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Prepared for:
Southwest Telehealth Resource Center

Virtual Visit & Reimbursement Guide

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Definition:

There are two 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.

CPT/HCPCS Codes:

Synchronous Audio/Video CPT Codes:

- **98000:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
- **98001:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98002:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
- **98003:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded
- **98004:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded
- **98005:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
- **98006:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98007:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded

Other CPT/HCPCS are often eligible to be reported via synchronous audio/video telehealth (refer to payor guidelines section for specific code sets)

Synchronous Audio-Only CPT Codes:

- **98008:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
- **98009:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98010:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
- **98011:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of

medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded

- **98012:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded
- **98013:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
- **98014:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98015:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded

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

- 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

Modifiers

Synchronous Telehealth Modifiers:

- **95**: synchronous telemedicine service rendered via real-time Interactive audio and video telecommunications system
- **GT**: Via interactive audio and video telecommunication systems
- **G0**: Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke
- **FQ**: The service was furnished using audio-only communication technology.
- **93**: Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system

Asynchronous Telehealth Modifier:

- **GQ**: Via an asynchronous telecommunications system

Reporting Criteria:

- Must be initiated by the patient
- Communication must be a direct interaction between the patient and the healthcare professional
- HIPAA compliant platform must be utilized

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, and the length of the call. Obtain 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**: Nonphysician qualified healthcare professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- **G2062/98971**: Nonphysician qualified healthcare professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
- **G2063/98972**: Nonphysician qualified healthcare professional online digital assessment and management, for an established patient, for up to 7 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
- 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:

- **98016**: Brief communication technology-based service (eg, 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 evaluation and management service provided within the previous 7 days nor leading to an evaluation and management 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
- 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 assessment and management service provided by a nonphysician qualified health care professional via audio telecommunication

CPT/HCPCS Codes:

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

Reporting Criteria:

- Call must be initiated by the patient
- 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
- The patient must be established

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 consent at the start of the visit and ensure the consent is documented. Maintain a permanent record of the telehealth visit in the patient's medical record.

PAYOR MATRIX

PAYOR	E-VISIT	TELEHEALTH-AUDIO/VIDEO	TELEHEALTH-AUDIO ONLY	VIRTUAL CHECK-IN
AETNA	CONDITIONAL Check Contracted Fee Schedule	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: GT, 95, FR	ALLOWABLE Allowable Codes: Audio Only Telehealth Eligible Code POS: 02 or 10 Modifier: 93, FQ	CONDITIONAL Check Contracted Fee Schedule
BCBS	CONDITIONAL Check Contracted Fee Schedule	ALLOWABLE Allowable Codes: Fee Schedule Codes POS: 02 or 10 Modifier: 95, GT	ALLOWABLE Allowable Codes: Fee Schedule Codes POS: 02 or 10 Modifier: 93, FQ	CONDITIONAL Check Contracted Fee Schedule
CIGNA	NOT ALLOWABLE	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 Modifier: 95, GT	ALLOWABLE Allowable Codes: CPT 98008-98015 POS: 02 Modifier: Not Required	ALLOWABLE 98016
MEDICA	ALLOWABLE 99421-99423 98970 -98972 G2061-G2063	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: GT, 95	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: 93, FQ	ALLOWABLE G2010 98016
MEDICARE	ALLOWABLE 99421-99423 G2061-G2063 RHC: G0071	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: Hospital Based Provider-95 Method II: Modifier GT RHC: G2025	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: 93 Method II: Modifier GT RHC: G2025	ALLOWABLE 98016 G2010 G2250-G2252
MEDICAID	NOT ALLOWABLE	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: FR,95 GT for Specific Providers Listed	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: FQ, 93 GT for Specific Providers Listed	NOT ALLOWABLE
UHC COMMERCIAL	ALLOWABLE 99421-99423 98970 -98972	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: 95 or GT	ALLOWABLE Allowable Codes: Audio Only Telehealth Eligible Code POS: 02 or 10 Modifier: 93	ALLOWABLE 98016 G2010 G2250-G2252

Payor Specific Key Points

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: Check Contracted Fee Schedule
- **Virtual Check-Ins**: Check Contracted Fee Schedule

Remote Patient Monitoring:

Allowable Codes:

- 98975, 98976, 98977, 98978, 98980, 98981, 99453, 99454, 99457, 99458

Interprofessional Codes:

Allowable Codes:

- 99446-99449, 99451, 99452, G9037, G0546-G0551

Modifier:

- No telehealth modifier required

Telehealth:

Allowable Services:

See table below for allowable code set

Audio Only Services:

Designated codes, highlighted in blue in the below “Telehealth Allowable Codes” matrix, can be performed via an audio only connection

Modifiers/POS:

- **POS** 02 or 10
- **Modifiers**
  - **Audio-Visual:** GT, 95, FR
  - **Audio-Only**: 93, FQ
  - **Asynchronous:** GQ

Direct Patient Contact:

Unless listed as a covered service, medical services that do not include direct in-person patient contact are not payable

Not Reimbursable:.

- Care Plan Oversight
- Concierge Medicine (boutique medicine)
- Missed appointments

Reimbursement: Per

CO Revised Statutes 10-16-123(2)(b)(I) subject to all terms and conditions of the health benefit plan or dental plan, a carrier shall reimburse the treating participating provider or the consulting participating provider for the diagnosis, consultation, or treatment of the covered person delivered through telehealth on the same basis that the carrier is responsible for reimbursing that provider for the provision of the same service through in-person consultation or contact by that provider

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.

Reference:

- Telemedicine and Direct Patient Contact Payment Policy available on Availity
- Colorado Revised Statues 10-16-123 (2)(b)(II)

AETNA ELIGIBLE TELEHEALTH CODES													
Telehealth Allowable Codes													
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845	90846	90847
90849	90853	90863	90951	90952	90954	90955	90957	90958	90960	90961	90963	90964	90965
90966	90967	90968	90969	90970	92227	92228	92507	92508	92521	92522	92523	92524	92526
92601	92602	92603	92604	93228	93229	93268	93270	93271	93272	94664	96041	96105	96110
96112	96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138	96139
96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171	97110	97112	97116
97129	97130	97151	97153	97155	97156	97157	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	99231	99232	99233	99252	99253	99254
99255	99307	99308	99309	99310	99406	99407	99408	99409	99417	99418	99446	99447	99448
99449	99451	99452	99483	99495	99496	99497	99498	C7900	C7901	C7902	G0108	G0109	G0270
G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0425	G0426	G0427	G0438
G0439	G0442	G0443	G0444	G0445	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087
G2088	G2212	G3002	G3003	H0015	H0035	H0038	H2012	H2036	S9443	S9480	97152	97154	97158
97542	98000	98001	98002	98003	98004	98005	98006	98007					
Cells Highlighted in Yellow do **NOT** Require a Modifier Codes in Blue are Allowable via an audio only connection													

Payor Specific Key Points

E-Visits/Virtual Check-In:

Allowable Codes:

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

Remote Patient Monitoring

Allowable Codes:

- Remote patient monitoring codes on contracted fee schedule

Modifiers/POS:

- Place of service or revenue code appropriate to the location of the billing provider
- No modifier required

Telehealth:

Allowable Services:

Medically necessary professional and facility virtual visits are allowed with the appropriate CPT/HCPCS, available on the provider's contracted fee schedule, with the applicable POS and/or modifier

- Anthem notes an Administrative Policy: Allowed Virtual Services (Telehealth/Telemedicine) as a related policy, however this policy is not found on Athem.com
- Colorado allows for facility virtual visits for non-behavioral health, and audio only services

Audio-Only:

Audio only telehealth allowed billed with modifier 93 or FQ

Modifiers/POS:

- **POS** 02 or 10
- **Modifier** 95, GT, G0, 93, FQ, GQ
- **Revenue Code (Facility):** Appropriate revenue code for the service rendered

Non-Covered Services:

- Non-direct patient services
- 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
- PT/OT/ST services provided without live audio and visual communication

Patient Location:

Patient may be located at any originating location, including their home

Provider Type:

Licensed healthcare professional

Reimbursement:

Per CO Revised Statutes 10-16-123(2)(b)(I) subject to all terms and conditions of the health benefit plan or dental plan, a carrier shall reimburse the treating participating provider or the consulting participating provider for the diagnosis, consultation, or treatment of the covered person delivered through telehealth on the same basis that the carrier is responsible for reimbursing that provider for the provision of the same service through in-person consultation or contact by that provider

Transmission & Originating Site Fees:

Originating site fee, Q3014, allowed when patient presents to an eligible healthcare facility. Transmission fees not allowable.

Reference:

- Anthem Commercial Telehealth Reimbursement Policy
- Colorado Revised Statues 10-16-123 (2)(b)(II)

Payor Specific Key Points

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits:** Not Allowable
- **Virtual Check-Ins:** 98016

Interprofessional Consultations:

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

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

Remote Patient Monitoring:

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

- **Allowable codes:** 99091, 99453, 99454, 99457, 99458, 99473, 99474, G0322
- Detailed Medical Policy for Conditions Allowed via RPM

Telehealth Medical:

Allowable Services:

See below table for allowable medical telehealth codes

Audio Only:

An audiovisual connection is required, except for audio-only telehealth E/M CPT 98008-98015

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
  - Exception for CPT 98008-98015
- The patient or involved caregiver must be present on the receiving end and the service must occur in real time
- All technology used must be secure and meet or exceed federal and state privacy requirements
- A permanent record of online communications relevant to the ongoing medical care and follow-up is maintained as part of the record as if the service were provided as an in-office visit
- The permanent record must include documentation which identifies the virtual service delivery method. i.e.: audio/video or telephone only
- All services provided are medically appropriate and necessary
- The evaluation and management services (E/M) provided virtually must meet E/M criteria
- The patient's clinical condition is of low to moderate complexity, and while it may be an urgent encounter, it should not be an emergent clinical condition
- Virtual care services must be provided by a health care professional who is licensed, registered, or otherwise acting within the scope of his/her licensure.

Excluded Services:

- The virtual care service occurs on the same day as a face to face visit, when performed by the same provider and for the same condition.
- Transmission of digitalized data is considered integral to the procedure performed and is not separately reimbursable.
- Virtual care services billed within the post-operative period of a previously surgical procedure will be considered part of the global payment for the procedure.
- Services were performed via asynchronous communications systems (e.g., fax).

- Store and forward telecommunication, whether an appropriate virtual care modifier is appended to the procedure code or not.
- Patient communications are incidental to E/M services, counseling, or medical services, including, but not limited to reporting of test results and provision of educational materials.
- Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.
- No reimbursement will be made for any equipment used for virtual care communications.

Telehealth Behavioral Health:

Allowable Services:

See below table for allowable medical telehealth codes.

All of the following must also be met:

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

Excluded Services:

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

Modifiers/POS:

- **POS** 02
  - Do not bill POS 10 until further notice
- **Modifier** 95, GT, GQ, 93 or FQ

Provider Type:

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

Reimbursement: Per CO Revised Statutes 10-16-123(2)(b)(I) subject to all terms and conditions of the health benefit plan or dental plan, a carrier shall reimburse the treating participating provider or the consulting participating provider for the diagnosis, consultation, or treatment of the covered person delivered through telehealth on the same basis that the carrier is responsible for reimbursing that provider for the provision of the same service through in-person consultation or contact by that provider

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.

References:

- Reimbursement Policy- Virtual Care and Remote Patient Monitoring
- Colorado Revised Statues 10-16-123 (2)(b)(II)

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	99404	99411	99412	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
98016	S9123	S9128	S9129	S9131	S9152	99446	99447	99448	99449	99451	99452	99091
99453	99454	99457	99458	99473	99474	99381	99382	99833	99384	99385	99386	99387
99391	99392	99393	99394	99395	99396	99397	99401	99402	99403	98000	98001	98002
98003	98004	98005	98006	98007	98008	98009	98010	98011	98012	98013	98014	98015

NON-REIMBURSABLE CODES REGARDLESS OF MODIFIER												
98966	98967	98968	98970	98971	98972	99421	99422	99423	G0406	G0407	G0408	G0425
G0426	G0427	G0459	G0508	G0509	G2025	Q3014	S0320	T1014				

CIGNA BEHAVIORAL HEALTH ELIGIBLE VIRTUAL CODES												
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845	90846
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	H2011	S0201	S9480	99446	99447	99448	99449	99456	994484	99495	99496
0591T	0592T	G0410	H0015	H0035	H0038							

Payor Specific Key Points:

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 99421-99423, 98970-98972, G2061-G2063
- **Virtual Check-In:** G2010, 98016

Telehealth:

Synchronous Telehealth Allowable Codes:
See table below for specific codes.

- **Wellness Visits:** Medica will temporarily allow preventive care services, CPT 99381-99387 and 99391-99397, to be provided via telehealth services. Providers may perform all, or portions of, a preventive medicine visit that can be done so appropriately via telehealth services. Services that require face-to-face interaction may be provided later, however, providers may only bill one preventive medicine code to cover both the portion done via telehealth and any necessary face-to-face interaction associated with the preventive care service.
- **Behavioral Health:** Allowable services:
  - Services recognized by the Centers for Medicare and Medicaid Services (CMS), and
  - Services recognized by the American Medical Association (AMA) included in Appendix P of the CPT code set, and
  - Additional services identified by Optum behavioral health that can be effectively performed via Telehealth

Store and Forward Telehealth:
Medica allows asynchronous (store and forward) telehealth. Utilize modifier GQ. Medical information may include without limitation: video clips, still images, X-rays, MRIs, EKGs, laboratory results, audio clips and text. The physician at the distant site reviews the case without the member being present. Store and Forward substitutes for an interactive encounter with the member present (i.e., the member is not present in real-time).

Modifiers/POS:

- **POS** 02 or 10
- **Modifier** 95, 93, FQ, G0, GQ, or GT

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:
Per CO Revised Statutes 10-16-123(2)(b)(I) subject to all terms and conditions of the health benefit plan or dental plan, a carrier shall reimburse the treating participating provider or the consulting participating provider for the diagnosis, consultation, or treatment of the covered person delivered through telehealth on the same basis that the carrier is responsible for reimbursing that provider for the provision of the same service through in-person consultation or contact by that provider

Originating Sites:
The following are examples of originating sites: Community mental health center, Critical-access hospital (CAH), End stage renal disease (ESRD) facilities, Home, Hospital (inpatient or outpatient), Hospital or CAH-based renal dialysis center (including satellites), Office of physician or practitioner, Other eligible medical facilities, Other locations as required by applicable state law, Residential substance abuse treatment facility, Rural health clinic (RHC) and federally qualified health center (FQHC), Skilled nursing facility (SNF)

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.

Coverage Limitations:
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

Audio Only:
Interactive audio and video communications that permit real-time communication between the distant site physician or practitioner and the member. The services must be of sufficient audio and visual fidelity with clarity and function equivalent to a face-to-face encounter

References:

- Reimbursement Policy: Telehealth excluding Minnesota Health Care Program (MHCP) Members
- Reimbursement Policy: Telephone and Virtual Care Services
- Colorado Revised Statues 10-16-123 (2)(b)(II)

MEDICA ALLOWABLE TELEHEALTH CODES											
0362T	0373T	77427	90785*	90791*	90792*	90832*	90833*	90834*	90836*	90837*	90838*
90839*	90840*	90845*	90846*	90847*	90853*	90901	90951	90952	90953	90954	90955
90956	90957	90958	90959	90960	9061	90962	90963	90964	90965	90966	90967
90968	90969	90970	92002	92004	92012	92014	92507*	92521*	92522*	92523*	92524*
92526	92550	92552	92553	92555	92556	92557	92563	92565	92567	92568	92570
92587	92588	92601	92602	92603	92604	92607	92608	92609	92610	92625	92626
92627	93750	93797	93798	94002	94003	94004	94625	94626	94464	95970	95971
95972	95983	95984	96105	96112	96113	96116*	96121*	96125	96127*	96130*	96131*
96132*	96133*	96136*	96137*	96138*	96139*	96156*	96158*	96159*	96160*	96161*	96164*
96165*	96167*	96168*	97110	97112	97116	97129	97130	97150	97151	97152	97153
97154	97155	97156	97157	97158	97161	97162	97163	97164	97165	97166	97167
97168	97530	97535*	97537	97542	97750	97755	97760	97761	97763	97802*	97803*
97804*	98966*	98967*	98968*	99202	99203	99204	99205	99211	99212	99213	99214
99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238	99239
99281	99284	99285	99291	9992	99304	99305	99306	99307	99308	99309	99310
99315	99316	99341	99342	99344	99345	99347	99348	99349	99350	99406*	99407*
G9685	G3003	G3002	99468	99469	99471	99472	99473	99475	99476	99477	99478
99479	99480	99483	99495	99496	99497*	99498*	G0108*	G0109*	G0270*	G0296*	G0317
G0318	G0396*	G0397*	G0406*	G0407*	G0408*	G0420*	G0421*	G0422	G0423	G0425*	G0426*
G0427*	G0438*	G0439*	G0442*	G0443*	G0444*	G0445*	G0446*	G0447*	G0459*	G0447*	G0459*
G0506*	G0508	G0509	G0513*	G0514*	G2086*	G2087*	G2088*	G2212*			
Codes With An * Can Be Performed via an Audio only (Telephone) or Audiovisual Connection											

MEDICA BEHAVIORAL HEALTH TELEHEALTH CODES											
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90480	90845
90846	90847	90853	99202	99203	99204	99205	99211	992212	99213	99214	99215
Covered Telehealth Services CPT Codes listed above are not intended as an exhaustive list of all relevant codes											

Payor Specific Key Points:

E-Visits/ Virtual Check Ins:

Allowable Codes:

- **E-Visits:** 99421-99423, G2061-G2063
- **Virtual Check-In**: G2010, 98016, G2250-G2252

Modifiers: None

Telehealth:

Full Year Continuing Appropriations and Extensions Act, 2025:
Extends certain telehealth flexibilities for Medicare patients through September 30th, 2025:

- Originating Site & Geographic Restriction waived
- Allows any health care provider who is eligible to bill Medicare for covered services to continue to provide and bill for telehealth services
- In person requirement for mental health services via telehealth waived
- 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

- For CY 2025, CMS will continue to allow the suspension of frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations

Audio Only:
Effective January 1, 2025, an interactive telecommunications system may include two-way, real-time, audio-only communication technology for any Medicare telehealth service furnished to a beneficiary in their home, if the distant site physician or practitioner is technically capable of using an interactive telecommunications system, but the patient is not capable of, or does not consent to, the use of video technology

Consent:
Providers may get patient consent at the same time they initially provide the services. Direct supervision isn't required to get consent. In general, auxiliary personnel under general supervision of the billing practitioner can get patient consent for these services.

***Hospital Based Providers*:**
Hospitals and other providers of PT, OT, SLP, diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services can continue to bill for telehealth services through September 30th, 2025

- For outpatient hospitals, patients' homes no longer need to be registered as provider-based entities to allow for hospitals to bill for these services
- The 95 modifier is required on claims from all providers, except for Critical Access Hospitals (CAHs) electing Method II (which utilize a GT modifier)

Modifiers/POS:

- **POS:**
  - 02 or 10
- **Modifier:**
  - Modifier 95 when the clinician is in the hospital and the patient is in the home, as well as for outpatient therapy services provided via telehealth by qualified PTs, OTs, or SLPs through September 30th, 2025
  - Modifier GT for CAH Method II (UB) Claims

Patient Location:
Through September 30th, 2025, there is no originating site or geographic restriction

Mental Health Place of Service:
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 the decision in the patient's medical record
- Through September 30th 2025, the initial 6 month visit requirement and the in person visit every 12 month requirement, is waived

Provider Type:
Allowable telehealth providers are physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals

- Through September 30th, 2025, any health care provider who is eligible to bill Medicare for covered services can provide and bill for telehealth services

Provider Location:
Through CY 2025, CMS will continue to permit distant site practitioners to use their currently enrolled practice locations instead of their home addresses when providing telehealth services from their home

Reimbursement:
When telehealth services are provided to people in their homes (POS 10), the service will be reimbursed at the non-facility rate. However, if the telehealth service is provided when the patient is not in their home, and POS 02 is utilized, then the service will be reimbursed at the facility rate.

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

Supervision:
Effective January 1st, 2025 CMS will permanently adopt a definition of direct supervision that allows the supervising physician or practitioner to provide such supervision via a virtual presence through real-time audio and visual interactive telecommunications.

The supervising physician or practitioner may provide virtual direct supervision:

- For services furnished incident to a physician or other practitioner's professional service, when provided by auxiliary personnel employed by the billing physician or supervising practitioner and working under their direct supervision, and for which the underlying HCPCS code has been assigned a PC/TC indicator of "5" and services described by CPT code 99211
- For office or other outpatient visits for the evaluation and management of an established patient who may not require the presence of a physician or other qualified health care professional

For all other services furnished incident to that require the direct supervision of the physician or other supervising practitioner, CMS will continue to permit direct supervision be provided through real-time audio and visual interactive telecommunications technology through December 31, 2025

Teaching Physicians:
CMS will allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings, but only in clinical instances when the service is furnished virtually (for example, a three-way telehealth visit, with the patient, resident, and teaching physician in separate locations) through December 31, 2025

- Virtual presence will continue to meet the requirement that the teaching physician be present for the key portion of the service

Transmission/ Originating Site Fees:
Medicare will reimburse an originating site fee (HCPCS Q3014) if the patient is present at a healthcare facility. Medicare does not reimburse for transmission fees.

- Modifier 95 not required when billing Q3014

Reference:

- MLN Matters-Telehealth Services
- SE22001 Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers
- H.R.1968 - Full-Year Continuing Appropriations and Extensions Act, 2025
- Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule
- CMS List of Telehealth Services

MEDICARE ELIGIBLE TELEHEALTH CODES											
2025 Telehealth Codes											
0362T	0373T	0591T	0592T	0593T	77427	90785	90791	90792	90832	90833	90834
90836	90837	90838	90839	90840	90845	90846	90847	90853	90875	90901	90951
90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962	90963
90964	90965	90966	90967	90968	90969	90970	92002	92004	92012	92014	92507
92508	92521	92522	92523	92524	92526	92550	92552	92553	92555	92556	92557
92563	92565	92567	92568	92570	92587	92588	92601	92602	92603	92604	92607
92608	92609	92610	92625	92626	92627	93750	93797	93798	94002	94003	94004
94005	94625	94626	94664	95970	95971	95972	95983	95984	96105	96110	96112
96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138
96139	96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171
97110	97112	97116	97129	97130	97150	97151	97152	97153	97154	97155	97156
97157	97158	97161	97162	97163	97164	97165	97166	97167	97168	97530	97535
97537	97542	97750	97755	97760	97761	97763	97802	97803	97804	98960	98961
98962	98966	98967	98968	99202	99203	99204	99205	99211	99212	99213	99214
99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238	99239
99281	99282	99283	99284	99285	99291	99292	99304	99305	99306	99307	99308
99309	99310	99315	99316	99341	99342	99344	99345	99347	99348	99349	99350
99406	99407	97550	97551	97552	99468	99469	99471	99472	99473	99475	99476
99477	99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0136
G0270	G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0420
G0421	G0422	G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445
G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211
G2212	G3002	G3003	G9685	96202	96203	G0011	G00113	G0539	G0540	G0541	G0542
G0543	G0560										

Payor Specific Key Points:

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: Not Allowable
- **Virtual Check-In**: Not Allowable

Interprofessional Consults (eConsults):

Definition:

An eConsult is defined as an asynchronous dialogue initiated by a Treating Practitioner seeking a Consulting Practitioner's expert opinion without a face-to-face member encounter with the Consulting Practitioner.

- Treating Practitioner is defined as a member's treating physician or other qualified health care practitioner who is a primary care provider contracted with a Regional Accountable Entity to participate in the Accountable Care Collaborative as a Network Provider
- Consulting Practitioner is defined as a provider who has education, training, or qualifications in a specialty field other than primary care.

Providers can utilize the Department's eConsult platform, Colorado Medicaid eConsult, or a third-party eConsult platform that meets the Department's criteria.

Approved Third Pary eConsult Platform Criteria:

Platform must be capable of maintaining documentation that the eConsult is directly relevant to the individual patient's diagnosis and treatment, and the consulting practitioner has specialized expertise in the particular health concerns of the patient.

1. Platform must be capable of identifying the Colorado Medicaid enrollment status of providers using the platform. All providers must be licensed in the state of Colorado.
2. Platform meets all state and federal privacy laws regarding the exchange of patient information
3. Platform must be capable of providing sufficient documentation for the treating and consulting provider to demonstrate that the consultation was provided for the direct benefit of the member
4. Platform must provide the treating and consulting practitioner with the information necessary to file a claim including date of service; name of recipient; Medicaid identification number; name of provider agency or person providing the service; nature, extent, or units of service; and the place of service

Allowable Codes

Treating practitioners can bill this service using Procedure Code 99452

- The date of service for 99452 should be the date the eConsult was completed
- Treating practitioners use 99452 to report an eConsult outside of an evaluation and management service. An eConsult completed on the same date of service as an office visit is considered part of the evaluation and management service and will not be reimbursed separately.
- Services must meet the procedural definition and components, including time requirements, of the CPT code as defined by the AMA in addition to requirements listed here.

Consulting practitioners can bill this service using Procedure Code 99451

Reimbursement:

Treating Practitioner Reimbursement:

- All practitioners rendering services should submit claims for completed eConsults for fee-for-service reimbursement.

Consulting Practitioner Reimbursement:

- Consulting practitioners who use the Department's eConsult platform will be paid by Safety Net Connect's subcontractor, ConferMED.
- Consulting practitioners who use an approved eConsult platform should submit claims for completed eConsults to the Colorado interChange for fee-for-service reimbursement.

Telehealth:

Allowable Services

See allowable code set below

Services may be rendered via telemedicine when the service is:

- A covered Health First Colorado benefit,
- Within the scope and training of an enrolled provider's license, and
- Appropriate to be rendered via telemedicine

Telehealth Delivery Arrangements

Health First Colorado defines telemedicine as services provided under either of the below arrangements:

- A member receives services via a live audio/visual connection from a single provider
- A member and a provider are physically in the same location and additional services are provided by a second (distant) provider via a live audio/visual connection.
    - The provider who is present with the member is called the originating provider
    - The provider located at a different site is called the distant provider

Telehealth Requirements

- Providers may only bill procedure codes which they are already eligible to bill
- Services must meet the same standard of care as in-person care
- For initial visits, providers must comply with the requirements posted under Waiving the Face-to-Face Requirement & Required Disclosure Statements
    - For each subsequent visit, providers must document the member's consent, either verbal or written, to receive telemedicine services
- Providers must document the member's consent, either verbal or written
- Contact with the provider must be initiated by the member
- Does not alter the scope of practice of any health care provider, nor does it authorize the delivery of services in a setting or manner not otherwise authorized by law
- Services not otherwise covered by Health First Colorado are not covered when delivered via telemedicine
- The use of telemedicine does not change prior authorization requirements

Telehealth Confidentiality

Transmissions must be performed on dedicated secure lines or must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver. Providers of telemedicine services must implement confidentiality procedures that include, but are not limited to:

- Specifying the individuals who have access to electronic records
- Using unique passwords or identifiers for each employee or other person with access to the member records
- Ensuring a system to routinely track and permanently record such electronic medical information
- Advising members of their right to privacy and that their selection of a location to receive telemedicine services in private or public environments is at the member's discretion

Non-Covered Services

- Services not otherwise covered by Health First Colorado are not covered when delivered via telemedicine
- Consultations provided by telephone (interactive audio), email or facsimile machines
- Provider education via telemedicine
- Use of equipment for delivery of services does not change prior authorization requirements established for the services being provided

Face to Face Requirement

The Health First Colorado requirement for an initial face-to-face contact between provider and member may be waived when treating the member through telemedicine

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

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

Modifier/POS:

- **POS** 02 or 10
    - When the patient is located in a hospital, use the appropriate place of service code for where the patient is located.
- **Modifiers** FQ, FR, 93, 95

  The following providers may use modifier GT: physician, clinic, osteopath, FQHC, doctorate psychologist, MA psychologist, physician assistant, nurse practitioner, RHC

Patient Location

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

Provider Type

Telemedicine services will only be reimbursed for providers who are enrolled in Health First Colorado at the time of service.

Primary Care Provider:

- A primary care provider can be reimbursed as the "originating provider" for any eligible Telemedicine Services where the member is present with the provider at the "originating site."
- In order for a primary care provider to be reimbursed for Telemedicine Services as the "distant provider" the primary care provider must be able to facilitate an in-person visit in the state of Colorado if necessary for treatment of the member's condition.

Specialty Care Provider:

- A medical specialist provider can be reimbursed as the "originating provider" for any Telemedicine Services where the member is present with the provider at the "originating site."
- A medical specialist provider can be reimbursed as the "distant provider."

Other Providers:

- Physical therapists, occupational therapists, hospice, home health providers and pediatric behavioral health providers are eligible to deliver telemedicine services.
    - Home Health Agency services and therapies, Hospice, and Pediatric Behavioral Treatment may be provided via any telemedicine modality
    - Outpatient Physical, Occupational, and Speech Therapy services must have an interactive audio/visual connection with the member to be provided via telemedicine.
- Telemedicine is covered for behavioral health providers under the capitated behavioral health benefit administered by the Regional Accountable Entities (RAEs). Behavioral health providers should contact their RAE for guidance.

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

Audio Only Services
An audio/visual connection is required, except for telephone E/M codes

Originating Site:
The originating site (originating provider) is where the member is located. For an allowable provider type to bill for the originating site facility fee, the member and provider must be physically present in the same location.

The following provider types may bill procedure code Q3014 (telemedicine originating site facility fee): physician, clinic, osteopath, FQHC, doctrate psychologist, MA psychologist, physician assistant, nurse practitioner, RHC

If practitioners at both the originating site and the distant site provide the same service to the member, both providers submit claims using the same procedure code with modifier 77 (Repeat procedure by another physician).

In some cases, the originating provider site will not be providing clinical services, but only providing a site and telecommunications equipment. In this situation, the telemedicine originating site facility fee is billed using procedure code Q3014.

Originating providers bill as follows:

- If the originating provider is making a room and telecommunications equipment available but is not providing clinical services, the originating provider bills Q3014
- If the originating provider also provides clinical services to the member, the provider bills the rendering provider's appropriate procedure code and bills Q3014
- The originating provider may also bill, as appropriate, on the UB-04 paper claim form or as an 837I transaction for any clinical services provided on-site on the same day that a telemedicine originating site claim is made. The originating provider must submit two separate claims for the member's two separate services.

Transmission Fees
The procedure codes code the below matrix, when billed with modifier GT by appropriate providers, pay the telemedicine transmission fee (an additional $5.00 to the fee listed in the most recent Health First Colorado Fee Schedule). Any other procedure codes billed with modifier GT will not pay the telemedicine transmission fee.

References:
Colorado Department of Healthcare Policy Telemedicine Billing Manual

MEDICAID ELIGIBLE TELEHEALTH CODES												
76801	76802	76805	76811	76812	76813	76814	76815	76816	76817	90791	90792	90832
90833	9083	90836	90837	90838	90839	90840	90846	90847	90849	90853	90863	92507
92508	92521	92522	92523	92524	92526	92606	92607	92608	92609	92610	92630	92633
96040	96101	96102	96110	96111	96112	96113	96116	96118	96119	96121	96125	96130
96131	96132	96133	96136	96137	96138	96139	96146	97110	97112	97129	97130	97140
97150	97151	97153	97154	97155	97158	97161	97162	97163	97164	97165	97166	97167
97168	97530	97533	97535	97537	97542	97755	97760	97761	97763	97802	97803	97804
98966	98967	98968	99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
99382	99383	99384	99392	99393	99394	99401	99402	99403	99404	99406	99407	99408
99409	99417	99411	99442	99443	G0108	G0109	G8431	G8510	G9006	H0001	H0002	H0004
H0006	H0025	H0031	H0032	H0049	H1005	H2000	H2011	H2015	H2016	S9445	S9485	T1017
V5011	S9443											
Allowed for Outpatient Hospital Telemedicine Billing												

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

Payor Specific Key Points:

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 98970-98972, 99421-99423
- **Virtual Check-In**: 98016, G2010, G2250-G2252

POS/Modifier:

POS utilized if visit would have in person and no modifier

Remote Patient Monitoring Codes:

Allowable Codes:

- 98975-98978, 98980-98981, 99091, 99457, 99458, 99473-99474

POS/Modifier:

POS utilized if visit would have in person and no modifier

Interprofessional Assessment Codes:

Allowable Codes:

- 99446-99449, 99451-99454, G9037, G0546-G0551

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
- Consistent with CMS, UHC will not recognize CPT 98000-98015, as they are assigned to status code “I” on the NPFS Relative Value File, indicating another code (replacement code) is used to report the procedure or service and that replacement code has an assigned RVU

Modifiers/POS:

- **POS** 02 or 10
- **Modifiers**
    - **Audio/Video:** 95, GT, GQ, and G0 are not required to identify telehealth services but are accepted as informational if reported on claims
    - **Audio-Only**: 93

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.

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 telepresenter: 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)

Reimbursement:
Per CO Revised Statutes 10-16-123(2)(b)(I) subject to all terms and conditions of the health benefit plan or dental plan, a carrier shall reimburse the treating participating provider or the consulting participating provider for the diagnosis, consultation, or treatment of the covered person delivered through telehealth on the same basis that the carrier is responsible for reimbursing that provider for the provision of the same service through in-person consultation or contact by that provider

Transmission & Originating Site Fees:
UHC will allow the originating site to submit a claim for services of the telepresenter using HCPS Q3014. Note: Telehealth POS codes 02 and 10 do not apply to originating site facilities reporting code Q3014 and POS codes 02 and 10 should not be reported by an originating site facility if code Q3014 is reported. For POS where code Q3014 is reported, report the valid POS code reflecting the location of the patient. T1014 is not eligible for payment, UHC considers these services as incidental to the charges associated with the E/M.

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

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

Reference:
- Reimbursement Policy-Telehealth/Virtual Health Policy, Professional
- Colorado Revised Statues 10-16-123 (2)(b)(II)

UHC ELIGIBLE TELEHEALTH CODES											
0362T	0373T	0591T	0592T	0593T	77427	90785	90791	90792	90832	90833	90834
90836	90837	90838	90839	90840	90845	90846	90847	90853	90863	90875	90901
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962
90963	90964	90965	90966	90967	90968	90969	90970	92002	92004	92012	92014
92227	92228	92507	92508	92521	92522	92523	92524	92526	92550	92552	92553
92555	92556	92557	92563	92565	92567	92568	92570	92587	92588	92601	92602
92603	92604	92607	92608	92609	92610	92625	92626	92627	93228	93229	93268
93270	93271	93272	93750	93797	93798	94002	94003	94004	94005	94625	94626
94664	95970	95971	95972	95983	95984	96105	96110	96112	96113	96116	96121
96125	96127	96130	96131	96132	96133	96136	96137	96138	96139	96156	96158
96159	96160	96161	96164	96165	96167	96168	96170	96171	96202	96203	97110
97112	97129	97130	97150	97151	97152	97153	97154	97155	97156	97157	97158
97161	97162	97163	97164	97165	97166	97167	97168	97530	97535	97537	97542
97550	97551	97552	97750	97755	97760	97761	97763	97802	97803	97804	98960
98961	98962	98966	98967	98968	99202	99203	99204	99205	99211	99212	99213
99214	99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238
99239	99281	99282	99283	99284	99285	99291	99292	99304	99305	99306	99307
99308	99309	99310	99315	99316	99341	99342	99344	99345	99347	99348	99349
99350	99406	99407	99408	99409	99417	99418	99468	99469	99471	99472	99473
99475	99476	99477	99478	99479	99480	99483	99495	99496	99497	99498	G0011

G0013	G0108	G0109	G0136	G0270	G0296	G0316	G0317	G0318	G0396	G0397	G0406
G0407	G0408	G0410	G0420	G0421	G0422	G0423	G0425	G0426	G0427	G0438	G0439
G0442	G0443	G0444	G0445	G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514
G0539	G0540	G0541	G0542	G0543	G0560	G2086	G2087	G2088	G2211	G2212	G3002
G3003	G9685										

PT/OT/ST											
92507	92521	92522	92523	92524	97110	97112	97116	97161	97162	97163	97164
97165	97166	97167	97168	97535	97750	97755	97760	97761			

AUDIO ONLY CODES											
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845
90846	90847	92507	92508	92521	92522	92523	92524	96041	96110	96116	96121
96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171	97802
97803	97804	99406	99407	99408	99409	99497	99498				

Virtual Check Ins/E-Visits:

Virtual Check-Ins & E-Visits:
RHC/FQHCs can perform E-Visits and Virtual Check Ins

- Utilize 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 E-visits and Virtual Check-In codes. For 2025 the rate is set at $13.91
- **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

Care Coordination Services

Effective January 1st, 2025 RHCs and FQHCs will report the individual CPT and HCPCS codes that describe care coordination services instead of the single HCPCS code G0511

- Add on codes associated with these services will also be allowed

CMS is allowing for a transition period of six-months, at least until July 1, 2025, to allow RHCs/FQHCs to update their billing systems

CARE COORDINATION SERVICES- RHC/FQHC											
99425	99426	99427	99437	99439	99453	99454	99457	99458	99474	99484	99487
99489	99490	99491	G0019	G0022	G0023	G0024	G0071	G0140	G0416	G0323	G0511
G0512	G0556	G0557	G0558	G3002	G3003						

Telehealth:

RHC/FQHC Distant Site Provider Extension:
Under the 2025 Medicare Physician Final Rule, RHCs and FQHCs can continue to bill for RHC and FQHC services furnished using telecommunication technology, including services furnished using audio-only communications technology through December 31, 2025

Allowable Codes:
RHCs/FQHCs can perform any service listed in the below telehealth allowable code set matrix, but must bill G2025

Audio Only:
Effective January 1, 2025, an interactive telecommunications system may include two-way, real-time, audio-only communication technology for any Medicare telehealth service furnished to a beneficiary in their home, if the distant site physician or practitioner is technically capable of using an interactive telecommunications system, but the patient is not capable of, or does not consent to, the use of video technology

Billing:

- **HCPCS**: G2025
- **POS:** 02 or 10
- **Modifier:** FQ if provided via audio only
- **Mental Health Claims**: POS 02 or 10 and modifier FQ if performed via audio only

Mental Health Services:

- CMS will permanently allow mental health telehealth services performed by an RHC/FQHC
- The service must be either audio visual OR
- Audio-only if the following are present:
    - The patient is incapable of, or fails to consent to, the use of video technology for the service
    - The provider has conducted an in-person visit within the last 6 months of the initial tele-mental service

- The services are medical necessary
- After the initial telehealth visit, the provider conducts an in-person visit at least once every 12 months of each tele-mental visit.
  - However, if the patient and provider consider the risks of an in person service and agree that these risks outweigh the benefits, then the annual visit may be skipped.
  - Providers must document the decision
- Until January 1st, 2026, the initial 6 month visit and the in person visit every 12 month requirement is waived

Provider Type:

Physicians, Nurse practitioners (NPs), Physician assistants (PAs), Certified nurse-midwives (CNMs), Clinical psychologists (CPs), Clinical social workers (CSWs), Marriage and family therapists (MFTs), Mental health counselors ((MHCs)

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 2025 the rate is $94.45

Supervision:

CMS will continue to allow direct supervision via interactive audio and video telecommunications and to extend the definition of "immediate availability" as including real-time audio and visual interactive telecommunications (excluding audio-only) through December 31, 2025

Transmission/ Originating Site Fees:

Medicare will reimburse an originating site fee (HCPCS Q3014) if the patient is present at a healthcare facility. Medicare does not reimburse for transmission fees.

Reference:

- MLN Matters-Telehealth Services
- SE22001 Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers
- H.R.1968 - Full-Year Continuing Appropriations and Extensions Act, 2025
- Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule
- CMS List of Telehealth Services

MEDICARE ELIGIBLE TELEHEALTH SERVICES											
2025 Telehealth Codes											
0362T	0373T	0591T	0592T	0593T	77427	90785	90791	90792	90832	90833	90834
90836	90837	90838	90839	90840	90845	90846	90847	90853	90875	90901	90951
90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962	90963
90964	90965	90966	90967	90968	90969	90970	92002	92004	92012	92014	92507
92508	92521	92522	92523	92524	92526	92550	92552	92553	92555	92556	92557
92563	92565	92567	92568	92570	92587	92588	92601	92602	92603	92604	92607
92608	92609	92610	92625	92626	92627	93750	93797	93798	94002	94003	94004
94005	94625	94626	94664	95970	95971	95972	95983	95984	96105	96110	96112
96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138
96139	96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171
97110	97112	97116	97129	97130	97150	97151	97152	97153	97154	97155	97156
97157	97158	97161	97162	97163	97164	97165	97166	97167	97168	97530	97535
97537	97542	97750	97755	97760	97761	97763	97802	97803	97804	98960	98961
98962	98966	98967	98968	99202	99203	99204	99205	99211	99212	99213	99214
99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238	99239
99281	99282	99283	99284	99285	99291	99292	99304	99305	99306	99307	99308

99309	99310	99315	99316	99341	99342	99344	99345	99347	99348	99349	99350
99406	99407	97550	97551	97552	99468	99469	99471	99472	99473	99475	99476
99477	99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0136
G0270	G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0420
G0421	G0422	G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445
G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211
G2212	G3002	G3003	G9685	96202	96203	G0011	G00113	G0539	G0540	G0541	G0542
G0543	G0560										

MEDICAID

Payor Specific Key Points:

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: Not Allowable
- **Virtual Check-In**: Not Allowable

Interprofessional Consults (eConsults):

Definition:

An eConsult is defined as an asynchronous dialogue initiated by a Treating Practitioner seeking a Consulting Practitioner's expert opinion without a face-to-face member encounter with the Consulting Practitioner.

- Treating Practitioner is defined as a member's treating physician or other qualified health care practitioner who is a primary care provider contracted with a Regional Accountable Entity to participate in the Accountable Care Collaborative as a Network Provider
- Consulting Practitioner is defined as a provider who has education, training, or qualifications in a specialty field other than primary care.

Providers can utilize the Department's eConsult platform, Colorado Medicaid eConsult, or a third-party eConsult platform that meets the Department's criteria.

Approved Third Pary eConsult Platform Criteria:

Platform must be capable of maintaining documentation that the eConsult is directly relevant to the individual patient's diagnosis and treatment, and the consulting practitioner has specialized expertise in the particular health concerns of the patient.

5. Platform must be capable of identifying the Colorado Medicaid enrollment status of providers using the platform. All providers must be licensed in the state of Colorado.
6. Platform meets all state and federal privacy laws regarding the exchange of patient information
7. Platform must be capable of providing sufficient documentation for the treating and consulting provider to demonstrate that the consultation was provided for the direct benefit of the member
8. Platform must provide the treating and consulting practitioner with the information necessary to file a claim including date of service; name of recipient; Medicaid identification number; name of provider agency or person providing the service; nature, extent, or units of service; and the place of service

Allowable Codes

Treating practitioners can bill this service using Procedure Code 99452

- The date of service for 99452 should be the date the eConsult was completed

- Treating practitioners use 99452 to report an eConsult outside of an evaluation and management service. An eConsult completed on the same date of service as an office visit is considered part of the evaluation and management service and will not be reimbursed separately.
- Services must meet the procedural definition and components, including time requirements, of the CPT code as defined by the AMA in addition to requirements listed here.

Consulting practitioners can bill this service using Procedure Code 99451

Reimbursement:

Treating Practitioner Reimbursement:

- All practitioners rendering services should submit claims for completed eConsults for fee-for-service reimbursement.

Consulting Practitioner Reimbursement:

- Consulting practitioners who use the Department's eConsult platform will be paid by Safety Net Connect's subcontractor, ConferMED.
- Consulting practitioners who use an approved eConsult platform should submit claims for completed eConsults to the Colorado interChange for fee-for-service reimbursement.

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)

eConsult dialogues between Treating Practitioners and Consulting Practitioners do not meet the definition of an FQHC or RHC visit as defined in CCR 8.700. Costs associated with performing eConsults through an FQHC/RHC are considered allowable costs for the cost report and will be included in the calculation of the reimbursement rate for a patient visit at an FQHC/RHC.

Telehealth:

Allowable Services

See allowable code set below

Services may be rendered via telemedicine when the service is:

- A covered Health First Colorado benefit,
- Within the scope and training of an enrolled provider's license, and
- Appropriate to be rendered via telemedicine

Telehealth Delivery Arrangements

Health First Colorado defines telemedicine as services provided under either of the below arrangements:

- A member receives services via a live audio/visual connection from a single provider
- A member and a provider are physically in the same location and additional services are provided by a second (distant) provider via a live audio/visual connection.
    - The provider who is present with the member is called the originating provider
    - The provider located at a different site is called the distant provider

Telehealth Requirements

- Providers may only bill procedure codes which they are already eligible to bill
- Services must meet the same standard of care as in-person care
- For initial visits, providers must comply with the requirements posted under Waiving the Face-to-Face Requirement & Required Disclosure Statements
    - For each subsequent visit, providers must document the member's consent, either verbal or written, to receive telemedicine services
- Providers must document the member's consent, either verbal or written
- Contact with the provider must be initiated by the member
- Does not alter the scope of practice of any health care provider, nor does it authorize the delivery of services in a setting or manner not otherwise authorized by law
- Services not otherwise covered by Health First Colorado are not covered when delivered via telemedicine
- The use of telemedicine does not change prior authorization requirements

Telehealth Confidentiality

Transmissions must be performed on dedicated secure lines or must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver. Providers of telemedicine services must implement confidentiality procedures that include, but are not limited to:

- Specifying the individuals who have access to electronic records
- Using unique passwords or identifiers for each employee or other person with access to the member records
- Ensuring a system to routinely track and permanently record such electronic medical information
- Advising members of their right to privacy and that their selection of a location to receive telemedicine services in private or public environments is at the member's discretion

Non-Covered Services

- Services not otherwise covered by Health First Colorado are not covered when delivered via telemedicine
- Consultations provided by telephone (interactive audio), email or facsimile machines
- Provider education via telemedicine
- Use of equipment for delivery of services does not change prior authorization requirements established for the services being provided

Face to Face Requirement

The Health First Colorado requirement for an initial face-to-face contact between provider and member may be waived when treating the member through telemedicine

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

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

Modifier/POS:

- **POS** 02 or 10
    - When the patient is located in a hospital, use the appropriate place of service code for where the patient is located.
- **Modifiers** FQ, FR, 93, 95

  The following providers may use modifier GT: physician, clinic, osteopath, FQHC, doctorate psychologist, MA psychologist, physician assistant, nurse practitioner, RHC

Patient Location

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

Provider Type

Telemedicine services will only be reimbursed for providers who are enrolled in Health First Colorado at the time of service.

Primary Care Provider:

- A primary care provider can be reimbursed as the "originating provider" for any eligible Telemedicine Services where the member is present with the provider at the "originating site."
- In order for a primary care provider to be reimbursed for Telemedicine Services as the "distant provider" the primary care provider must be able to facilitate an in-person visit in the state of Colorado if necessary for treatment of the member's condition.

Specialty Care Provider:

- A medical specialist provider can be reimbursed as the "originating provider" for any Telemedicine Services where the member is present with the provider at the "originating site."
- A medical specialist provider can be reimbursed as the "distant provider."

Other Providers:

- Physical therapists, occupational therapists, hospice, home health providers and pediatric behavioral health providers are eligible to deliver telemedicine services.
    - Home Health Agency services and therapies, Hospice, and Pediatric Behavioral Treatment may be provided via any telemedicine modality
    - Outpatient Physical, Occupational, and Speech Therapy services must have an interactive audio/visual connection with the member to be provided via telemedicine.
- Telemedicine is covered for behavioral health providers under the capitated behavioral health benefit administered by the Regional Accountable Entities (RAEs). Behavioral health providers should contact their RAE for guidance.

Reimbursement

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

Audio Only Services

An audio/visual connection is required, except for telephone E/M codes

Originating Site:

The originating site (originating provider) is where the member is located. For an allowable provider type to bill for the originating site facility fee, the member and provider must be physically present in the same location.

The following provider types may bill procedure code Q3014 (telemedicine originating site facility fee): physician, clinic, osteopath, FQHC, doctrate psychologist, MA psychologist, physician assistant, nurse practitioner, RHC

If practitioners at both the originating site and the distant site provide the same service to the member, both providers submit claims using the same procedure code with modifier 77 (Repeat procedure by another physician).

In some cases, the originating provider site will not be providing clinical services, but only providing a site and telecommunications equipment. In this situation, the telemedicine originating site facility fee is billed using procedure code Q3014.

Originating providers bill as follows:

- If the originating provider is making a room and telecommunications equipment available but is not providing clinical services, the originating provider bills Q3014
- If the originating provider also provides clinical services to the member, the provider bills the rendering provider's appropriate procedure code and bills Q3014
- The originating provider may also bill, as appropriate, on the UB-04 paper claim form or as an 837I transaction for any clinical services provided on-site on the same day that a telemedicine originating site claim is made. The originating provider must submit two separate claims for the member's two separate services.

Transmission Fees

The procedure codes code the below matrix, when billed with modifier GT by appropriate providers, pay the telemedicine transmission fee (an additional $5.00 to the fee listed in the most recent Health First Colorado Fee Schedule). Any other procedure codes billed with modifier GT will not pay the telemedicine transmission fee.

References:

Colorado Department of Healthcare Policy Telemedicine Billing Manual

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

92508	92521	92522	92523	92524	92526	92606	92607	92608	92609	92610	92630	92633
96040	96101	96102	96110	96111	96112	96113	96116	96118	96119	96121	96125	96130
96131	96132	96133	96136	96137	96138	96139	96146	97110	97112	97129	97130	97140
97150	97151	97153	97154	97155	97158	97161	97162	97163	97164	97165	97166	97167
97168	97530	97533	97535	97537	97542	97755	97760	97761	97763	97802	97803	97804
98966	98967	98968	99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
99382	99383	99384	99392	99393	99394	99401	99402	99403	99404	99406	99407	99408
99409	99417	99411	99442	99443	G0108	G0109	G8431	G8510	G9006	H0001	H0002	H0004
H0006	H0025	H0031	H0032	H0049	H1005	H2000	H2011	H2015	H2016	S9445	S9485	T1017
V5011	S9443											
Allowed for Outpatient Hospital Telemedicine Billing												

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

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