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Virtual Visit Types

**Telehealth**

**Definition:** There are three types of telehealth services:

- **Asynchronous Telehealth (Store & Forward)** is the transfer of digital images, sounds, or previously recorded video from one location to another to allow a consulting practitioner (usually a specialist) to obtain information, analyze it, and report back to the referring practitioner. This is a non-interactive telecommunication because the physician or health care practitioner views the medical information without the patient being present.

- **Synchronous Telehealth** is real-time interactive video teleconferencing that involves communication between the patient and a distant practitioner who is performing the medical service. The practitioner sees the patient throughout the communication, so that two-way communication (sight and sound) can take place.

- **Remote Patient Monitoring** is use of digital technologies to collect health data from individuals in one location and electronically transmit that information to providers in a different location for assessment.

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

**CPT/HCPCS Codes:**

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

**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.

**E-Visits**

**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.

**VIRTUAL CHECK-IN**

**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.

*Disclaimer: Although the data found here has been produced and processed from payer sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability or usefulness of any information.*
• **G0071**: Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only.

**Reporting Criteria:**

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

**Documentation Requirements:**

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

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**TELEPHONE**

**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

<table>
<thead>
<tr>
<th>PAYOR</th>
<th>E-VISIT CODES</th>
<th>TELEHEALTH-NO ORIGINATING SITE RESTRICTION</th>
<th>VIRTUAL CHECK-IN CODES</th>
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Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes:**
  - E-Visits: 99421-99423, 98970-98972, G2061-G2063.
  - Telephone: 99441-99443, 98966-98968
  - Virtual Check-Ins: G2010, G2012
- **Effective Date:** March 6th, 2020-Further Notice
- **Modifier:** None
- **Patient Type:** Established
- **Telephone Reimbursement:** Telephone services (99441-99443) provided March 5th, 2020 through September 30th, 2020 were reimbursed at the same rate as a 99212-99214 E/M office visit (ex. 99441 equaled a 99212 E/M reimbursement). After September 30, 2020, telephone-only services resumed to pre-March 5, 2020 rates.

Telehealth:

- **Allowable Codes:** 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.
- **Effective Date:**
  - Expanded telehealth code set: March 6th, 2020-Further Notice
  - Original telehealth code set: N/A
- **HIPAA Compliant Platform:** 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 for CMS recognized CPTs or modifier 95 for AMA Appendix P.
    - UB: Modifier GT or 95
  - **Medicare Advantage:**
    - 1500: POS that would have been used if the service were performed in person (e.g. POS 11) with modifier 95.
    - UB: Modifier 95
- **Not Reimbursable:**
  - Asynchronous Telemedicine Services (services reported w/ GQ modifier).
  - Services that do not include direct patient contact, such as physician standby services.
- **Provider Type:** Not specified
  - 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.
- **Transmission & Originating Site Fees:** For their commercial product, T1014 and Q3014 are not eligible for payment, Aetna considers these services as incidental to the charges associated with the E/M. For their Medicare Advantage product Aetna will allow an originating site fee (Q3014) as appropriate.
- **Video Component:** The telehealth video component is required, except on codes indicated below that can be provided over audio only.

Cost Share Waiver:

- **Commercial:**
Effective March 6th, 2020 through June 4th, 2020, Aetna will waive member cost sharing for in-network telemedicine visits, regardless of diagnosis.

Effective June 5th, 2020 through January 31st, 2021, Aetna will waive member cost sharing for in-network telemedicine visits for behavioral and mental health counseling services only.

Self-insured plans can opt-out at their discretion.

**Medicare Advantage**

- Effective March 6th, 2020 through May 13th, 2020, Aetna will waive member cost sharing for in-network telemedicine visits, regardless of diagnosis.
- Effective May 13th, 2020 through January 31st, 2021 Aetna will waive member out-of-pocket costs for all in-network primary care and specialist visits, regardless of diagnosis.
- Effective January 31st, 2021 through March 31st, 2021, Aetna will waive member cost sharing for in-network telehealth visits for primary care and behavioral health.
- Effective January 31st, 2021 through End of PHE, Aetna will waive member cost sharing for in-network telehealth visits for primary care visits only.

### AETNA ELIGIBLE TELEHEALTH CODES

<table>
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<tr>
<th>Original Telehealth Allowable Codes</th>
<th>COVID-19 Pandemic Commercial Codes</th>
<th>COVID-19 Pandemic Medicare Advantage Codes</th>
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**Disclaimer:** Although the data found here has been produced and processed from payer sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability or usefulness of any information.
Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes:**
  - E-Visits: Not Allowable
  - Telephone: 99441-99443
  - Virtual Check-Ins: Not Allowable
- **Effective Date:** March 16th, 2020 until Further Notice
- **Modifier:** None
- **Patient Type:** Established

Telehealth:

- **Allowable Codes:** BCBS MS has created two temporary policies, a provider policy and a network hospital policy. The below information applies to BCBS MS fully insured and self-insured members only. See table below for allowable codes.
- **Effective Date:** March 16th, 2020 until Further Notice
- **HIPAA Compliant Platform:** Non-HIPAA compliant, non-public facing software can be utilized for telehealth visits, such as Skype & FaceTime.
- **Modifiers/POS:**
  - Professional (1500) claims: POS 02
  - Network Hospital-Facility (UB) Claims: Modifier 95 or GT
  - Network Hospital-Professional (1500) Claims: POS for In Person Visit & Modifier 95
- **Provider Type:** Allowable provider type is dependent on code, see matrix below.
- **Patient Type:** New and established patients, except for physical and occupational therapy codes, which can only be provided to established patients.
- **Reimbursement:** Reimbursement will be at the same rate as in-person face-to-face visits, refer to your BCBS MS contract for allowable rates.
- **Transmission & Originating Site Fees:** Originating site (HCPCS Q3014) and transmission fees (T1014) are not on the allowable telehealth fee schedule.
- **Video Component:** The video component is waived for select codes only, see matrix below.
  - Initial admission history and physical and hospital discharge are preferred to be performed in person.

Cost Share Waiver:

Effective March 16th, 2020-June 30th, 2020 BCBS MS will waive member cost sharing for telehealth. Effective July 1st, 2020 BCBS MS will apply member cost share to telehealth.

### BCBS MS ALLOWABLE TELEHEALTH CODES

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Disclaimer: Although the data found here has been produced and processed from payer sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability or usefulness of any information.
The below codes may be billed by Network Hospitals

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Codes in Blue Require an Audiovisual Connection
Codes in Green Can be Performed Over a Telephone or Audiovisual Connection.

MISSISSIPPI STATE AND SCHOOL EMPLOYEES’

E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes:**
  - E-Visits: 99421-99423
  - Telephone: 99441-99443
  - Virtual Check-Ins: Not Allowable
- **Effective Date:** March 16th, 2020 until Further Notice
- **Modifier:** None
- **Patient Type:** Established

Telehealth:

- **Allowable Codes:** BCBS MS State and School Employee plans has created two temporary policies, a provider policy and a network hospital policy. The below information applies to BCBS MS Mississippi State and School Employee members only.
- **Effective Date:** March 16th, 2020 until Further Notice
- **HIPAA Compliant Platform:** Non-HIPAA compliant, non-public facing software can be utilized for telehealth visits, such as Skype & FaceTime.
- **Modifiers/POS:**
  - Professional (1500) claims: POS 02
  - Network Hospital-Facility (UB) Claims: Modifier 95 or GT
  - Network Hospital-Professional (1500) Claims: POS for In Person Visit & Modifier 95
- **Provider Type:** Allowable provider type is dependent on code, see matrix below.
- **Patient Type:** New and established patients, except for physical and occupational therapy codes, which can only be provided to established patients.
- **Reimbursement:** Reimbursement will be at the same rate as in-person face-to-face visits, refer to your BCBS MS contract for allowable rates.
- **Transmission & Originating Site Fees:** Originating site (HCPCS Q3014) and transmission fees (T1014) are not on the allowable telehealth fee schedule.
- **Video Component:** The video component is waived for select codes only, see matrix below.
  - Initial admission history and physical and hospital discharge are preferred to be performed in person.

**Cost Share Waiver:**

Effective March 16th, 2020-June 30th, 2020 BCBS MS will waive member cost sharing for allowable telehealth codes shown below, EXCEPT for the network hospital codes. Effective July 1st, 2020 BCBS MS will apply member cost share to telehealth.

Disclaimer: Although the data found here has been produced and processed from payer sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability or usefulness of any information.
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<td>The below codes may be billed by Behavioral Health Providers (Psychiatrists, Psychologists, Licensed Professional Counselors, Licensed Certified Social Workers, and Board Certified Behavioral Analysts)</td>
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<td>The below codes may be billed by Physical and Occupational Therapists</td>
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**Codes in Blue** Require an Audiovisual Connection

**Codes in Green** Can be Performed Over a Telephone or Audiovisual Connection.
Payor Specific Key Points
Effective January 1st, 2021

E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes:**
  - **E-Visits:** Not Allowable
  - **Telephone:** 99441-99443
  - **Virtual Check-Ins:** G2012-reimbursable only through April 20, 2021
- **Effective Date:** Effective January 1st, 2021 Cigna implemented a permanent Virtual Care Policy.
- **Modifier:** None
- **Patient Type:** Established

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
- **Effective Date:** March 2nd, 2020-April 20, 2021
- **Modifier & POS:** No modifier, unless COVID-19 related, then utilize modifier CS. POS used if visit was performed in person.
- **Patient Type:** New or Established
- **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.

Telehealth:

- **Allowable Codes:** See below table for allowable telehealth codes.
  - Cigna will reimburse telehealth when ALL of the following are met:
    - Services must be provided over an interactive audiovisual connection.
      - Services rendered via telephone only are considered interactive and will be reimbursed when the appropriate telephone only code is billed.
    - Service would be reimbursable if the service were provided face-to-face.
    - The patient and/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 of the customer is maintained as part of the customer’s 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 as defined in the 1997 Centers for Medicare and Medicaid Services (CMS) Documentation guidelines for codes outside of the 99202 through 99215 range and the 2021 CPT E/M documentation guidelines outlined by the American Medical Association for codes within the range 99202 through 99215.
    - 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.
- Services must be provided by a health care professional who is licensed, registered, or otherwise acting within the scope of his/her licensure.
- Services must be billed on a 1500 form or electronic equivalent.

**Effective Date:** Effective January 1st, 2021 Cigna implemented a permanent Virtual Care Policy.

**Excluded Services:**
- Service occurs on the same day as a face to face visit, when performed by the same provider and for the same condition.
- Services billed within the post-operative period of a previously completed major or minor surgical procedure will be considered part of the global payment for the procedure and not reimbursed separately.
- Services performed via asynchronous communications systems (e.g., fax).
- Store and forward telecommunication [transferring data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation] whether an appropriate virtual care modifier is appended to the procedure code or not.
- Communications are incidental to E/M services, counseling, or medical services included in this policy, including, but not limited to reporting of test results and provision of educational materials.
- Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.
- Urgent Care centers will not be reimbursed for virtual care under the Cigna’s virtual care policy.

**HIPAA Compliant Platform:** All technology used must be secure and meet or exceed federal and state privacy requirements.
- However, through the PHE (currently set to end April 20th, 2021) providers may use non public facing, non-HIPAA compliant platforms, such as FaceTime, Skype, Zoom, etc.

**Modifiers/POS:**
- **Professional/1500 Claims:** POS that would have been used if the service were performed in person (e.g. POS 11) and modifier 95 or GT.
  - Modifier 95 (Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunication system)
  - Modifier GT (Via interactive audio and video telecommunications systems) should be reported with the applicable procedure code when performing a service virtually to indicate the type of technology used and to differentiate a virtual care encounter from an encounter when the physician and patient are at the same site.
- **Facility/UB Claims:** Services billed on a UB-04 claim will not be reimbursed under Cigna’s virtual care policy. However, Cigna will temporarily reimburse virtual care services billed on a UB-04 through April 20th, 2021 when the service is:
  - Reasonable to be provided in a virtual setting; and
  - Reimbursable per a provider’s contract; and
  - Synchronous audiovisual technology is utilized (except for CPTs 99441-99443)

- **COVID-19 Related Telehealth Care:**
  - Suspected or Likely COVID-19 Exposure: ICD-10 Z03.818, Z20.822 or Z20.828, CS modifier, and GT or 95 modifier.
  - Confirmed COVID-19 Case: ICD-10 U07.1, J12.82, M35.81, M35.89, and GT or 95 modifier

**Patient Type:** New or established patients.
- **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 or 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.
**Disclaimer:** Although the data found here has been produced and processed from payer sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability or usefulness of any information.

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- Preventive care codes (99381-99387 and 99391-99397) will be temporarily allowed through April 20th, 2021.

### Cost Share Waiver:

- Effective March 13th, 2020 through April 20th, 2021, 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).


**Effective March 2nd, 2020-December 31st, 2020**

### E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes**:
  - E-Visits: Check Provider Fee Schedule
  - Telephone: Check Provider Fee Schedule
  - Virtual Check-Ins: G2012 (Cigna classifies a Virtual Check-In as “5-10-minute virtual screening telephone consult”

- **Effective Date**: March 2nd, 2020-January 21st, 2021
- **Modifier**: None
- **Patient Type**: Established

### 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
- **Effective Date**: March 2nd, 2020-January 21st, 2021
- **Modifier & POS**: No modifier, unless COVID-19 related, then utilize modifier CS. POS used if visit was performed in person.
- **Patient Type**: New or Established
- **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.

### Telehealth:

- **Allowable Codes**: Cigna will allow any existing face-to-face service on a provider’s fee schedule to be performed and billed via telehealth.
  - **Level Four & Five Codes**: Cigna has encouraged providers to bill the appropriate E/M code that was performed; however providers should be cognizant when billing level four and five codes for virtual services. Cigna will reimburse these services consistent with face-to-face rates but will monitor the use of level 4 and 5 codes and audit as necessary.
Inappropriate Virtual Services: Cigna will closely monitor and audit claims for inappropriate services that should not be performed virtually (including but not limited to: acupuncture, all surgical codes, anesthesia, radiology services, laboratory testing, administration of drugs and biologics, infusions or vaccines, and EEG or EKG testing).

Urgent Care Centers: Virtual care services are covered, including S9083 for services that require a more complex telephone call. Cigna will reimburse the full face to face rate of insured and NON-ERISA ASO providers where telehealth parity laws exist. For all other providers, Cigna will reimburse urgent care centers a flat rate of $88.00 per visit.

- **Effective Date:** March 2nd, 2020-December 31st, 2020.
- **HIPAA Compliant Platform:** Telehealth visits can be performed via non-compliant HIPAA platforms, such as FaceTime, Facebook Messenger, Skype, and Google Hangouts.
- **Modifiers/POS:**
  - **Professional/1500 Claims:** Modifiers GT or 95 with POS that would have been used if service had been provided in-person. DO NOT use POS 02 for virtual visits, as that will result in reduced payment or denied claims.
  - **Facility/UB Claims:** Appropriate revenue code and modifiers GT or 95
  - **COVID-19 Related Telehealth Care:**
    - Suspected or Likely COVID-19 Exposure: ICD-10 Z03.818 or Z20.828, CS modifier, and GT or 95 modifier.
    - Confirmed COVID-19 Case: ICD-10 U07.1
  - **DX Code Placement:**
    - Cigna does not require any specific placement for COVID-19 DX codes, however they recommend providers place the COVID-19 DX code for confirmed or suspected cases in the first position when the primary reason for the visit is to determine if the patient has COVID-19.
    - For services where COVID-19 is not the reason for visit (ex.-labor/delivery), but the patient is also tested for COVID-19, the provider should bill the DX code specific to the primary reason for visit in the first position, and the COVID-19 DX code in any position after the first.

- **Patient Type:** New or established patients.
- **Provider Type:** If the provider can deliver the service in a clinic/facility setting, then they can also provide the service virtually. Providers should bill virtual visits on the same form they usually do (UB/1500) for in-person visits.
- **Reimbursement:** Reimbursement will be allowed at 100% of the provider’s contracted rate, refer to your Cigna contract for allowable rates.
- **Video Component:** Telehealth codes can be performed over an audiovisual or audio only connection.
- **Transmission & Originating Site Fees:** Cigna will not reimburse an originating site of service fee or facility fee for telehealth visits (HCPCS Q3014). Cigna will also not reimburse for transmission fees.

**Cost Share Waiver:**

- Effective March 13th, 2020 through January 21st, 2021, 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).
- Effective March 30th, 2020 through December 31st, 2020, Cigna will waive member cost sharing for all COVID-19 related treatment.
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
- **Effective Date**: March 6th, 2020- the duration of the federal PHE or February 1st, 2021, whichever is later
- **Modifier**: None
- **Patient Type**: Established

Telehealth:

- **Allowable Codes**: See table below for specific codes. Medica has provided a list of examples of allowable telehealth services, including, but not limited to the following:
  - Consultations
  - Telemedicine consults: emergency department or initial inpatient care
  - Subsequent hospital care services
  - Subsequent nursing facility care services
  - End stage renal disease services
  - Individual medical nutrition therapy
  - Individual and group diabetes self-management training
  - Smoking cessation
  - Alcohol and substance abuse (other than tobacco) structured assessment and intervention services
  - Individual psychotherapy
  - Psychiatric diagnostic interview examinations
  - Family psychotherapy with or without patient present
- **Wellness Visits**: Effective June 1st, 2020, Medica is allowing 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 and effectively via telehealth. Services that require face-to-face interaction may be provided at a later date, 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.
- **Effective Date**: March 6th, 2020- the duration of the federal PHE or February 1st, 2021, whichever is later
- **HIPAA Compliant Platform**: Telehealth visits can be performed via non-compliant HIPAA platforms, such as FaceTime, Facebook Messenger, and Skype.
- **Modifiers/POS**:
  - **Professional (1500) Claims**:
    - **Commercial**: POS 02 with modifier GT for CMS recognized CPTs or modifier 95 for AMA Appendix P CPTs.
    - **Medicare Advantage**: POS that would have been used if the visit were performed in person with modifier 95.
  - **Facility (UB) Claims**: Utilize modifier GT or 95.
  - **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**: Not Specified.
- **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).

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 (i.e. updating patient information), providing educational materials, brief follow-up of a medical procedure to confirm stability of the patient’s condition 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 chronic condition 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.

Cost Share Waiver:
- Effective March 1st, 2020 through April 30th, 2021 Medica will waive cost-sharing for in-network telehealth visits when related to administration of a COVID-19 test. Utilize the Medica provider portal for details regarding cost-share waivers for specific patients, as the cost share waiver for telehealth may vary by plan.

**MEDICA ALLOWABLE TELEHEALTH CODES**

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*Codes Highlighted in Blue - Require an Audiovisual Connection*

*Codes Highlighted in Green - Can Be Performed via an Audio only (Telephone) or Audiovisual Connection*
**Payor Specific Key Points:**

**E-Visits/Telephone/Virtual Check Ins:**

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

- **Effective Date:**
  - E-Visits & Virtual Check-Ins: Permanently Allowed
  - Telephone: March 6th, 2020-End of PHE

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

- **Patient Type:** New & Established (New patients allowable only for COVID-19 PHE)

- **Provider Type:**
  - E-Visits (G2061-G2063) Virtual Check-In (G2250 & G2251): Effective January 1st, 2021 Medicare clarified that licensed clinical social workers, clinical psychologists, physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) can furnish E-Visits (G2061-G2063) and Virtual Check-Ins. Medicare created two new HCPCS codes, G2250 & G2251, for virtual check-ins for these provider types.

- **Telephone Services Reporting:** 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 Reimbursement Change:** Effective March 1st, 2020, CMS has increased payments for telephone visits to match payments for similar office and outpatient visits.

**Telehealth:**

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

- **Effective Date:** Effective March 6th, 2020-End of COVID-19 PHE.
  - CMS implemented an 1135 blanket waiver for Medicare telehealth services. This waiver allows for additional flexibilities in Medicare telehealth services. Specifically, 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. Prior to this waiver, Medicare required telehealth to originate from a healthcare facility within a rural area.

- **HIPAA Compliant Platform:** Effective March 17th, 2020-End of COVID-19 PHE, the 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.

- **Hospitals-CAH & PPS:** See “Hospital” section for details on Medicare telehealth hospital regulations.

- **Modifiers/POS:**
  - Professional (1500) Claims: POS that would have been used if the visit were provided in person with modifier 95.
  - 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: If COVID-19 Part B related services were performed also append a CS modifier to applicable line items.

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Cost Share Waiver:

- The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible). Therefore, cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the PHE 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, and other services.

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emergency department services, nursing facility services, domiciliary, rest home, or custodial care services, home services, online digital evaluation, and management services.


  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).

- Providers who bill for Medicare Part B services should use CS modifier on applicable claim lines.

- Providers should NOT charge Medicare patients any co-insurance and/or deductible amounts for these services.

<table>
<thead>
<tr>
<th>2020 MEDICARE ELEGIBLE TELEHEALTH CODES</th>
<th>2020 Standard Telehealth Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90785 90840 90961 96156 97804 99215 99356 G0109 G0425 G0445 G2087</td>
<td></td>
</tr>
<tr>
<td>90791 90845 90963 96159 99201 99231 99357 G0270 G0426 G0446 G2088</td>
<td></td>
</tr>
<tr>
<td>90792 90846 90964 96160 99202 99232 99406 G0296 G0427 G0447</td>
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</tr>
<tr>
<td>90832 90847 90965 96161 99203 99233 99407 G0396 G0436 G0459</td>
<td></td>
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<tr>
<td>90833 90951 90966 96164 99204 99307 99495 G0397 G0437 G0506</td>
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<tr>
<td>90834 90954 90967 96165 99205 99308 99496 G0406 G0438 G0508</td>
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<tr>
<td>90836 90955 90968 96167 99211 99309 99497 G0407 G0439 G0509</td>
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<tr>
<td>90837 90957 90969 96168 99212 99310 99498 G0408 G0442 G0513</td>
<td></td>
</tr>
<tr>
<td>90838 90958 90970 97802 99213 99354 90785 G0420 G0443 G0514</td>
<td></td>
</tr>
<tr>
<td>90839 90960 96116 97803 99214 99355 G0108 G0421 G0444 G2086</td>
<td></td>
</tr>
</tbody>
</table>

Temporarily Added Telehealth Codes for the COVID-19 Pandemic- Effective March 1st 2020

| 77427 92508 94664 96139 97156 97542 99225 99292 99336 99443 0373T | |
| 90853 92521 96110 96158 97157 97750 99226 99304 99337 99468 S9152 | |
| 90875 92522 96112 96170 97158 97755 99234 99305 99341 99469 0362T | |
| 90952 92523 96113 96171 97161 97760 99235 99306 99342 G0410 | |
| 90953 92524 96121 97110 97162 97761 99236 99315 9943 99472 G6985 | |
| 90956 92601 96127 97112 97163 99217 99238 99316 99344 99473 93797 | |
| 90959 92602 96130 97116 97164 99218 99239 99324 99345 99475 93798 | |
| 90962 92603 96131 97150 97165 99219 99281 99325 99347 99476 93750 | |
| 92002 92604 96132 97151 97166 99220 99282 99326 99348 99477 95971 | |
| 92004 94002 96133 97152 97167 99221 99283 99327 99349 99478 95972 | |
| 92012 94003 96136 97153 97168 99222 99284 99328 99350 99479 95983 | |
| 92014 94004 96137 97154 97530 99223 99285 99334 99441 99480 95984 | |
| 92507 94005 96138 97155 97535 99224 99291 99335 99442 99483 G0422 | |

| Codes Highlighted in Blue -Require an Audiovisual Connection |
| Codes Highlighted in Green -Can Be Performed via an Audio only (Telephone) or Audiovisual Connection |
| Codes Highlighted in Yellow -Have a Medicare Payment Limitation (See Table Below) |
**2021 MEDICARE ELEGIBLE TELEHEALTH CODES**

**2021 Standard Telehealth Codes**

<table>
<thead>
<tr>
<th>CPT</th>
<th>Codes Available up Through the Year in Which the PHE Ends</th>
</tr>
</thead>
<tbody>
<tr>
<td>90785 90840 90961 96156 97804 99215 99356</td>
<td>G0109  G0425  G0445  G2087</td>
</tr>
<tr>
<td>90791 90845 90963 96159 90952 99231 99357</td>
<td>G0270  G0426  G0446  G2088</td>
</tr>
<tr>
<td>90792 90846 90964 96160 99202 99232 99406</td>
<td>G0296  G0427  G0447  90853</td>
</tr>
<tr>
<td>90832 90847 90965 96161 99203 99233 99407</td>
<td>G0396  G2211  G0459  96121</td>
</tr>
<tr>
<td>90833 90951 90966 96164 99204 99307 99495</td>
<td>G0397  G2086  G0506  99347</td>
</tr>
<tr>
<td>90834 90954 90967 96165 99205 99308 99496</td>
<td>G0406  G0438  G0508  99348</td>
</tr>
<tr>
<td>90836 90955 90968 96167 99211 99309 99497</td>
<td>G0407  G0439  G0509  99483</td>
</tr>
<tr>
<td>90837 90957 90969 96168 99212 99310 99498</td>
<td>G0408  G0442  G0513  99334</td>
</tr>
<tr>
<td>90838 90958 90970 97802 99213 99354</td>
<td>G2212  G0420  G0443  G0514  99335</td>
</tr>
<tr>
<td>90839 90960 96116 97803 99214 99355 90108</td>
<td>G0421  G0444</td>
</tr>
</tbody>
</table>

**Codes Available for the COVID-19 PHE Only**

<table>
<thead>
<tr>
<th>CPT</th>
<th>Codes Available for the COVID-19 PHE Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>77427 90875 92002 92004 92012 92014 92508</td>
<td>92601 92602 92603 92604</td>
</tr>
<tr>
<td>93797 93798 93750 94002 94003 94004 94005</td>
<td>94664 95970 95971 95972</td>
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<tr>
<td>95983 95984 96110 96112 96113 96137 96138</td>
<td>96139 97110 97116 97163</td>
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<td>97755 97760 97761 99217</td>
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<td>99224 99225 99226 99228 99239 99281 99282</td>
<td>99283 99284 99285 99291</td>
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<tr>
<td>99292 99315 99316 99336 99337 99349 99350</td>
<td>99469 99472 99476 99478</td>
</tr>
<tr>
<td>99479 99480</td>
<td></td>
</tr>
</tbody>
</table>

**Codes Highlighted in Blue** - Require an Audiovisual Connection

**Codes Highlighted in Green** - Can Be Performed via an Audio only (Telephone) or Audiovisual Connection during the COVID-19 PHE ONLY

**Codes Highlighted in Yellow** - Have a Medicare Payment Limitation (See Table Below)

---

**Medicare Telehealth Codes Payment Limitations**

<table>
<thead>
<tr>
<th>CPT/HPCPS</th>
<th>Medicare Payment Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>90875</td>
<td>Non-covered service</td>
</tr>
<tr>
<td>94005</td>
<td>Bundled code</td>
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<tr>
<td>96112</td>
<td>Non-covered service</td>
</tr>
<tr>
<td>96170</td>
<td>Non-covered service</td>
</tr>
<tr>
<td>96171</td>
<td>Non-covered service</td>
</tr>
<tr>
<td>S9152</td>
<td>Not valid for Medicare purposes</td>
</tr>
<tr>
<td>G0410</td>
<td>Statutory exclusion</td>
</tr>
</tbody>
</table>

---

Disclaimer: Although the data found here has been produced and processed from payer sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability or usefulness of any information.
Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

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

- **Effective Date:**
  - **Virtual Check-In:** March 19th, 2020-End of PHE
  - **Telephone:** March 1st, 2020-End of PHE

- **Modifier/POS:** POS 02, no modifier required

- **Patient Type:** Established

<table>
<thead>
<tr>
<th>Virtual Check-In &amp; Telephone Codes</th>
<th>Fee Schedule Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>G2010</td>
<td>$10.19</td>
<td>3/19/2020</td>
</tr>
<tr>
<td>G2012</td>
<td>$12.35</td>
<td>3/19/2020</td>
</tr>
<tr>
<td>99441</td>
<td>$37.29</td>
<td>3/1/2020</td>
</tr>
<tr>
<td>99442</td>
<td>$62.33</td>
<td>3/1/2020</td>
</tr>
<tr>
<td>99443</td>
<td>$90.90</td>
<td>3/1/2020</td>
</tr>
</tbody>
</table>

**Telehealth:**

- **Allowable Codes:** Providers may bill telehealth for procedure codes that they are already eligible to bill for. The provider should bill the appropriate code for services rendered as if rendered in person.
  - Level 4 and 5 visits should have documentation that supports the time and complexity required for these visits.
    - MS Medicaid will monitor services rendered through telehealth for medical appropriateness and conduct post-payment reviews, with a focus on level 4 and 5 visits.
  - Services not otherwise covered by the Mississippi Division of Medicaid are not covered when delivered via telehealth.
  - Billable services for Community Mental Health Centers (CMHCS) and Private Mental Health Centers (PMHCs) Acting as distant site providers are shown in the matrix at the bottom of this section.
  - MS Medicaid is also allowing Psychosocial Rehabilitation Services (H2030).
    - Audiovisual connection is preferred, but audio only sessions are also allowed.
    - Extra steps need to be taken at the beginning of the telehealth session to review confidentiality and privacy concerns.
    - Patients must have the opportunity to participate in at least one hour-long group per day on PSR topics. One-hour PSR groups do not have to be consecutive hours. When using the telehealth format, PSR participants are only required to participate if the individual is able.
    - Telehealth only Psychosocial Rehabilitation must be provided by at least one clinical staff member.

- **Requirements for Telehealth Services:** Telehealth provided during this temporary period must meet the following requirements:
  - The service rendered from the distant site must be safe and medically appropriate for delivery in the originating site.
  - Any services provided through telehealth must meet the same standard of care as if provided in person.
  - The beneficiary must give either verbal or written consent to receive telehealth services. Providers must document this consent.

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The availability of services through telehealth does not alter the scope of practice of any health care provider, nor does it authorize the delivery of health care services in a setting or manner not otherwise authorized by law.

Services must be provided from the patient’s home with no telepresenter present, from an approved originating site with a telepresenter present, or from a temporarily approved originating site with a telepresenter present.

Services must be in accordance with the qualified healthcare professional’s scope-of-practice, license, medical certification or Mississippi Department of Mental Health (MDMH) certification and in accordance with state and federal guidelines, including but not limited to, authorization of prescription medications at both the originating and distant site.

- **Effective Date:** March 20th, 2020-End of PHE
- **HIPAA Compliant Platform:** Telehealth visits can be performed via non-compliant HIPAA platforms, such as FaceTime, Facebook Messenger, Skype, and Google Hangouts.
- **Modifiers/POS:**
  - **Professional (1500) claims:** Modifier GT and POS 02.
  - **Facility (UB) Claims:** Modifier GT
- **Patient Type:** New & Established, except speech, occupational, and physical therapists can only provide services to established patients.
- **Patient Location:** Mississippi Medicaid will allow patients to seek services from the patient’s home with no telepresenter present, from an approved originating site with a telepresenter present, or from a temporarily approved originating site with a telepresenter present.
- **Provider Type:**
  - **Approved Originating Site Providers:** Office of a physician or practitioner, Outpatient Hospital (including a Critical Access Hospital (CAH), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), Private Mental Health Centers, Therapeutic Group Homes, Indian Health Service Clinic, School-based clinics, Prescribed Pediatric Extended Care (PPEC) Centers, Inpatient hospital (provided the telepresenter is authorized to carry out the orders of the distant site provider).
  - **Approved Distant Site Providers:** Physicians, Physician Assistants, Nurse Practitioners, Psychologists, Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), Board Certified Behavior Analysts (BCBAs), Board Certified Behavior Analyst-Doctorals (BCBA-Ds), Speech Therapists*, Occupational Therapists*, Physical Therapists*, Rural Health Clinics, Federally Qualified Health Centers, Community Mental Health Centers, Private Mental Health Centers, MYPAC Providers.
    
    *Speech, Occupational, and Physical Therapists can only provide services to established patients.
  - **Telehealth Provider Approval Process:** Provider types not approved as an originating site or distant site provider should contact DOM for approval to serve as a telehealth provider. If you are a provider type that has not been approved, or you are a provider type approved as either a distant site or an originating site, but not both, you can submit a request to the state.
- **Reimbursement:** Refer to the Medicaid fee schedule for reimbursable: [https://medicaid.ms.gov/providers/fee-schedules-and-rates/#](https://medicaid.ms.gov/providers/fee-schedules-and-rates/#).
- **Transmission & Originating Site Fees:** Originating site providers will only be reimbursed for the originating site fee (HCPCS Q3014) if no other services are rendered, except in cases that the provider conducted a separately identifiable E&M visit while the patient was present in the originating site. Inpatient hospitals are not eligible to receive an originating site fee, as it is included in the hospital DRG.
  - Providers acting simultaneously as both a telehealth distant and originating site to deliver services to a patient can only bill either the originating or distant site fee-for-service rate, not both.
- **Video Component:** Telehealth services are expanded to include use of telephonic audio that does not include video when authorized by the State of Mississippi.

**Cost Share Waiver:**

- **Mississippi Medicaid:** Effective March 1st, 2020 through the end of the PHE, Mississippi Medicaid is waiving cost sharing for all beneficiaries, regardless of the ultimate diagnosis, for testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies.

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Providers should add the copay exception code “V” as a suffix to the beneficiary’s Medicaid ID number.

Mass claim adjustments will be made for dates of service March 1st, 2020, up to the date of the completion of the system update, reversing the copay deduction from the claim’s payment amount.

Providers are required to refund copayments to beneficiaries who have paid a copayment from March 1, 2020, up to the date of the system update. After the system change, providers can charge copayments for non-COVID-19-related treatments and services.

- **Magnolia Health**: Continuation of zero-member liability (copays, cost sharing, etc.) for care delivered via telehealth.
- **Molina Healthcare**: No cost share for in network telehealth visits through end of PHE.
- **United Healthcare Community Plan**: No co-pays are assessed on medical necessity care.

<table>
<thead>
<tr>
<th>Billable Services for Community Mental Health Centers (CMHCS) and Private Mental Health Centers (PMHCs) Acting as Distant Site Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service</strong></td>
</tr>
<tr>
<td>Psychiatric Diagnostic Evaluation</td>
</tr>
<tr>
<td>Assessment</td>
</tr>
<tr>
<td>Brief Behavioral Health Assessment (Screening)</td>
</tr>
<tr>
<td>Evaluation &amp; Management (E/M)</td>
</tr>
<tr>
<td>Nursing Facility Evaluation &amp; Management (E/M)</td>
</tr>
<tr>
<td>Assisted Living Evaluation &amp; Management (E/M)</td>
</tr>
<tr>
<td>Psychotherapy with E/M (must also bill E/M code on separate line)</td>
</tr>
<tr>
<td>Prolonged Service 60 min.</td>
</tr>
<tr>
<td>Prolonged Service 30 min add on</td>
</tr>
<tr>
<td>Treatment Plan Development &amp; Review</td>
</tr>
<tr>
<td>Psychotherapy</td>
</tr>
<tr>
<td>Nursing Assessment</td>
</tr>
<tr>
<td>Family Therapy</td>
</tr>
<tr>
<td>Group Therapy</td>
</tr>
<tr>
<td>Multi-Family Group Therapy</td>
</tr>
<tr>
<td>Interactive Complexity</td>
</tr>
<tr>
<td>Psychological Evaluation (First Hour) (Each Additional Hour)</td>
</tr>
<tr>
<td>Psychological Evaluation (First 30 Minutes) (Each Additional 30 Minutes)</td>
</tr>
<tr>
<td>Targeted Case Management - (management of the case record)</td>
</tr>
<tr>
<td>Assertive Community Treatment (ACT)</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation</td>
</tr>
<tr>
<td>Crisis Response (Phone rate $21.88)</td>
</tr>
<tr>
<td>Acute Partial Hospitalization</td>
</tr>
<tr>
<td>Community Support Services (management of the individual)</td>
</tr>
<tr>
<td>Peer Support</td>
</tr>
<tr>
<td>Wraparound Facilitation</td>
</tr>
<tr>
<td>Intensive Outpatient Psychiatric</td>
</tr>
<tr>
<td>MYPAC</td>
</tr>
</tbody>
</table>
**Payor Specific Key Points:**

**Effective January 1st, 2021**

**E-Visits/Telephone/Virtual Check Ins:**

- **Allowable Codes:**
  - **E-Visits:** 99421-99423, 98970-98972
  - **Interprofessional Consultation:** 99446-99449, 99451, 99452
  - **Remote Patient Monitoring:** 99091, 99453, 99454, 99457-99458, 99473-99474
  - **Telephone:** Check Fee Schedule
  - **Virtual Check-In:** G2010, G2012, G2250-G2252

- **Effective Date:**
  - **E-Visits, Interprofessional Consultations, Remote Patient Monitoring, Virtual Check-Ins:** Permanently allowable per UHC Telehealth/Telemedicine Policy effective 01/01/2021
  - **Telephone:** N/A

- **Modifier/POS:** None

- **Patient Type:** CPT code specific

**Telehealth:**

- **Allowable Codes:** See Telehealth Allowable Codes table below for allowable code sets. UHC will also allow any code on CMS’ Covered Telehealth Services list during the national PHE.
  - **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.

- **Effective Date:** UHC’s permanent Telehealth/Telemedicine Policy is effective 01/01/2021
  - **Out of Network:**
    - **COVID-19 Testing Related Visits:** March 18th, 2020-End of PHE

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

- **Modifiers/POS:**
  - **Professional (1500) claims:** POS 02. 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.

- **Originating Site:** 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 telpresenter using HCPS Q3014. T1014 is not eligible for payment, UHC considers these services as incidental to the charges associated with the E/M.
Video Component: Telehealth services must be performed over an audiovisual connection.

Cost Share Waiver:

COVID-19 Testing Related Telehealth:

- In & Out of Network: February 4th, 2020-End of PHE

<table>
<thead>
<tr>
<th>UHC ELEGIBLE TELEHEALTH CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>90785</td>
</tr>
<tr>
<td>90846</td>
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<td>G0442</td>
</tr>
<tr>
<td>G2086</td>
</tr>
<tr>
<td>G9488</td>
</tr>
</tbody>
</table>

PT/OT/ST

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

Effective March 18th, 2020-December 31st, 2020

E-Visits/Telephone/Virtual Check Ins:

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

- Effective Date:
  - E-Visits: Previously Allowable
  - Virtual Check-In & Telephone:
    - In-Network:
      - In-Network: March 18th, 2020 through December 31st, 2020
    - Out of Network:
      - COVID-19 Visits:
        - Out-of-Network for COVID-19 Testing: March 18th, 2020-End of PHE
        - As of October 23rd, 2020, telehealth services will be covered according to the member’s benefit plan and UHC’s standard telehealth reimbursement policy.
      - Non-COVID-19 Visits:

Disclaimer: Although the data found here has been produced and processed from payer sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability or usefulness of any information.
As of July 25th, 2020, telehealth services are covered according to the member's benefit plan and UHC's standard telehealth reimbursement policy.

- **Modifier:** None
- **Patient Type:**
  - **E-Visits:** Established Only
  - **Virtual Check-Ins & Telephone:** New & Established

### Telehealth

- **Allowable Codes:** UHC will allow any code on the Medicare covered telehealth code list to be billed. Any code on UHC's telehealth eligible code list can still also be used. See table below for allowable code set.
- **Effective Date:** UHC has waived the originating site requirement (allowing the patient to be at home) and has waived the telehealth video requirement with effective and term dates as listed below.
  - **In-Network:**
    - In-Network: March 18th, 2020 through December 31st, 2020
  - **Out of Network:**
    - COVID-19 Visits:
      - Out-of-Network for COVID-19 Testing: March 18th, 2020-End of PHE
    - As of October 23rd, 2020, telehealth services will be covered according to the member's benefit plan and UHC's standard telehealth reimbursement policy.
    - Non-COVID-19 Visits:
      - As of July 25th, 2020, telehealth services are covered according to the member’s benefit plan and UHC’s standard telehealth reimbursement policy.
- **HIPAA Compliant Platform:** Telehealth visits can be performed via non-compliant HIPAA platforms, such as FaceTime, Facebook Messenger, Skype, Google Hangouts and WhatsApp.
- **Modifiers/POS:**
  - Professional (1500) claims:
    - Commercial: Utilize modifier GT for CMS recognized CPTs, modifier 95 for AMA Appendix P CPTs, and modifier G0 for telehealth services for diagnosis, evaluation, or treatment, of an acute stroke with POS that would have been used if visit were furnished in person.
    - Medicare Advantage: Utilize modifier 95 and POS that would have been used if visit were furnished in person.
  - Facility (UB) claims: Utilize revenue code 780.
- **Provider Type:** UHC follows CMS' policies on the types of care providers eligible to deliver telehealth services. These include physician, nurse practitioner, physician assistant, nurse-midwife, clinical nurse specialist, registered dietitian or nutrition professional, clinical psychologist, clinical social worker, certified registered nurse anesthetists. UHC will also allow physical therapists, occupational therapists, speech therapists, and chiropractic providers to provide limited services via telehealth.
- **Reimbursement:** Reimbursement will be at the same rate as in-person face-to-face visits, refer to your UHC contract for allowable rates.
- **Transmission & Originating Site Fees:** T1014 and Q3014 are not eligible for payment, UHC considers these services as incidental to the charges associated with the E/M.
- **Video Component:** The video component requirement for telehealth services has been waived, except in cases where UHC has specifically stated audiovisual is required, which includes PT/OT/ST, chiropractic therapy, home health, and hospice.
  - Medicare Advantage plans, including DSNP plans, still require an audiovisual connection, except for CMS indicated audio only codes.

### Cost Share Waiver

**Commercial:**

- **Non COVID-19 Telehealth:** March 31st, 2020 -September 30th, 2020, UHC waived member cost sharing for all in-network telehealth visits for medical, outpatient behavioral, PT/OT/ST, chiropractic therapy, home health and hospice, and remote patient monitoring services, regardless of DX.
- Effective October 1st, 2020, benefits will be adjudicated in accordance with the member’s benefit plan.

**COVID-19 Testing Related Telehealth:**
- In & Out of Network: February 4th, 2020-End of PHE

**COVID-19 Treatment Related Telehealth:**
- In-Network: February 4th, 2020-December 31st, 2020
- Out of Network: February 4th, 2020-October 22nd, 2020

### Medicare Advantage:

- **Non COVID-19 Telehealth:**
  - March 31st, 2020 - September 30th, 2020, UHC waived member cost sharing for all in-network telehealth visits for medical, outpatient behavioral, PT/OT/ST, chiropractic therapy, home health and hospice, and remote patient monitoring services, regardless of DX.
  - October 1st, 2020-December 31st, 2020, UHC will waive the cost share for in-network and covered out-of-network primary care telehealth services only.
    - Effective October 1st, 2020 UHC will adjudicate in accordance with the member’s benefit plan for non-primary care telehealth services.

- **COVID-19 Testing Related Telehealth:**
  - In & Out of Network: February 4th, 2020-End of PHE

- **COVID-19 Treatment Related Telehealth:**
  - In & Out of Network: February 4th, 2020-December 31st, 2020

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**UHC ELEGIBLE TELEHEALTH CODES**

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### Disclaimer:

Although the data found here has been produced and processed from payer sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability or usefulness of any information.
All major insurance companies have issued statements that costs will be waived for physician ordered diagnostic testing related to COVID-19 provided at approved locations in accordance with CDC guidelines. Self-insured plan sponsors are not required to implement the same policy. Other payors have gone a step further and issued waivers for other services

<table>
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<tr>
<th>Payor</th>
<th>Cost Sharing Guidelines</th>
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<tr>
<td>Aetna</td>
<td><strong>Commercial</strong>: Effective March 6th, 2020 through June 4th, 2020, Aetna waived member cost sharing for in-network telemedicine visits, regardless of diagnosis. Effective June 5th, 2020 through January 31st, 2021, Aetna will waive member cost sharing for in-network telemedicine visits for behavioral health services only. <strong>Medicare Advantage</strong>: Effective May 13th, 2020 through January 31st, 2021, Aetna will waive member out-of-pocket costs for all in-network primary care and specialist visits, whether done in-office or via telehealth, for any reason. Effective January 31st, 2021 through March 31st, 2021, Aetna will waive member cost sharing for in-network telehealth visits for primary care and behavioral health. Effective January 31st, 2021 through End of PHE, Aetna will waive member cost sharing for in-network telehealth visits for primary care visits only.</td>
</tr>
<tr>
<td>BCBS Mississippi</td>
<td><strong>Fully Insured and Self-Insured</strong>: Effective March 16th, 2020-June 30th, 2020, BCBS MS will waive member cost sharing for telehealth services. Effective July 1st, 2020-Cost share will apply. <strong>Mississippi State and School Employee</strong>: Effective March 16th, 2020-June 30th, 2020: BCBS MS will waive member cost sharing for telehealth services, EXCEPT for the network hospital codes. Clarification is being sought to ensure BCBS MS never did waive cost sharing for the network hospital codes for telehealth services. Effective July 1st, 2020-Cost share will apply.</td>
</tr>
<tr>
<td>Cigna</td>
<td><strong>Effective March 13th, 2020 through April 20th, 2021</strong>: 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). <strong>Effective March 13th, 2020 through February 15th, 2021</strong>: Cigna will waive member cost sharing for treatment related virtual care for a confirmed COVID-19 case. <strong>Effective February 16th, 2021</strong>: Cigna will apply member cost sharing to all COVID-19 related treatment.</td>
</tr>
<tr>
<td>Medica</td>
<td><strong>Effective March 1st, 2020 through April 30th, 2021</strong>: Medica will waive cost-sharing for in-network telehealth visits when related to administration of a COVID-19 test.</td>
</tr>
<tr>
<td>Medicare</td>
<td><strong>Effective March 18th, 2020-End of PHE</strong>: Medicare 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; and are in a specified set of HCPCS E/M codes.</td>
</tr>
<tr>
<td>Mississippi Medicaid</td>
<td><strong>Mississippi Medicaid</strong>: Effective March 1st, 2020 through the end of the PHE, Mississippi Medicaid will waive cost sharing for all beneficiaries, regardless of the ultimate diagnosis, for testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies. <strong>Magnolia Health</strong>: Continuation of zero-member liability (copays, cost sharing, etc.) for care delivered via telehealth. <strong>Molina Healthcare</strong>: No cost share for in network telehealth visits through end of PHE <strong>UHC Community Plan</strong>: No co-pays are assessed on medical necessity care.</td>
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<tr>
<td>UHC</td>
<td><strong>Effective February 4th-End of PHE</strong>: In &amp; Out of Network-COVID-19 Testing Related Telehealth.</td>
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On March 27th, 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law. As part of the CARES Act, Congress has authorized RHCs to be a “distant site” for telehealth visits, therefore allowing RHC practitioners to provide telehealth services.

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

- **Billing**:
  - **Telehealth Services Provided January 27, 2020- June 30, 2020**: RHCs must report HCPCS code G2025 on their claims with the CG modifier. Modifier “95” may also be appended but is not required.
    - Claims will be paid at the RHC’s all-inclusive rate (AIR).
    - Claims will automatically reprocess in July when the Medicare claims processing system is updated with the new payment rate.
    - RHCs do not need to resubmit these claims for the payment adjustment.
  - **Telehealth Services Provided July 1, 2020 and Forward**: RHCs will no longer need to append the CG modifier on claims with HCPCS code G2025. Modifier “95” may be appended but is not required.
  - **COVID-19 Related Care**: Append modifier CS

| RHC Claims for Telehealth Services from January 27, 2020 through June 30, 2020 |
|-------------------------------|--------------------------------|---------------|
| Revenue Code | HCPCS Code | Modifiers |
| 052X | G2025 | CG (required) 95 (optional) |

| RHC Claims for Telehealth Services starting July 1, 2020 |
|-------------------------------|--------------------------------|---------------|
| Revenue Code | HCPCS Code | Modifiers |
| 052X | G2025 | 95 (optional) |

- **Cost Report**: 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.”

- **Cost Share Waiver**: Effective March 18th-the end of the COVID-19 PHE, Medicare is waiving cost sharing for specified categories of E/M services if they result in an order for or an administration of a COVID-19 test and relate to the furnishing or administration of such test or to the evaluation of an individual for purposes of determining the need for such test.
  - RHCs must waive collection of co-insurance from beneficiaries.
  - Apply CS modifier to the service item.
  - Claims with CS modifier will automatically reprocess July 1st, 2020.

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

- **Reimbursement**: The RHC telehealth payment rate is set at $92.03 per visit, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS. This rate will apply to telehealth visits performed by independent or provider based RHCs.

- **Telephone Services**: Effective March 1st, 2020 RHCs 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.

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- Cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.
- **Virtual Check-Ins & E-Visits:** Medicare will allow RHCs to perform E-Visits (CPT codes 99421-99423), which are online digital E/M services that utilize a secure patient portal. Medicare will also allow RHCs to perform Virtual Check Ins (HCPCS G2012 and G2010).
  - RHCs should bill HCPCS G0071 if E-Visit or Virtual Check-In services are performed.
  - For claims submitted with G0071 on or after March 1, 2020, and for the duration of the COVID-19 PHE, payment for G0071 is set at the average of the national non-facility PFS payment rates for the 5 E-visits and Virtual Check-In codes, which is $24.76.
  - MACs will automatically reprocess any claims with G0071 for services furnished on or after March 1 that were paid at the CY 2020 rate of $13.53 before the claims processing system was updated.
  - **G0071:** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between RHC or FQHC practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC.

**MEDICAID**

Mississippi Medicaid has approved RHCs and FQHCs as temporary distant site providers. Services rendered via audiovisual telehealth will be reimbursed at the PPS rate. Services rendered via audio only telehealth will receive the fee-for-service payment listed in DOM’s Emergency Telehealth policy.

**FEDERALLY QUALIFIED HEALTH CENTERS**

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

- **Allowable Telehealth Codes:** During the COVID-19 PHE, FQHCs can furnish any telehealth service that is approved as a Medicare telehealth service under the PFS (see the Medicare Allowable Telehealth Code Table in the Medicare section).
- **Billing:**
  - **Telehealth Services Furnished January 27, 2020- June 30, 2020:** FQHCs should report 3 HCPCS/CPT codes: the FQHC Prospective Payment System (PPS) specific payment code (GO466, G0467, G0468, G0469, or G0470); the HCPCS/CPT code that describes the services furnished via telehealth with modifier 95; and G2025 with modifier 95.
    - Must be an FQHC qualifying visit.
    - These claims will be paid at the FQHC PPS rate until June 30th, 2020.
    - Claims will be automatically reprocessed beginning July 1st, 2020 at the $92.03 rate.
    - FQHCs do not need to resubmit these claims for payment adjustment.
    - Telehealth Services Furnished for Non-Qualifying FQHC Visits: FQHCs would need to hold these visits until July 1st, 2020 and then bill with HCPCS code G2025.
  - **Telehealth Services Furnished July 1, 2020 and Forward:** FQHCs will only need to submit HCPCS code G2025. Modifier “95” may be appended but is not required.
  - **COIVD-19 Related Care:** Append modifier CS
FQHC Claims for Telehealth Services January 27, 2020 through June 30, 2020

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FQHC Claims for Telehealth Services Starting July 1, 2020

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

- **Cost Share Insurance Waiver:** Effective March 18th-the end of the COVID-19 PHE, Medicare is waiving cost sharing for specified categories of E/M services if the service results in an order for or an administration of a COVID-19 test and relate to the furnishing or administration of such test or to the evaluation of an individual for purposes of determining the need for such test.
  - FQHCs must waive collection of co-insurance from beneficiaries.
  - Apply CS modifier to the service item.
  - Claims with CS modifier will automatically reprocess July 1st, 2020.

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

- **Reimbursement:** The FQHC telehealth payment rate is set at $92.03 per visit, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS.

- **Telephone Services:** Effective March 1st, 2020 FQHCs can perform audio only telephone E/M services utilizing CPT codes 99441, 99442, and 99443.
  - FQHCs can furnish and bill for these services using HCPCS code G2025.
  - At least 5 minutes of telephone E/M by physician or other qualified health care professional who may report E/M services must be provided to an established patient, parent, or guardian.
  - Cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

- **Virtual Check-Ins & E-Visits:** Medicare will allow FQHCs to perform E-Visits (CPT codes 99421-99423), which are online digital E/M services that utilize a secure patient portal. Medicare will also allow FQHCs to perform Virtual Check Ins (HCPCS G2012 and G2010).
  - FQHCs should bill HCPCS G0071 if E-Visit or Virtual Check-In services are performed.
  - For claims submitted with G0071 on or after March 1, 2020, and for the duration of the COVID-19 PHE, payment for G0071 is set at the average of the national non-facility PFS payment rates for the 5 E-visits and Virtual Check-In codes, which is $24.76.
  - MACs will automatically reprocess any claims with G0071 for services furnished on or after March 1 that were paid at the CY 2020 rate of $13.53 before the claims processing system was updated.
  - G0071 Definition: Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an 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.
Mississippi Medicaid has approved RHCs and FQHCs as temporary distant site providers. Services rendered via audiovisual telehealth will be reimbursed at the PPS rate. Services rendered via audio only telehealth will receive the fee-for-service payment listed in DOM’s Emergency Telehealth policy.

**HOSPITAL OUTPATIENT**

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

- **Professional Fees** such as emergency department visits, initial and subsequent observation and observation discharge day management, initial and subsequent hospital care and hospital discharge day management, critical care services, initial and continuing intensive care services, etc.

- **Diabetes management training** (individual & group) and **individual medical nutritional** (initial and subsequent) are allowed by most payors. CMS, along with many other payors, considers Registered Dietitians and Nutritional Professionals as eligible telehealth clinicians.

- **Facility Fees**: If the patient is not coming into the hospital, you cannot bill your normal facility fee, except for Medicare.
  - Effective April 30th, 2020, Medicare is allowing hospitals to bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home.

**Commercial Billing:**

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

**Medicare Billing:**

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

- **Facility (UB Form)**: CMS-5531-IFC specifically outlines appropriate billing for hospitals during the COVID-19 pandemic.
  - **CAHs**: The extraordinary circumstances policy in CMS-5531-IFC only applies to PPS hospitals and to services paid on OPPS. **It does not apply to CAHs.**
    - **CAH PT/OT/ST**: Append modifier 95 if therapy services are provided via telehealth.
  - **PPS Hospitals**:
    - Hospital OP services reimbursed at the OPPS rate (i.e. diabetic management services, behavioral health, etc.), have the following choices:
      - **Utilize** the extraordinary circumstances policy, appending a PO modifier reimbursed at the OPPS rate.
      - **Not utilize** the extraordinary circumstances policy appending a PN modifier and DR condition code which is reimbursed a using the Physician Fee Schedule (PFS).

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

- **Medicare FAQ**:
  - **Question**: When hospital clinical staff furnish a service using telecommunication technology to the patient who is a registered outpatient of the hospital and the hospital makes the service

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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)


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

- **Medicare FAQ:**

  **Question:** How do hospitals bill for outpatient therapy services furnished by employed or contracted therapists using telecommunications technology on the UB-04 claim form during the COVID-19 PHE?

  **Answer:** There are two options available to hospitals and their therapists.

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

  2.) A hospital could, instead, use the flexibilities available under the Hospital Without Walls initiative. The hospital would register the patient as a hospital outpatient, where the patient’s home acts as a provider-based department of the hospital. The hospital’s employed/contracted PT, OT, SLP would furnish the therapy care that the hospital believed could be furnished safely and effectively through telecommunications technology. The hospital is not limited to services included on the telehealth list (since these would not be considered telehealth services), but must ensure the care can be fully furnished remotely using telecommunications technology. The hospital would bill as if the therapy had been furnished in the hospital and the applicable PO/PN modifier would apply for the patient’s home since it would be serving as an off-campus department of the hospital. The option to bill for telehealth services, along with the -95 modifier, furnished by employed/contracted PTs, OTs, and SLPs using applicable audio-visual telecommunications technology applies to the following types of hospitals and institutions:

  - Hospital – 12X or 13X (for hospital outpatient therapy services);
  - Skilled Nursing Facility (SNF) – 22X or 23X (SNFs may, in some circumstances, furnish Part B PT/OT/SLP services to their own long-term residents);
  - Critical Access Hospital (CAH) – 85X (CAHs may separately provide and bill for PT, OT, and SLP services on 85X bill type);
  - Comprehensive Outpatient Rehabilitation Facility (CORF) – 75X (CORFs provide ambulatory outpatient PT, OT, SLP services);
  - Outpatient Rehabilitation Facility (ORF) – 74X (ORFs, also known as rehabilitation agencies, provide ambulatory outpatient PT and SLP, as well as OT services);
  - 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)


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

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

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

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

<table>
<thead>
<tr>
<th>Payor</th>
<th>Telehealth Codes</th>
<th>E-Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>• Allowable PT/OT/ST code set is available in the “Aetna” section of this guide. &lt;br&gt;• PT/OT/STs are considered providers eligible to bill for telehealth services. &lt;br&gt;• 1500 Form: Utilize modifier GT or 95 and POS 02. UB Form: Utilize GT or 95 modifier.</td>
<td>1500 FORM-ALLOWABLE &lt;br&gt;Individually enrolled therapists can bill CPT 98970-98972 or G2061-G2063 for E-visits. &lt;br&gt;UB FORM-UNCLEAR &lt;br&gt;No guidance for hospital-based therapists.</td>
</tr>
<tr>
<td>BCBS Mississippi</td>
<td>• Allowable PT/OT code set is available in the “BCBS Mississippi” section of this guide. &lt;br&gt;• PT/OTs are considered providers eligible to bill for telehealth services. &lt;br&gt;• 1500 Form: POS 02. UB Form: Codes Not Allowable for Hospital Based Therapists</td>
<td>NOT ALLOWABLE CONDITIONAL &lt;br&gt;BCBS of MS Fully Insured Plans: Not Allowable &lt;br&gt;BCBS of MS State and School Employee’s Plans: Pending Clarification if individually enrolled therapists can bill for CPT 98970-98972.</td>
</tr>
<tr>
<td>Cigna</td>
<td>• PT/OT/STs can provide therapy services on their fee schedule, if appropriate to be provided via telehealth PT/OT/STs are considered providers eligible to bill for telehealth services. &lt;br&gt;• 1500 Form: Utilize modifier GT or 95 and POS 02. UB Form: Not Allowable as of January 1st, 2021</td>
<td>NOT ALLOWABLE</td>
</tr>
<tr>
<td>Medica</td>
<td>• Allowable PT/OT/ST code set is available in the “Medica” section of this guide. &lt;br&gt;• PT/OT/STs are considered providers eligible to bill for telehealth services. &lt;br&gt;• 1500 Form: Utilize modifier GT or 95 and POS 02. UB Form: Utilize GT or 95 modifier.</td>
<td>1500 FORM-ALLOWABLE &lt;br&gt;Individually enrolled therapists can bill CPT 98970-98972 or G2061-G2063 for E-visits. &lt;br&gt;UB FORM-UNCLEAR &lt;br&gt;No guidance for hospital-based therapists.</td>
</tr>
<tr>
<td>Medicare</td>
<td>• Allowable PT/OT/ST code set is available in the “Medicare” section of this guide. &lt;br&gt;• PT/OT/STs are considered providers eligible to bill for telehealth services. &lt;br&gt;• PT/OT/ST services can be furnished to a beneficiary in their home by a hospital-based therapist when the beneficiary is registered as an outpatient of the hospital and the hospital considers the beneficiary’s home to be a provider-based department of the hospital. &lt;br&gt;• 1500 Form: Utilize POS for in person visit and POS 02. UB Form: Utilize POS for in person visit 95 and POS 02. UB Form: Utilize POS for in person visit 95 modifier.</td>
<td>1500 FORM-ALLOWABLE &lt;br&gt;Individually enrolled therapists can bill G2061-G2063 for E-visits. &lt;br&gt;UB FORM-UNCLEAR &lt;br&gt;No guidance for hospital-based therapists, however these codes are marked with a non-payable status indicator in the OPPS fee schedule, therefore they are most likely not reimbursable on a UB.</td>
</tr>
<tr>
<td>Mississippi Medicaid</td>
<td>ALLOWABLE</td>
<td>NOT ALLOWABLE</td>
</tr>
</tbody>
</table>

Disclaimer: Although the data found here has been produced and processed from payer sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability or usefulness of any information.
PT/OT/STs can provide any service via telehealth if it is on their current fee schedule. PT/OT/STs are considered distant site providers, for established patients only. 1500 Form: Utilize modifier GT POS 02. UB Form: Utilize GT modifier. E-visit codes are not on the allowable code set for Mississippi Medicaid.

<table>
<thead>
<tr>
<th>UHC</th>
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<tbody>
<tr>
<td>ALLOWABLE</td>
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<tr>
<td>Allowable PT/OT/ST code set is available in the “UHC” section of this guide. 1500 Form: POS 02. UB Form: Modifier 95 and revenue code 780.</td>
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</table>

1500 FORM-ALLOWABLE
Individually enrolled therapists can bill 98970 - 98972 for E-visits.

1500 FORM-ALLOWABLE
Individually enrolled therapists can bill 98970 - 98972 for E-visits.

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.


REFERENCES & RESOURCES

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

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

Cigna:

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

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