GT, 93, or 95, GQ
- **Facility (UB) claims:** Modifier GT, 93, 95, GQ
- **CAH:** GT modifier

Patient Location: No restrictions in place for patient location

Provider Type: Services provided via telehealth must be clinically appropriate and within the health care professional's scope of practice as established by its licensing agency.

Reimbursement: Services provided via telehealth have parity with in-person health care services.

Video Component: Audio only telehealth for behavioral health delivery is limited to targeted case management and crisis intervention services.

- During the COVID-19 PHE, the telephonic restriction is lifted temporarily.

Transmission & Originating Site Fees: In order to bill the facility fee, an originating site must be enrolled as a Nevada Medicaid provider. A provider is not eligible for payment as both the originating and distant site for the same patient, same date of service.

- **Eligible Sites:** Office of Provider, Critical Access Hospital, Rural Health Clinic, Federally Qualified Health Center, Hospital, End Stage Renal Disease (ESRD) facility, Skilled Nursing Facility (SNF), Community Mental Health Centers, Indian Health Services/Tribal Organization/Urban Indian Organization, School-Based Health Center, Schools family Planning Clinics, Public Health Clinics, Comprehensive Inpatient Rehabilitation Facilities, Special Children's Clinics, Community Health Clinics, Human Immunodeficiency Virus (HIV) Clinics, Therapy offices, Chiropractic offices, Emergency Medical Services (EMS) performing Community Paramedicine Services
- Providers that bill per diem or encounter rates may bill an encounter rate in lieu of the originating site fee. Per diem or encounter-based providers would not bill HCPCS code Q3014 and an encounter code, as the facility fee is already included in the per diem/encounter rates. If the telecommunication system used is a recipient's smart phone or home computer, the facility fee may not be billed.

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

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

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

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

Remote Patient Monitoring Codes:

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

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

Interprofessional Assessment Codes:

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

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

Telehealth:

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

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

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

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

Cost Share Waiver:

Duration of COVID-19 PHE: UHC 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



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

Current cost share waivers:

Payor	Cost Sharing Guidelines
Aetna	Effective March 6th, 2020, 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-January 11th, 2023, 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. Cigna will also waive member cost sharing for all virtual screening telephone consults (regardless of DX).
Medica	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.
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: 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
UHC	Duration of COVID-19 PHE: UHC 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

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

MEDICARE

Payor Specific Key Points:

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

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

Telehealth:

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

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

Cost Report:

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

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

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.

Billing:

- **HCPCS:** G2025
- **Professional (1500) Claims:**
 - **During PHE:** POS that would have been used if the visit were provided in person with modifier 95
 - **Post PHE:** RHC/FQHC no longer allowed to be originating site
 - **Modifier:** FR if applicable
- **Mental Health Claims: After PHE Ends:** POS 02 or 10 and modifier FQ if performed via audio only
 - MACs have instructed providers not to use modifier FQ, 93, or FR during the PHE
- **During PHE: 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.

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

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

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

Preventative Services: During the PHE, 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 2023 the rate is \$95.88.

Removal of Frequency Limitations on Medicare Telehealth: During the PHE, 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)

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

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

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

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

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

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.

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).

2023 MEDICARE ELEGIBLE TELEHEALTH CODES											
2023 Telehealth Codes											
0362T	90956	92508	92602	95970	96139	97153	97760	99223	99308	99471	G0318
0373T	90957	92521	92603	95971	96156	97154	97761	99231	99309	99472	G0396
77427	90958	92522	92604	95972	96158	97155	97763	99232	99310	99473	G0397
90785	90959	92523	92607	95983	96159	97156	97802	99233	99315	99475	G0406
90791	90960	92524	92608	95984	96160	97157	97803	99234	99316	99476	G0407
90792	90961	92526	92609	96105	96161	97158	97804	99235	99341	99477	G0408
90832	90962	92550	92610	96110	96164	97161	98960	99236	99342	99478	G0410
90833	90963	92552	92625	96112	96165	97162	98961	99238	99344	99479	G0420
90834	90964	92553	92626	96113	96167	97163	98962	99239	99345	99480	G0421



90836	90965	92555	92627	96116	96168	97164	99202	99281	99347	99483	G0422
90837	90966	92556	93750	96121	96170	97165	99203	99282	99348	99495	G0423
90838	90967	92557	93797	96125	96171	97166	99204	99283	99349	99496	G0425
90839	90968	92563	93798	96127	97110	97167	99205	99284	99350	99497	G0426
90840	90969	92565	94002	96130	97112	97168	99211	99285	99406	99498	G0427
90845	90970	92567	94003	96131	97116	97530	99212	99291	99407	G0108	G0438
90846	92002	92568	94004	96132	97129	97535	99213	99292	99441	G0109	G0439
90847	92004	92570	94005	96133	97130	97537	99214	99304	99442	G0270	G0442
90853	92012	92587	94625	96136	97150	97542	99215	99305	99443	G0296	G0443
90954	92014	92588	94626	96137	97151	97750	99221	99306	99468	G0316	G0444
90955	92507	92601	94664	96138	97152	97755	99222	99307	99469	G0317	G0445
G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211
G2212	G3002	G3003	G9685	S9152							

Codes Highlighted in **Green**-Can Be Performed via an Audio only

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

MEDICAID

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits:** Not Allowable
- **Telephone:** Not Allowable
 - During the COVID-19 PHE, the telephonic restriction is lifted temporarily. Utilize the CPT that would have been utilized if visit was performed in person.
- **Virtual Check-In:** Not Allowable

Telehealth:

Telehealth Definition: DHCFP defines telehealth as the delivery of service from a provider of health care to a patient

at a different location through the use of telecommunication technologies, not including facsimile or electronic mail.

Allowable Services: Any service within the scope of practice of the rendering provider and is clinically appropriate may be provided via telehealth.

Asynchronous Telehealth DHCFP reimburses for services delivered via asynchronous telehealth, however, these services are not eligible for originating site facility fees.

Allowable Services Through The COVID-19 PHE: The below services are allowable during the COVID-19 PHE. Services must be within scope of practice and be appropriate to be delivered via a telehealth platform. Additionally, Providers are required to maintain visual sight of the recipient while providing services.

- Physical therapy/occupational therapy/speech therapy (PT/OT/ST)
- Applied Behavior Analysis (ABA):
 - One-on-one Adaptive Behavior Treatment
 - Supervision, assessments and parent training
- Group therapy
 - Restrictions are still in effect for Private Duty Nursing (PDN), Day and Residential Habilitation, Adult Day Health and Home Health.
- Psychosocial Rehabilitation (PSR) for individuals under the age of 18 These services are prior authorized and require existing treatment plans and established provider relationships.
- Initial and recertification assessments to determine patients' homebound status remotely or by record review for home health agencies
- Initial and recertification assessments for hospice agencies
- DME equipment evaluation, setup, and use training, that not multifaceted or complex, can be performed via telehealth while ensuring damage, warranty negation, and safety is not a risk.

Non-Covered Services:

- Telephone calls, images transmitted via facsimile machines (faxes); text messages; and e-mail.
- The following services must be provided in-person and are not considered appropriate services to be provided via telehealth:
 - Basic Skills Training and Psychosocial Rehabilitation services, whether authorized, provided, and billed as stand-alone services or as components of Intensive Outpatient Program, Partial Hospitalization, and Day Treatment must be provided in person.
 - Personal care services provided by a Personal Care Attendant (PCA) as identified in provider qualifications found in MSM Chapter 2600, Intermediary Service Organization and MSM Chapter 3500, Personal Care Services.
 - Home Health Services provided by a Registered Nurse (RN), Physical Therapist (PT), Occupational Therapist, Speech Therapist, Respiratory Therapist, Dietician or Home Health Aide as identified in provider qualifications found in MSM Chapter 1400, Home Health Agency (HHA)
 - Private Duty Nursing services provided by an RN as identified in provider qualifications found in MSM Chapter 900, Private Duty Nursing

HIPAA Compliant Platform: Required

Modifiers/POS:

- **Professional (1500) claims:** POS 02 or 10 w/ modifier GT, 93, or 95, GQ
- **Facility (UB) claims:** Modifier GT, 93, 95, GQ
- **CAH:** GT modifier

Patient Location: No restrictions in place for patient location

Provider Type: Services provided via telehealth must be clinically appropriate and within the health care professional's scope of practice as established by its licensing agency.

Reimbursement: Services provided via telehealth have parity with in-person health care services.

Video Component: Audio only telehealth for behavioral health delivery is limited to targeted case management and crisis intervention services.

- During the COVID-19 PHE, the telephonic restriction is lifted temporarily.

Transmission & Originating Site Fees: In order to bill the facility fee, an originating site must be enrolled as a Nevada Medicaid provider. A provider is not eligible for payment as both the originating and distant site for the same patient, same date of service.

- Eligible Sites: Office of Provider, Critical Access Hospital, Rural Health Clinic, Federally Qualified Health Center, Hospital, End Stage Renal Disease (ESRD) facility, Skilled Nursing Facility (SNF), Community Mental Health Centers, Indian Health Services/Tribal Organization/Urban Indian Organization, School-Based Health Center, Schools family Planning Clinics, Public Health Clinics, Comprehensive Inpatient Rehabilitation Facilities, Special Children's Clinics, Community Health Clinics, Human Immunodeficiency Virus (HIV) Clinics, Therapy offices, Chiropractic offices, Emergency Medical Services (EMS) performing Community Paramedicine Services
- Providers that bill per diem or encounter rates may bill an encounter rate in lieu of the originating site fee. Per diem or encounter-based providers would not bill HCPCS code Q3014 and an encounter code, as the facility fee is already included in the per diem/encounter rates. If the telecommunication system used is a recipient's smart phone or home computer, the facility fee may not be billed.

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

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 OPSS. **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 OPSS 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 OPSS rate.
 - Not utilize the extraordinary circumstances policy appending a PN modifier and DR condition code which is reimbursed 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-medicare-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 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/MedicareGeneralInformation/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

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 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
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

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/nevada/article/information-from-anthem-for-care-providers-about-covid-19-updated-march-19-2020>

<https://providernews.anthem.com/nevada/article/information-from-anthem-for-care-providers-that-perform-aba-services-during-covid-19-10>

<https://providernews.anthem.com/nevada/article/reimbursement-policy-update-virtual-visits-professional-and-facility-10>

<https://www.anthem.com/docs/public/inline/C-08002.pdf>

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/TelehealthSrvcsfctsh.pdf>

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

<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-education/outreachffsprovpartprogprovider-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>
[1#:~:text=In%20the%20CY%202021%20PFS%20proposed%20rule%2C%20CMS%20proposed%20to,ends%20or%20December%202021%2C%202021.](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%202021%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>

Nevada Medicaid:

https://www.medicaid.nv.gov/Downloads/provider/NV_Billing_Telehealth.pdf
<https://dhcfp.nv.gov/covid19/>
https://dhcfp.nv.gov/uploadedFiles/dhcfpnhgov/content/Resources/AdminSupport/Manuals/MSM/C3400/MSM_3400_17_07_27.pdf

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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