

# COVID-19 Virtual Visit Billing Guide ARKANSAS

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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 conferencing that involves communication between the patient and a distant practitioner who is performing the medical service. The practitioner sees the patient throughout the communication, so that two-way communication (sight and sound) can take place.
- **Remote Patient Monitoring** is use of digital technologies to collect health data from individuals in one location and electronically transmit that information to providers in a different location for assessment.

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

### **CPT/HCPCS Codes:**

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

### **Place of Service Codes**

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

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

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

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

\*Note-Renamed on January 1<sup>st</sup>, 2022, previously was only called "Telehealth"

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

### **Reporting Criteria:**

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

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

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

**CPT/HCPCS Codes:**

Reportable by a Qualified Healthcare Professionals:

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

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

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

**Reporting Criteria:**

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

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

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

**CPT/HCPCS Codes:**

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

**Reporting Criteria:**

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

**Documentation Requirements:**

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

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

**CPT/HCPCS Codes:**

Reportable by Qualified Healthcare Professionals:

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

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

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

**Reporting Criteria:**

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

**Documentation Requirements:**

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

# PAYOR MATRIX

PAYOR	E-VISIT CODES	TELEHEALTH-NO ORIGINATING SITE RESTRICTION	VIRTUAL CHECK-IN CODES	TELEPHONE CODES
AETNA	ALLOWABLE  99421-99423 98970 -98972 G2061-G2063	ALLOWABLE  <b>Allowable Codes:</b> Telehealth Eligible Code <b>Professional:</b> Modifier GT (CMS CPTs) or 95 (Appendix P CPTs) w/ POS 02. <b>Facility:</b> Modifier GT or 95	ALLOWABLE  G2010 G2012	ALLOWABLE  99441-99443 98966-98968
ARKANSAS BCBS	ALLOWABLE  99421-99423	ALLOWABLE  <b>Allowable Codes:</b> Telehealth Eligible Code <b>Professional:</b> Modifier 95 or GT & POS 02. <b>Facility:</b> Modifier 95 or GT	NOT ALLOWABLE	ALLOWABLE  99441-99443
CIGNA	NOT ALLOWABLE	ALLOWABLE  <b>Allowable Codes:</b> Telehealth Eligible Code <b>Professional:</b> Modifier 95 or GT & POS used for in-person visit. <b>Facility:</b> Not Allowable	ALLOWABLE  G2010 G2012	ALLOWABLE  99441-99443
MEDICA* *Excludes MHCP Members	ALLOWABLE  99421-99423 98970 -98972 G2061-G2063	ALLOWABLE  <b>Allowable Codes:</b> Telehealth Eligible Code <b>Professional:</b> Modifier GT (CMS CPTs) or 95 (Appendix P CPTs) & POS 02.  <b>Facility:</b> Modifier GT or 95	ALLOWABLE  G2010 G2012	ALLOWABLE  99441-99443 98966-98968
MEDICARE	ALLOWABLE  99421-99423 G2061-G2063 RHC: G0071	ALLOWABLE  <b>Allowable Codes:</b> Telehealth Eligible Code <b>Professional:</b> Modifier 95 w/ POS used for in-person visit. <b>Facility:</b> PN or PO modifier w/ DR condition code. <b>Method II:</b> Modifier GT. <b>RHC:</b> G2025. <b>Facility PT/OT/ST:</b> Modifier 95	ALLOWABLE  G2010 G2012 G2250-G2252 RHC: G0071	ALLOWABLE  99441-99443 98966-98968 Modifier 95 RHC: G2025
ARKANSAS MEDICAID & PASSE MANGED CARE PAYORS	NOT ALLOWABLE	ALLOWABLE  <b>Allowable Codes:</b> Telehealth Eligible Code <b>Professional:</b> POS 02 or 10 <b>Facility:</b> Modifier GT	ALLOWABLE  G2012	NOT ALLOWABLE
UHC COMMERCIAL	ALLOWABLE  99421-99423 98970 -98972	ALLOWABLE  <b>Allowable Codes:</b> Telehealth Eligible Code <b>Professional:</b> 02 or 10	ALLOWABLE  G2010 G2012 G2250-G2252	ALLOWABLE  99441-99443 98966-98968

## AETNA

### Payor Specific Key Points:

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

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

#### Telehealth:

- **Allowable Services:** See table below
  - **Wellness:** Appropriate E/M codes with a wellness diagnosis for wellness aspects of the visit done via telehealth will be covered. Preventative visit codes should be billed when routine in-office visits can resume, and the remaining parts of the well visit can be completed. Both services will be fully reimbursed, and the patient will not incur a cost share.
- **HIPAA Compliant Platform:** Through the end of the federal COVID-19 PHE, non-HIPAA compliant, non-public facing software can be utilized for telehealth visits, such as Skype & FaceTime.
- **Modifiers/POS:**
  - **Commercial:**
    - **1500:** POS 02 with modifier GT 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 Location:** Aetna will allow physicians to provide care from any location, including the provider's home.
- **Reimbursement:** Reimbursement will be at the same rate as in-person face-to-face visits, refer to your Aetna contract for allowable rates.
  - **Capitation:** Telemedicine will be covered within the capitation agreement, similar to an in-office visit
- **Transmission & Originating Site Fees:** 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 6<sup>th</sup>, 2020 through June 4<sup>th</sup>, 2020, Aetna waived member cost sharing for in-network telemedicine visits, regardless of diagnosis.
  - Effective June 5<sup>th</sup>, 2020 through January 31<sup>st</sup>, 2021, Aetna waived member cost sharing for in-network telemedicine visits for behavioral and mental health counseling services only.
- **Medicare Advantage:**
  - Effective March 6<sup>th</sup>, 2020 through May 13<sup>th</sup>, 2020, Aetna waived member cost sharing for in-network telemedicine visits, regardless of diagnosis.
  - Effective May 13<sup>th</sup>, 2020 through January 31<sup>st</sup>, 2021 Aetna waived member out-of-pocket costs for all in-network primary care and specialist visits, regardless of diagnosis.

- Effective January 31<sup>st</sup>, 2021 through March 31<sup>st</sup>, 2021, Aetna waived member cost sharing for n-network telehealth visits for primary care and behavioral health.

**Both Commercial & Medicare Advantage:**

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

AETNA ELIGIBLE TELEHEALTH CODES													
Telehealth Allowable Codes													
90791	90845	90960	92227	96161	99203	99243	99309	99408	G0396	G0442	G2086	90840	G0439
90792	90846	90961	93228	97802	99204	99244	99310	99409	G0397	G0443	G2087	90958	G0513
90832	90847	90963	93229	97803	99205	99245	99354	99495	G0406	G0444	G2088	90970	99453
90833	90853	90964	93268	97804	99211	99231	99355	99496	G0407	G0446	90955	96160	99454
90834	90863	90965	93270	G0270	99212	99232	99356	99497	G0408	G0447	99252	99202	99457
90836	90951	90966	93271	98960	99213	99233	99357	99498	G0425	G0459	99253	99242	99458
90837	90952	90967	93272	98961	99214	99251	99406	97085	G0426	G0506	99254	99308	
90838	90954	90968	96040	98962	99215	99255	99407	G0108	G0427	G0508	G0445	G0437	
90839	90957	90969	96116	99201	99241	99307	G0436	G0109	G0438	G0509	G0514	G0296	
Commercial Codes Effective March 6 <sup>th</sup> , 2020-Until Further Notice Due to COVID-19 Pandemic													
G0410	92002	96170	97164	99217	99235	99307	99344	99476	G0408	G2010	90839	96121	96161
G2061	92012	96171	97165	99218	99236	99308	99345	99477	G0425	G2012	90840	96127	96164
G2062	92065	97110	97166	99219	99238	99309	99347	99478	G0426	G2086	90845	96130	96165
G2063	92526	97112	97167	99220	99239	99310	99348	99479	G0427	G2087	90846	96131	96167
H0015	92601	97116	97168	99221	99281	99315	99349	99480	G0442	G2088	90847	96132	96168
H0035	92602	97150	97530	99222	99282	99316	99350	99483	G0443	97085	90853	96133	97535
H2012	92603	97151	97542	99223	99283	99327	99421	G0108	G0444	90791	90863	96136	97802
H2036	92604	97153	S9443	99224	99284	99328	99422	G0109	G0445	90792	92507	96137	97803
S9480	92606	97155	97755	99225	99285	99334	99423	G0270	G0446	90832	92508	96138	97804
77427	92609	97156	97760	99226	99291	99335	99468	G0296	G0447	90833	92521	96139	G0270
90953	94664	97157	97761	99231	99292	99336	99469	G0396	G0459	90834	92522	96156	98966
90956	96110	97161	98970	99232	99304	99337	99471	G0397	G0506	90836	92523	96158	98967
90959	96112	97162	98971	99233	99305	99341	99472	G0406	G0513	90837	92524	96159	98968
90962	96113	97163	98972	99234	99306	99343	99475	G0407	G0514	90838	96116	96160	99451
99354	99355	99356	99357	99406	99407	G0436	G0437	99441	99442	99443	99446	99447	99448
99449	99497	99498	99452	H0038	G0422	G0423	G0424	99342	90875	93750	93798	95970	95791
95972	95983	95984	90849	96125	97129	97130	92228	94625	94626				
Medicare Advantage Codes Effective March 6 <sup>th</sup> , 2020-Until Further Notice Due to COVID-19 Pandemic													
G0071	90956	96112	97161	98972	99281	99324	99349	0362T	G0443	90791	92508	96156	98968
G0410	90959	96113	97162	99217	99282	99325	99350	0373T	G0444	90792	92521	96158	99354
G2025	90962	96170	97163	99218	99283	99326	99421	G0108	G0445	90832	92522	96159	99355
G2061	92002	96171	97164	99219	99284	99327	99422	G0109	G0446	90833	92523	96160	99356
G2062	92004	97110	97165	99223	99285	99328	99423	G0296	G0447	90834	92524	96161	99357
G2063	92014	97112	97166	99224	99291	99334	99468	G0396	G0459	90836	96116	96164	99406
G9685	92601	97116	97167	99225	99292	99335	99469	G0397	G0270	90837	96121	96165	99407
H0015	92602	97150	97168	99226	99304	99336	99471	G0406	G0506	90838	96127	96167	G0436
H0035	92603	97151	97530	99231	99305	99337	99472	G0407	G0513	90839	96130	96168	G0437
H2012	92604	97152	97542	99232	99306	99341	99475	G0408	G0514	90840	96131	97535	99441
H2036	94002	97153	97750	99233	99307	99342	99476	G0420	G2010	90845	96132	97802	99442
Q3014	94003	97154	97755	99234	99308	99343	99477	G0421	G2012	90846	96133	97803	99443



S9152	94004	97155	97760	99235	99309	99344	99478	G0425	G2086	90847	96136	97804	99446
77427	94005	97156	97761	99236	99310	99345	99479	G0426	G2087	90853	96137	G0270	99447
90875	94664	97157	98970	99238	99315	99347	99480	G0427	G2088	90863	96138	98966	99448
90953	96110	97158	98971	99239	99316	99348	99483	60442	90785	92507	96139	98967	99449
99451	99452	99497	99498	G0438	G0439	G0422	G0423	G0424	G0422	G0423	G0424	99221	99222
92012	93750	93797	93798	95970	95971	95972	95983	95984	92526	92550	92552	92553	92555
92556	92557	92563	92565	92567	92568	92570	92587	92607	92608	92609	92610	92625	92626
92627	96105	96125	97129	97130	94625	94626							

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

## Payor Specific Key Points:

The below is applicable only to fully insured Arkansas Blue Cross and Health Advantage plans including Individual Metallic Exchange Plans. The below does not necessarily apply to self-funded plans (like Walmart, Tyson Foods, or J.B. Hunt, etc.) as they can decide their own telehealth coverage policies. The Arkansas State Employees/Public School Employees have opted into these temporary policy changes regarding telehealth.

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

#### **Allowable Codes:**

- **E-Visits:** 99421-99423
- **Telephone:** 99441-99443
- **Virtual Check-Ins:** Not Allowable

**Modifier/POS:** POS 02

### Telehealth:

- **Allowable Codes:** AR BCBS will allow providers to bill the codes in the provided matrix at the end of this section, note that these codes are specific to certain providers.
- **HIPAA Compliant Platform:** Through the end of the federal COVID-19 PHE, non-HIPAA compliant, non-public facing software can be utilized for telehealth visits, such as Skype & FaceTime.
- **Modifiers/POS:**
  - **Professional (1500) claims:** Modifier 95 or GT with POS 02.
  - **Facility (UB) Claims:** Modifier 95 or GT
  - **CS Modifier:**
    - If billing a COVID-19 related treatment in an office, urgent care, emergency room, or inpatient setting, and COVID-19 is the primary DX, then modifier CS should be appended.
- **Provider Type:** Allowable provider types are specific to each code set, see below telehealth code matrix
- **Patient Type:** Telehealth codes can be billed for both new and established patients. Patient may be located at their home, or other originating site.
- **Reimbursement:** Reimbursement will be consistent with the provider's BCBS fee schedule. Effective March 16th AR BCBS has increased the overall compensation for telehealth services for fully insured members by reimbursing all such services at the "office" level.
- **Transmission & Originating Site Fees:** AR BCBS allows HCPCS Q3014 (originating site fee), but does not allow T1014 (transmission fees).
- **Video Component:** Codes that can be provided over audio only are highlighted in green in the below allowable code matrix. BCBS AR has specifically stated that physicians (MDs and DOs), advance practice nurse practitioners, physician assistants and behavioral health professionals who provide services via audiovisual or telephone should use the telehealth CPT (E&M) codes, not the telephone CPT codes. These services, whether provided via audiovisual or telephone, will be reimbursed at the telehealth rate.
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### Cost Share Waiver:

Effective March 16<sup>th</sup>, 2020-September 30<sup>th</sup>, 2021 AR BCBS waived the member's cost share for telehealth services, for any DX, as indicated by the highlighted codes in the allowable telehealth code matrix.

Effective October 1<sup>st</sup>, 2021-End of PHE: AR BCBS will apply cost share for telehealth services, except for telehealth visits that result in the evaluation or administration of a COVID-19 diagnostic test or any visit that has COVID-19 as a primary DX. For these two situations, they will waive cost sharing.

## AR BCBS ALLOWABLE TELEHEALTH CODES

The below codes may be billed by MD/DOs and APRN/CNP/CNW/PAs

99201	99202	99203	99204	99211	99212	99213	99214			
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The below codes may be billed by MDs/DOS, APRN, and Pas (Wellness Visits)

99381	99382	99383	99384	99385	99386	99387	99391	99392	99393	99394
99395	99396	99397								

The below codes may be billed by clinical psychologists (PhD/PsyD/EdD), licensed psychological examiners (LPE), advance nurse practitioners (APNs) with psychiatric certification, licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), and physicians (MDs and DOs).

90791	90792	90832	90833	90834	90836	90837	90838	90845	90846	90847
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The below codes may be billed by clinical psychologists (PhD/PsyD/EdD), licensed Psychological examiners (LPE), advance nurse practitioners (APNs) with/without psychiatric certification, certified nurse practitioners (CNP), certified nurse midwives (CNW), physician assistants (PAs), licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), and physicians (MDs and DOs).

99421	99422	99423	99441	99442	99443					
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The below codes may be billed by Psychologists, Psychological Examiners or MDs/DOs.

96132	96136	96138	96139							
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The below codes may be billed by Physical Therapists

97161	97162	97163	97164	97110	97112	97116	97535			
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The below codes may be billed by Occupational Therapists

97165	97166	97167	97168	97110	97112	97116	97535	92523		
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The below codes may be billed by Speech and Language

92507	92521	92522	92523	92524	92526	92610	96105	97110		
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The below codes may be billed by Chiropractic Medicine

99201	99202	99203	99204	99211	99212	99213	99214			
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The below codes may be billed by Podiatrists

99201	99202	99203	99204	99211	99212	99213	99214			
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The below codes may be billed by Registered Dieticians

97153	97155	97156	97151	97152						
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The below codes may be billed by Optometrists

99201	99202	99203	99204	99211	99212	99213	99214			
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The below codes may be billed by Board Certified Behavioral Analyst

97153	97155	97156	97151	97152						
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Codes in **Blue** Require an Audiovisual Connection  
 Codes in **Green** Can be Performed Over a Telephone or Audiovisual Connection.  
**Cells Highlighted in Yellow Have NO Cost Share**

## Payor Specific Key Points

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

- **Allowable Codes:**
  - **E-Visits:** Not Allowable
  - **Telephone:** 99441-99443
  - **Virtual Check-Ins:** G2010, G2012
- **POS:** Utilize POS 02

### 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
- **POS:** Utilize POS 02
- **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 Services:** See below table for allowable telehealth codes. All of the following must also be met:
  - Provided over an interactive audiovisual connection.
    - Services rendered via telephone only are considered interactive and will be reimbursed when the appropriate telephone only code is billed.
  - Would be reimbursable if the service were provided face-to face.
  - The patient and/or actively involved caregiver must be present and the service must occur in real time.
  - A permanent record of online communications is maintained as part of the patient's medical record as if the service were provided as an in-office visit.
    - Must include documentation which identifies the virtual service delivery method. I.e.: audio/video or telephone only.
  - Medically appropriate and necessary
  - Provided by a health care professional who is licensed, registered, or otherwise acting within the scope of his/her licensure.
- **Excluded Services:**
  - Service on the same day as a face-to-face visit, when performed by the same provider and for the same condition.
  - Services billed within a post-operative period
  - Services performed via asynchronous communications systems (e.g., fax).
  - Store and forward telecommunication
  - Communications incidental to E/M services, counseling, or medical services included in this policy, including, but not limited to reporting of test results and provision of educational materials.
  - 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.
    - Note: Cigna will reimburse urgent care centers for virtual care services provided on and before March 12, 2022. After March 13th, Cigna will no longer reimburse claims submitted by urgent care centers for virtual care services.
  - Specific Excluded CPT Codes: 98966, 98967, 98968, 98970, 988971, 98972, 99421, 99422, 99423, G0406, G0407, G0408, G0408, G0425, G0426, G0427, G0459, G0508, G0509, G2025, S0320.

- **HIPAA Compliant Platform:** Through the end of the PHE providers may use non public facing, non-HIPAA compliant platforms, such as FaceTime, Skype, Zoom, etc).
- **Modifiers/POS:**
  - **Professional/1500 Claims:**
    - **Effective 7/1/2022:** POS 02 and modifier 93, 95, FQ, GQ, or GT (do not bill POS 10 until further notice)
    - **Prior to 7/1/2022:** Cigna stated on 12/28/21 to hold off billing POS 02 or 10 until further notice. Utilize only 95, GT, or GQ
    - **Note-**Do not bill POS 10 until further notice
  - **Facility/UB Claims:** Modifier 95
    - During the COVID-19 PHE, Cigna will temporarily reimburse virtual care services billed on a UB until further notice, 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)
    - Note: Intensive outpatient program (IOP) telehealth services were covered prior to the pandemic, and will continue to be covered
- **Provider Type:** Providers who are licensed, registered, or otherwise acting within the scope of their licensure may provide telehealth services.
- **Reimbursement:** Reimbursement will be at the same rate as in-person face-to-face visits, refer to your Cigna contract for allowable rates.
- **Video Component:** An audiovisual connection is required except for telephone codes.
- **Transmission & Originating Site Fees:** Cigna will not reimburse an originating site of service fee 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.

CIGNA ELIGIBLE VIRTUAL CODES												
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962	90963
90964	90965	90966	90967	90968	90969	90970	92507	92508	92521	92522	92523	92524
92601	92602	92603	92604	96040	96112	96113	96116	96156	96158	96159	96160	96161
96164	96165	96167	96168	97110	97112	97161	97162	97163	97164	97165	97166	97167
97168	97530	97755	97760	97761	97802	97803	97804	99202	99203	99204	99205	99211
99212	99213	99214	99215	99406	99407	99408	99409	99441	99442	99443	99495	99496
99497	99498	G0108	G0151	G0152	G0153	G0155	G0157	G0158	G0270	G0296	G0299	G0300
G0396	G0397	G0438	G0439	G0442	G0443	G0444	G0445	G0446	G0447	G0459	G0493	G0513
G0514	G2012	S9123	S9128	S9129	S9131	S9152	S9110	G2010				

**Cost Share Waiver:**

Effective March 13<sup>th</sup>, 2020 through February 15<sup>th</sup>, 2021, Cigna waived member cost sharing for treatment related virtual care for a confirmed COVID-19 case. Effective February 16<sup>th</sup>, 2021 Cigna will apply member cost sharing to all COVID-19 related treatment.

Effective March 13<sup>th</sup>, 2020 through End of PHE: Cigna will waive member cost sharing for diagnostic testing and office visits/telehealth visits related to assessment and administration of diagnostic testing. Cigna will also waive member cost sharing for all virtual screening telephone consults (regardless of DX). Cigna will also waive member cost sharing for all virtual screening telephone consults (regardless of DX).

## Payor Specific Key Points:

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

- **Allowable Codes:**
  - **E-Visits:** 99421-99423, 98970-98972, G2061-G2063
  - **Telephone:** 98966-98968, 99441-99443
  - **Virtual Check-In:** G2010, G2012
- **E-Visit Exclusions:**
  - Provider initiated email, appointment scheduling, refilling or renewing existing prescriptions without substantial change in clinical situation, scheduling diagnostic tests, reporting test results, 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, reminders of scheduled office visits, requests for a referral, consultative message exchanges with an individual who is seen in the provider's office immediately afterward, clarification of simple instructions or issues from a previous visit.

### Telehealth:

- **Allowable Codes:** See table below for specific codes.
  - **Wellness Visits:** During the COVID-19 PHE, effective June 1<sup>st</sup>, 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.
- **HIPAA Compliant Platform:** Through the end of the federal COVID-19 PHE, non-HIPAA compliant, non-public facing software can be utilized for telehealth visits, such as Skype & FaceTime.
- **Modifiers/POS:**
  - **Professional (1500) Claims:**
    - **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.
- **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.

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

Codes Highlighted in Blue -Require an Audiovisual Connection

**Cost Share Waiver:**

- Effective March 1<sup>st</sup>, 2020, through April 30<sup>th</sup>, 2022: 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.

## 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
- **Modifier:**
  - **E-Visits & Virtual Check-Ins:** None
  - **Telephone:** Modifier 95
- New patients allowable for COVID-19 PHE

### Telehealth:

- **Allowable Codes:** See table below for codes allowable via telehealth.
  - Telehealth rules do not apply when the beneficiary and the practitioner are in the same location and are utilizing telehealth to reduce exposure risks, even if audio/video technology assists in furnishing a service.
- **HIPAA Compliant Platform:** Through the end of the COVID-19 PHE, HHS Office for Civil Rights (OCR) will waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime.
- **Modifiers/POS:**
  - **Professional (1500) Claims:** POS that would have been used if the visit were provided in person with modifier 95.
  - **CAH Method II (UB) Claims:** Modifier GT
  - **CAH & PPS PT/OT/Speech UB Claims:** Modifier 95
  - **PPS Facility (UB) Claims:** PN or PO modifier with condition code DR. Appropriate use of the PN and PO modifier is dependent on your specific services and locations. See the “hospital” section for details.
  - **COVID-19 Related:** For services relating to the order for or administration of a COVID-19 diagnostic test or for services related to the evaluation of an individual for purposes of determining the need for diagnostic testing, append modifier CS.
  - **DR Condition Code & CR Modifier:** For all services relating to a COVID-19 waiver, except telehealth services, append the “DR” condition code (UB claims) or “CR” modifier (1500 claims).
- **Patient Type:** As part of the CARES Act, practitioners can provide telehealth services to both new and established patients.
- **Patient Location:** During the COVID-19 PHE, CMS implemented an 1135 blanket waiver for Medicare telehealth services.
  - 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. Effective January 1<sup>st</sup>, 2022:
    - CMS permanently added a patient’s home as an originating site for patients receiving mental health services via telehealth. “Home” includes temporary lodging. Must meet the following requirements:
      - The provider (or another provider in the same practice and subspecialty) has conducted an in-person (non-telehealth) visit within 6 months
      - After the initial tele-mental health visit, the provider must conduct an in-person visit at least once every 12 months
        - However, this visit is not required if the patient and provider consider the risks of an in-person visit and agree that the risks outweigh the benefits
        - Provider should document decision in the patient’s medical record
- **Provider Type:** All health care practitioners who are authorized to bill Medicare for their professional services may also furnish and bill for telehealth services. This allows health care professionals who were not previously authorized under the statute to furnish and bill for Medicare telehealth services, including physical therapists,

occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.

- There are no payment restrictions on distant site providers furnishing Medicare telehealth services from their home during the PHE. Report the place of service code that would have been reported had the service been furnished in person.
- Direct supervision may be provided using real-time, interactive audio and video technology through the later of the end of the calendar year in which the PHE ends or December 31, 2021.
- **Reimbursement:** Reimbursement will be at the same rate as in-person face-to-face visits, refer to the Medicare fee schedule for allowable rates.
  - **Site of Service Differential:** Prior to CMS-1744-IFC, services that had a site differential (facility versus office), were paid on the facility payment rate when services were furnished via telehealth. Effective March 1<sup>st</sup>, 2020, CMS now allows physicians' offices to be paid at the office rate.
    - Providers should report the POS code that would have been reported had the service been furnished in person with modifier 95.
    - CMS is maintaining the facility payment rate for services billed using the POS code 02 if providers choose to not change their current billing practices.
- **Removal of Frequency Limitations on Medicare Telehealth:** Per CMS, the following services no longer have limitations on the number of times they can be provided by telehealth:
  - A subsequent inpatient visit can be furnished via telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233).
  - A subsequent skilled nursing facility visit can be furnished via telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310).
    - Effective January 1<sup>st</sup>, 2021, Medicare has permanently changed the frequency limitation of subsequent skilled nursing visits to one visit every 14 days.
  - Critical care consult codes may be furnished by telehealth beyond the once per day limitation (CPT codes G0508-G0509).
- **Rural Health Clinics & Federally Qualified Health Centers:** See the RHC and FQHC section for specific billing regulations.
- **Transmission/ Originating Site Fees:** Medicare does not reimburse for transmission fees. If applicable, Medicare will reimburse an originating site fee (HCPCS Q3014).
  - Effective April 30<sup>th</sup>, 2020, through the end of the PHE:
    - Hospitals may bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home.
- **Video Component:** When providers are providing an E/M service that would otherwise be reported as an in-person or telehealth visit, using audio-only technology, providers should utilize the appropriate telephone E/M code (99441-99443), not the in person or telehealth visit code.
  - Effective January 1<sup>st</sup>, 2022:
    - Medicare redefined "interactive telecommunications system" definition to include interactive, real-time, two way audio-only technology for telehealth services for mental health disorders
    - Audio only mental health telehealth will be reimbursable if:
      - The provider has the technical capability, at the time of the service, to use an interactive telecommunications system
      - The patient is incapable of, or fails to consent to, the use of video technology for the service
      - The beneficiary is located at his or her home
      - The practitioner documents the reason for using audio-only technology uses the appropriate service level modifier

### **Cost Share Waiver:**

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

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

Use these HCPCS codes for billing:

- [Physicians and non-physician practitioners](#)
  - [Outpatient Prospective Payment System \(OPPS\)](#)
  - [RHCs and FQHCs](#)
  - CAHs: use OPPS codes
  - Method II CAHs: use the OPPS list or the physician and non-physician practitioner list, as appropriate.
- Cost-sharing does not apply to the above medical visit services for which payment is made to:
    - Hospital Outpatient Departments paid under the Outpatient Prospective Payment System, Physicians and other professionals under the Physician Fee Schedule, Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs).
  - 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.

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

99441	99442	99443	99468	99471	99473	99475	99477	G0410	G9685	S9152
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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 during the COVID-19 PHE ONLY

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

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

### Payor Specific Key Points:

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

##### Allowable Codes:

- **E-Visits:** Not Allowed
- **Telephone:** Not Allowed
- **Virtual Check-Ins:** G2012

**Patient Type:** Established

#### Telehealth:

**Allowed Codes:** Arkansas Medicaid will allow services provided through telemedicine if the service is comparable to the same service provided in person. Store & Forward & Remote Patient Monitoring are included within the definition of telemedicine.

- **Standard of Care:** Services provided by telemedicine, including a prescription through telemedicine, shall be held to the same standard of care as services provided in person.
- **Professional Relationship:** A professional relationship must exist between the provider and patient:
  - The provider has previously conducted an in-person examination of the patient and is available to provide appropriate follow-up care;
  - The provider personally knows the patient and the patient's health status through an ongoing relationship and is available to provide follow-up care;
  - The treatment is provided by a provider in consultation with, or upon referral by, another provider who has an ongoing professional relationship with the patient and who has agreed to supervise the patient's treatment including follow-up care;
  - An on-call or cross-coverage arrangement exists with the patient's regular treating healthcare provider or another provider who has established a professional relationship with the patient;
  - A relationship exists in other circumstances as defined by the Arkansas State Medical Board or a licensing or certification board for other healthcare providers under the jurisdiction of the appropriate board if the rules are no less restrictive than the rules of the ASMB.
  - A professional relationship is established if the provider performs a face to face examination using real time audio and visual telemedicine technology that provides information at least equal to such information as would have been obtained by an in-person examination.
  - If the establishment of a professional relationship is permitted via telemedicine under the guidelines outlined in ASMB regulations, telemedicine may be used to establish the professional relationship only for situations in which the standard of care does not require an in-person encounter and only under the safeguards established by the healthcare professional's licensing board.
  - The healthcare professional who is licensed in Arkansas has access to a patient's personal health record maintained by a healthcare professional and uses any technology deemed appropriate by the healthcare professional, including the telephone, with a patient located in Arkansas to diagnose, treat, and if clinically appropriate, prescribe a noncontrolled drug to the patient.
- **Exclusions:** A professional relationship does not include a relationship between a provider and a patient established only by the following: An internet questionnaire, an email message, a client-generated medical history, text messaging, a facsimile machine (Fax) and E-Fax, or any future technology that does not meet the criteria outlined in this section.
- **Exceptions:** The existence of a professional relationship is not required when: An emergency situation exists or the transaction involves providing information of a generic nature not meant to be specific to an individual patient.

- **Minor:** If a provider seeks to provide telemedicine services to a minor in a school setting and the minor client is enrolled in Arkansas Medicaid, the provider shall:
  - Be the designated Primary Care Provider (PCP) for the minor patient.
  - Have a cross-coverage arrangement with the designated PCP of the minor patient; or
  - Have a referral from the designated PCP of the minor patient.
- **HIPAA Compliant Platform:** Through the end of the federal COVID-19 PHE, non-HIPAA compliant, non-public facing software can be utilized for telehealth visits, such as Skype & FaceTime.
- **Modifiers/POS:**
  - **Professional (1500) claims:** POS 02 or 10
    - The GT modifier must continue to be used when billing any claim related to a prior authorization (PA) created prior to January 1, 2022, until the expiration date of the PA, regardless of the date of service.
      - Once the PA expires, discontinue use of the GT modifier
  - **Facility (UB) Claims:** Modifier GT.
- **Provider Type:** Providers must be fully licensed or certified to practice in Arkansas and is subject to the rules of the appropriate state licensing or certification board. Provider also must be credentialed with Arkansas Medicaid.
- **Patient Type:** Professional relationship must be established.
- **Reimbursement:** Reimbursement for services provided through telehealth will be on the same basis as for services provided in person.
- **Transmission & Originating Site Fees:** Arkansas Medicaid will allow an originating site to billed utilizing HCPCS Q3014 (originating site fee), as appropriate. T1014 (transmission fees) are allowed as appropriate.
- **Video Component:** Real time, interactive, audio-only communication is allowed if it meets the requirements for a service that would otherwise be covered.
  - Documentation of the engagement between patient and provider via audio-only communication shall be placed in the medical record addressing the problem, content of the conversation, medical decision-making, and plan of care after the contact.

**Cost Share Waiver:**

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

**PASSE MEDICAID MANAGED CARE ORGANIZATIONS**

The PASSE Model of Care is a state health plan created for Medicaid recipients with complex behavioral health, developmental, or intellectual disabilities. The care for these beneficiaries is managed by three payors: Arkansas Total Care, Empower Healthcare Solutions, and Summit Community Care.

These payors are following the State of Arkansas Medicaid guidance, including applicable billing modifiers.

The PASSE program does not apply member cost share to any medical necessity service, therefore there would be no member cost sharing for medically necessary telehealth and COVID-19 testing and care.

## Payor Specific Key Points:

### 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:** 99441-99443, 98966-98968
  - **Virtual Check-In:** G2010, G2012, G2250-G2252
- **POS:** POS utilized if visit would have in person (11, 21, 22, etc)

### 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.
- **HIPAA Compliant Platform:** Through the COVID-19 PHE, telehealth visits can be performed via non-compliant HIPAA platforms, such as FaceTime, Facebook Messenger, Skype, Google Hangouts and WhatsApp. After the PHE ends, visits must be performed over a HIPAA compliant platform.
- **Modifiers/POS:**
  - **Professional (1500) claims:** POS 02. Modifiers 95, GT, GQ, and G0 are not required to identify telehealth services but are accepted as information if reported on claims.
  - **Facility (UB) claims:** Revenue code 780 (allowable during the PHE only)
- **Provider Type:** Physician, nurse practitioner, physician assistant, nurse-midwife, clinical nurse specialist, registered dietitian or nutrition professional, clinical psychologist, clinical social worker, certified registered nurse anesthetists, physical therapists, occupational therapists, and speech therapists.
- **Reimbursement:** Reimbursement will be at the same rate as in-person face-to-face visits, refer to your UHC contract for allowable rates.
- **Patient Location:** UHC will recognize CMS designated originating sites considered eligible for furnishing telehealth services to a patient located in an originating site.
  - Examples of CMS originating sites with a telepresenter: the office of a physician or practitioner, hospital, critical access hospital (CAH), rural health clinic (RHC), federally qualified health center (FQHC), hospital based renal dialysis center, skilled nursing facility (SNF), community mental health center (CMHC), mobile stroke unit, patient home-for monthly end stage renal, ESRD-related clinical assessments, for purposes of treatment of a substance use disorder or a co-occurring mental health disorder.
  - UHC will also recognize home as an originating site for telehealth services (no telepresenter present)
- **Transmission & Originating Site Fees:** UHC will allow the originating site to submit a claim for services of the telepresenter using HCPCS Q3014. T1014 is not eligible for payment, UHC considers these services as incidental to the charges associated with the E/M.
- **Video Component:** Telehealth services must be performed over an audiovisual connection.

UHC ELEGIBLE TELEHEALTH CODES											
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845
90846	90847	90853	90863	90951	90952	90953	90954	90955	90956	90957	90958
90959	90960	90961	90962	90963	90964	90965	90966	90967	90968	90969	90970
92227	92228	92507	92521	92522	92523	92524	93228	93229	93268	93270	93271
93272	96040	96116	96121	96130	96131	96132	96133	96136	96137	96138	96139

96156	96158	96159	96160	96161	96164	96165	96167	96168	97110	97112	97116
97161	97162	97163	97164	97165	97166	97167	97168	97535	97750	97755	97760
97761	97802	97803	97804	98960	98961	98962	99202	99203	99204	99205	99211
92212	99213	99214	99215	99217	99224	99225	99226	99231	99232	99233	99238
99239	99281	99282	99283	99284	99285	99291	99292	99307	99308	99309	99310
99315	99316	99334	99335	99336	99337	99347	99348	99349	99350	99354	99355
99356	99357	99395	99396	99397	99406	99407	99408	99409	99469	99472	99476
99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0270	G0296
G0396	G0397	G0406	G0407	G0408	G0420	G0421	G0425	G0426	G0427	G0438	G0439
G0442	G0443	G0444	G0445	G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514
G2086	G2087	G2088	G9986	G2212	G9481	G9482	G9483	G9484	G9485	G9486	G9487
G9488	G9489	G9978	G9979	G9980	G9981	G9982	G9983	G9984	G9985		
<b>PT/OT/ST</b>											
92507	92521	92522	92523	92524	97110	97112	97116	97161	97162	97163	97164
97165	97166	97167	97168	97535	97750	97755	97760	97761			

**Cost Share Waiver:**

**Duration of COVID-19 PHE:** UHC is waiving cost sharing for in-network and out-of-network testing and testing-related telehealth visits.

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

Current cost share waivers:

Payor	Cost Sharing Guidelines
<b>Aetna</b>	<b>Effective March 6th, 2021, through End of PHE:</b> Aetna will waive cost sharing for COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test
<b>AR BCBS</b>	<b>Effective October 1st, 2021-End of PHE:</b> AR BCBS will apply cost share for telehealth services, except for telehealth visits that result in the evaluation or administration of a COVID-19 diagnostic test or any visit that has COVID-19 as a primary DX. For these two situations, they will waive cost sharing.
<b>Cigna</b>	<b>Effective March 13th, 2020 through End of PHE:</b> 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).
<b>Medica</b>	<b>Effective March 1st, 2020 through April 30<sup>th</sup>, 2022:</b> Medica will waive cost-sharing for in-network telehealth visits when related to administration of a COVID-19 test.
<b>Medicare</b>	<b>Effective March 18<sup>th</sup>, 2020-End of PHE:</b> 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
<b>Arkansas Medicaid</b>	<b>Effective March 18th, 2020, through End of PHE:</b> Cost share is waived on COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test
<b>UHC</b>	<b>Effective February 4<sup>th</sup>-End of PHE:</b> Cost share is waived on COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test

## RURAL HEALTH CLINICS

### MEDICARE

On March 27<sup>th</sup>, 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 18<sup>th</sup>-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 1<sup>st</sup>, 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.
- **Mental Health Services:**
  - As of January 1<sup>st</sup>, 2022, CMS will continue to allow mental health telehealth services, performed by an RHC/FQHC even after the PHE ends
    - The service must be either audio visual OR
    - Audio-only, IF the following are present:
      - The patient is incapable of, or fails to consent to, the use of video technology for the service
      - The provider has conducted an in-person visit within the last 6 months of the initial tele-mental service

- The services are medical necessary
- After the initial telehealth visit, the provider conducts an in-person visit at least once every 12 months of each tele-mental visit.
  - However, if the patient and provider consider the risks of an in person service and agree that these risks outweigh the benefits, then the annual visit may be skipped.
  - Providers must document the decision
- **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 1<sup>st</sup>, 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.
  - 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

Effective April 28<sup>th</sup>, 2020 Arkansas Medicaid issued the below billable code for RHCs/FQHCs telehealth services:

Code	Description
<b>April 28<sup>th</sup>-August 27<sup>th</sup>, 2020:</b> T1015, U7, GT w/ POS 02  <b>August 28<sup>th</sup>, 2020-Forward:</b> G2025 w/ POS 02  *Note if billing on UB you do not need POS.	Distant site telemedicine services can be furnished by any health care practitioner working for the RHC or the FQHC within their scope of practice, if telemedicine is within their scope of practice (including the relaxed scope or practice rules during the public health emergency). Telemedicine encounters may not be billed in conjunction with a full, face-to-face encounter, but instead are considered part of that encounter. A nurse or other paraprofessional cannot provide telemedicine services exclusive of other licensed practitioners.

- A telemedicine service cannot be billed if a full, face-to-face encounter is provided seven days before the telemedicine service is billed or within 24 hours (or the next available appointment) after the encounter.
- These services may be provided to a beneficiary in their home under previous rule suspensions lifting the originating site requirement.
- Telemedicine services are not to be billed as an All-Inclusive Rate (AIR) or Prospective Payment (PPS).
- Telemedicine services are to be reported on the cost report but will not be used to set future AIR and PPS rates or included in the annual cost settlement.

# FEDERALLY QUALIFIED HEALTH CENTERS

## MEDICARE

On March 27<sup>th</sup>, 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 (G0466, 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 30<sup>th</sup>, 2020.
    - Claims will be automatically reprocessed beginning July 1<sup>st</sup>, 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 1<sup>st</sup>, 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.
  - **COVID-19 Related Care:** Append modifier CS

FQHC Claims for Telehealth Services January 27, 2020 through June 30, 2020		
Revenue Code	HCPCS Code	Modifiers
052X	FQHC Specific Payment Code- G0466, G0467, G0468, G0469, G0470	None
052X	FQHC PPS Qualifying Payment Code	95
052X	G2025	95
FQHC 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 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 18<sup>th</sup>-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 1<sup>st</sup>, 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.
- **Mental Health Services:**

- As of January 1<sup>st</sup>, 2022, CMS will continue to allow mental health telehealth services, performed by an RHC/FQHC even after the PHE ends
  - The service must be either audio visual OR
  - Audio-only, IF the following are present:
    - The patient is incapable of, or fails to consent to, the use of video technology for the service
    - The provider has conducted an in-person visit within the last 6 months of the initial tele-mental service
    - The services are medical necessary
    - After the initial telehealth visit, the provider conducts an in-person visit at least once every 12 months of each tele-mental visit.
      - However, if the patient and provider consider the risks of an in person service and agree that these risks outweigh the benefits, then the annual visit may be skipped.
      - Providers must document the decision
- **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 1<sup>st</sup>, 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.

## MEDICAID

Effective April 28<sup>th</sup>, 2020 Arkansas Medicaid issued the below billable code for RHCs/FQHCs telehealth services:

Code	Description
<b>April 28<sup>th</sup>-August 27<sup>th</sup>, 2020:</b> T1015, U7, GT w/ POS 02  <b>August 28<sup>th</sup>, 2020-Forward:</b> G2025 w/ POS 02  *Note if billing on UB you do not need POS.	Distant site telemedicine services can be furnished by any health care practitioner working for the RHC or the FQHC within their scope of practice, if telemedicine is within their scope of practice (including the relaxed scope or practice rules during the public health emergency). Telemedicine encounters may not be billed in conjunction with a full, face-to-face encounter, but instead are considered part of that encounter. A nurse or other paraprofessional cannot provide telemedicine services exclusive of other licensed practitioners.

- A telemedicine service cannot be billed if a full, face-to-face encounter is provided seven days before the telemedicine service is billed or within 24 hours (or the next available appointment) after the encounter.
- These services may be provided to a beneficiary in their home under previous rule suspensions lifting the originating site requirement.
- Telemedicine services are not to be billed as an All-Inclusive Rate (AIR) or Prospective Payment (PPS).
- Telemedicine services are to be reported on the cost report but will not be used to set future AIR and PPS rates or included in the annual cost settlement.

## 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 OPSS. **It does not apply to CAHs.**
    - **CAH PT/OT/ST:** Append modifier 95 if therapy services are provided via telehealth.
  - **PPS Hospitals:**
    - Hospital OP services reimbursed at the OPSS rate (i.e. diabetic management services, behavioral health, etc.), have the following choices:
      - Utilize the extraordinary circumstances policy, appending a PO modifier reimbursed at the OPSS rate.
      - Not utilize the extraordinary circumstances policy appending a PN modifier and DR condition code which is reimbursed using the Physician Fee Schedule (PFS).

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

▪ **Medicare FAQ:**

**Question:** *When hospital clinical staff furnish a service using telecommunication technology*

*to the patient who is a registered outpatient of the hospital and the hospital makes the patient's home provider-based to the hospital as a temporary expansion site, should the hospital bill using the telehealth modifier (modifier 95)?*

**Answer:** *No. In this situation the hospital is furnishing an outpatient hospital service, not a telehealth service, to a patient in a temporarily relocated department of the hospital as discussed at 85 FR 27560. Accordingly, the hospital would bill as it ordinarily would bill and would include the DR condition code or CR condition code (as applicable) on the claim. If the situation involves a relocation of an on-campus or excepted off-campus provider-based department to an off-campus hospital location, the hospital would bill using the PO modifier (service provided at an excepted off-campus provider-based department) only if the hospital requests an extraordinary circumstances relocation request within 120 days of the date the temporary expansion site is made provider-based to the hospital; otherwise, the hospital would append the PN modifier (service provided at a non-excepted off-campus*

<https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>

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

• **Medicare FAQ:**

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

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

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

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

<https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>

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

## PT/OT/ST

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

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

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

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

Payor	Telehealth Codes	E-Visits
<b>Aetna</b>	<p style="text-align: center;"><b>ALLOWABLE</b></p> <ul style="list-style-type: none"> <li>• Allowable PT/OT/ST code set is available in the “Aetna” section of this guide.</li> <li>• PT/OT/STs are considered providers eligible to bill for telehealth services.</li> <li>• 1500 Form: Utilize modifier GT or 95 and 02 POS. UB Form: Utilize GT or 95 modifier.</li> </ul>	<p style="text-align: center;"><b>1500 FORM-ALLOWABLE</b></p> <p>Individually enrolled therapists can bill CPT 98970 -98972 or G2061-G2063 for E-visits.</p> <p style="text-align: center;"><b>UB FORM-UNCLEAR</b></p> <p>No guidance for hospital-based therapists.</p>
<b>Arkansas BCBS</b>	<p style="text-align: center;"><b>ALLOWABLE</b></p> <ul style="list-style-type: none"> <li>• Allowable PT/OT/ST code set is available in the “Arkansas BCBS” section of this guide.</li> <li>• PT/OT/STs are considered providers eligible to bill for telehealth services.</li> <li>• 1500 Form: Utilize modifier GT or 95 and POS 02. UB Form: Utilize modifier GT or 95.</li> </ul>	<b>NOT ALLOWABLE</b>
<b>Cigna</b>	<p style="text-align: center;"><b>ALLOWABLE</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 1500 Form: Utilize modifier GT or 95 and in person POS. UB Form: Not Allowable as of January 1<sup>st</sup>, 2021</li> </ul>	<b>NOT ALLOWABLE</b>
<b>Medica</b>	<p style="text-align: center;"><b>ALLOWABLE</b></p> <ul style="list-style-type: none"> <li>• Allowable PT/OT/ST code set is available in the “Medica” section of this guide.</li> <li>• PT/OT/STs are considered providers eligible to bill for telehealth services.</li> <li>• 1500 Form: Utilize modifier GT or 95 and POS 02. UB Form: Utilize GT or 95 modifier.</li> <li>•</li> </ul>	<p style="text-align: center;"><b>1500 FORM-ALLOWABLE</b></p> <p>Individually enrolled therapists can bill CPT 98970 -98972 or G2061-G2063 for E-visits.</p> <p style="text-align: center;"><b>UB FORM-UNCLEAR</b></p> <p>No guidance for hospital-based therapists.</p>
<b>Medicare</b>	<p style="text-align: center;"><b>ALLOWABLE</b></p> <ul style="list-style-type: none"> <li>• Allowable PT/OT/ST code set is available in the “Medicare” section of this guide.</li> <li>• PT/OT/STs are considered providers eligible to bill for telehealth services.</li> <li>• 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.</li> </ul>	<p style="text-align: center;"><b>1500 FORM-ALLOWABLE</b></p> <p>Individually enrolled therapists can bill G2061-G2063 for E-visits.</p> <p style="text-align: center;"><b>UB FORM-UNCLEAR</b></p> <p>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.</p>

	1500 Form: Utilize POS for in person visit and 95 modifier. UB Form: Utilize 95 modifier.	
<b>Arkansas Medicaid</b>	<p style="text-align: center;"><b>ALLOWABLE</b></p> <ul style="list-style-type: none"> <li>Allowable PT/OT/ST code set is available in the “Arkansas Medicaid” section of this guide.</li> <li>PT/OT/STs are considered providers eligible to bill for telehealth services.</li> <li>1500 Form: Utilize modifier GT and POS 02. UB Form: Utilize GT modifier.</li> </ul>	<b>NOT ALLOWABLE</b>
<b>UHC</b>	<p style="text-align: center;"><b>ALLOWABLE</b></p> <ul style="list-style-type: none"> <li>Allowable PT/OT/ST code set is available in the “UHC” section of this guide.</li> <li>1500 Form: POS 02. UB Form: Modifier 95 and revenue code 780.</li> </ul>	<p style="text-align: center;"><b>1500 FORM-ALLOWABLE</b></p> <p>Individually enrolled therapists can bill 98970 -98972 for E-visits.</p> <p style="text-align: center;"><b>UB FORM-NOT ALLOWABLE</b></p>

## HIPAA COMPLIANT SOFTWARE

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

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

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

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

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

## REFERENCES & RESOURCES

**Aetna:**

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

**Arkansas BCBS:**

- <https://www.arkansasbluecross.com/providers/medical-providers/providers-news>
- <https://www.arkansasbluecross.com/docs/librariesprovider9/default-document-library/june-providers-news-508.pdf>
- <https://www.arkansasbluecross.com/covid-19/members-covered-by-arkansas-blue-cross-health-advantage-fully-insured>

**Arkansas Department of Human Services:**

- <https://humanservices.arkansas.gov/resources/response-covid-19/response-covid-19-providers-1>

**AR Medicaid:**

- <https://medicaid.mmis.arkansas.gov/Provider/Provider.aspx#covidresp>
- <https://medicaid.mmis.arkansas.gov/Provider/Docs/physicn.aspx>
- <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/official-notices/>
- <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/all-prov/>



<https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/#current-fee-schedules>

**Arkansas Total Care:**

<https://www.arkasastotalcare.com/providers/coronavirus-information.html>

**HHS**

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

**Cigna:**

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

[https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/Notifications/R31\\_Virtual\\_Care.pdf](https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/Notifications/R31_Virtual_Care.pdf)

**CMS:**

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

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

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

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

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

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

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

<https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>

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

<https://www.cms.gov/files/document/se20016.pdf>

<https://www.cms.gov/outreach-and-education/outreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se>

<https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>

<https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf>

**Empower Healthcare Solutions:**

<https://www.getempowerhealth.com/providers/provider-alerts/>

**Medica:**

<https://www.medica.com/providers>

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

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

**NARHC:**

<https://narhc.org/>

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

**Summit Community Care:**

<https://provider.summitcommunitycare.com/arkansas-provider/covid-19-updates>

**UHC:**

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

<https://www.uhc.com/health-and-wellness/health-topics/covid-19>

<https://www.uhcprovider.com/en/resource-library/news/provider-telehealth-policies.html>

<https://www.uhcprovider.com/content/provider/en/viewer.html?file=https%3A%2F%2Fwww.uhcprovider.com%2Fcontent%2Fdam%2Fprovider%2Fdocs%2Fpublic%2Fpolicies%2Fcomm-reimbursement%2FCOMM-Telehealth-and-Telemedicine-Policy.pdf>

**Other:**

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

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