COVID-19 Virtual Visit Billing Guide
ARKANSAS

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Virtual Visit Types

- Telehealth
- Evisits
- Virtual Check In
- Telephone

Payor Matrix

Payor Guidelines

- Aetna
- Arkansas Blue Cross Blue Shield
- Cigna
- Medica
- Medicare
- Arkansas Medicaid
- United Healthcare

Cost Sharing Waiver

Telehealth Guidelines By Facility Type

- Rural Health Clinics/Federally Qualified Health Clinics
- Hospital Outpatient
- Physical Occupational Speech Therapy

HIPAA Compliant Software

References and Resources
Definition: There are three types of telehealth services:

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

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

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

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

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

**Place of Service Codes**

POS 02: Telehealth Provided Other than in Patient’s Home*
- The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.

POS 10: Telehealth Provider in Patient’s Home - Effective January 1st, 2022
- The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care)

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

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

**Reporting Criteria:**

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

**Documentation Requirements:** Telehealth services have the same documentation requirements as a face-to-face encounter. The information of the visit, history, review of systems, consultative notes, or any information used to make a medical decision about the patient should be documented. In addition, the documentation should note that the service was provided through telehealth, both the location of the patient and the provider, and the names and roles of any other persons participating in the telehealth visit. Obtain verbal consent at the start of the visit and ensure consent is documented. Maintain a permanent record of the telehealth visit in the patient’s medical record.
**Definition:** Online Digital Evaluation and Management Services (E-Visits) are an E/M service provided by a Qualified Healthcare Professional or an assessment provided by a Qualified Nonphysician Healthcare Professional to a patient using an audio and visual software-based communication, such as a patient portal.

**CPT/HCPCS Codes:**

Reportable by a Qualified Healthcare Professionals:

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

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

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

**Reporting Criteria:**

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

**Documentation Requirements:** These are time-based codes, and documentation must support what the physician did and for how long. Time is documented and calculated over the 7-day duration and must meet the CPTs time requirement. Obtain verbal consent at the start of the visit and ensure the consent is documented. Maintain a permanent record of the telehealth visit in the patient’s medical record.
**Definition:** A brief check in between a practitioner and a patient via telephone or other audiovisual device to decide whether an office visit or other service is needed. A remote evaluation is recorded video and/or images submitted by an established patient.

**CPT/HCPCS Codes:**

- **G2012:** Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

- **G2010:** Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

- **G2250:** Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.

- **G2251:** Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical 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 or 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 or leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- **98967:** 11-20 minutes of medical discussion.
- **98969:** 21-30 minutes of medical discussion.

**Reporting Criteria:**

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

**Documentation Requirements:**

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

<table>
<thead>
<tr>
<th>PAYOR</th>
<th>E-VISIT CODES</th>
<th>TELEHEALTH-NO ORIGINATING SITE RESTRICTION</th>
<th>VIRTUAL CHECK-IN CODES</th>
<th>TELEPHONE CODES</th>
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Disclaimer: Although the data found here has been produced and processed from payer sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability or usefulness of any information.
Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

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

Remote Patient Monitoring:

Allowable Codes: 99453, 99454, 99457, 99458

Telehealth:

**Allowable Services**: See table below

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

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

Modifiers/POS:

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

Not Reimbursable:

- Synchronous telemedicine rendered via an audio only connection.
  - Modifier FQ or 93*
    *Allowable during the COVID-19 PHE
- Asynchronous Telemedicine Services (services reported w/ GQ modifier).
- Services that do not include direct patient contact, such as physician standby services.

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

Reimbursement: Reimbursement will be at the same rate as in-person face-to-face visits, refer to your Aetna contract for allowable rates.

- **Capitation**: Telemedicine will be covered within the capitation agreement, similar to an in-office visit

Transmission & Originating Site Fees: T1014 and Q3014 are not eligible for payment, Aetna considers these services as incidental to the charges associated with the E/M.

Video Component: The telehealth video component is required, except on codes indicated below that can be provided over audio only during the COVID-19 PHE.
Cost Share Waiver:

- Effective March 6th, 2020 through End of PHE: Aetna will waive cost sharing for COVID-19 testing-related services, which are medical visits that result in an order for, or administration, of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test.

### AETNA ELIGIBLE TELEHEALTH CODES

#### Telehealth Allowable Codes

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<th>Code</th>
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#### Commercial Codes Effective March 6th, 2020-Until Further Notice Due to COVID-19 Pandemic

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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 do NOT Require Modifier GT,95, or FR

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

E-Visits/Telephone/Virtual Check Ins:

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

Modifier/POS: POS 02

Telehealth:

Allowable Codes: Telehealth is covered when all the following conditions are met:
- A professional relationship exists between the healthcare professional at the distant site and the patient.
  - Exceptions include an emergent situation or a situation in which only information of a generic nature is provided not meant to be specific to an individual.
- The service is allowed for the specific provider type and can be safely and effectively performed via telehealth to the same standard of care as with a face-to-face visit.
- The service is delivered either through a real-time audio-visual communication system in a traditional telemedicine model or a consumer-driven model through an interactive audio device when performed through an approved telehealth ecosystem (software).
- If the originating site is a clinical setting, a Presenter must be at the Originating Site to orient the patient, operate the equipment, problem solve, and gather clinical data.
- A clinical record of the encounter which contains at least the same elements as are included in a face-to-face encounter record is maintained. The location of the Originating Site and Distant Site must be recorded.
- For visits which include a physical exam, the equipment allows for remote examination by the healthcare professional or a qualified, licensed person capable of performing the exam supplements the examination and relays the findings to the healthcare professional.

See below table for telehealth allowable codes

Asynchronous: Allowed, utilize GQ modifier

HIPAA Compliant Platform: Data transmission must be through a HIPAA-compliant network, with sufficient bandwidth and screen resolution. The system must maintain a log of connections, with time, date, and duration. It must also include the following: patient's medical history, store and forward capabilities, e-prescribing tool, and interaction tools available for instant use (real time video, audio, imaging) patient/healthcare communication application.

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.

Non-Covered Services:
- The establishment of a professional relationship cannot be made through any of the following means: Internet questionnaire, email message, patient-generated medical history, audio-only communication (including without limitation, interactive audio), text messaging, facsimile machine (fax), or any combination of the above.
- eICU monitoring as an adjunct to intensive care unit services.
- Services which are, by definition, hands-on, such as surgery, interventional radiology, coronary angiography, anesthesia, and endoscopy.
- Telephonic (when performed outside of an approved telehealth ecosystem and through an interactive audio device), fax, email, remote monitoring and mobile health.
• Evaluation and management services of the highest level (eg 99205, 99285) are not covered when performed by telemedicine, because these require a level of interaction not possible by telemedicine.
• An originating site fee is not allowed if a patient and provider are on the same campus at the time of the visit.
• Prescribing and dispensing durable medical equipment (DME).

Provider Type: Licensed as required by the appropriate state's Medical Board, and the service provided must be within the scope of practice for that healthcare professional.

Patient Type: Established patient relationship is required. Patient may be located at their home, or other originating site.

Reimbursement: Reimbursement will be consistent with the provider’s BCBS fee schedule.

Transmission & Originating Site Fees: AR BCBS allows HCPCS Q3014 (originating site fee) but does not allow T1014 (transmission fees).

Video Component: Telephones without the use of a telehealth ecosystem, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.

Cost Share Waiver:
Effective October 1st, 2021- End of PHE: AR BCBS will waive cost sharing for COVID-19 testing-related services, which are medical visits that result in an order for, or administration, of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test or to the evaluation of an individual for purposes of determining the need for such a test. Note that the cost share waiver for COVID-19 visits for treatment (beyond the initial evaluation visit for a COVID-19 test) expired on July 31st, 2022.

<table>
<thead>
<tr>
<th>AR BCBS ALLOWABLE TELEHEALTH CODES</th>
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<tr>
<td>90791     90792     90832     90833     90836     90837     90838     90845     90846     90847</td>
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<td>99283     99284     99406     99407     99408     99409     99495     99496     G0180     Q3014</td>
</tr>
</tbody>
</table>
Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

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

E-Consults:
Cigna recognizes E-Consult codes, which occurs when a treating health provider seeks guidance from a specialist physician through electronic means (phone, internet, EHR consultation, etc.)
- **Allowable Codes**: 99446-99452
- **Non-Billable**:
  - If the consultation to a transfer of care or other face-to-face service (e.g., a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes should not be billed.
  - If the consultation lasted less than 5 minutes.
  - If the consultation was for the sole purpose to arrange transfer of care or a face-to-face visit.

Remote Patient Monitoring:
Cigna recognizes remote patient monitoring, which is the use of digital technologies to monitor and capture medical data from patients and electronically transmit this information to healthcare providers for assessment:
- **Allowable codes**: 99091, 99453, 99454, 99457, 99458, 99473, 99474, S9110

Telehealth:

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

**Excluded Services**:
- Service on the same day as a face-to-face visit, when performed by the same provider and for the same condition.
- Services billed within a post-operative period
- Services performed via asynchronous communications systems (e.g., fax).
- Store and forward telecommunication
- Communications incidental to E/M services, counseling, or medical services included in this policy, including, but not limited to reporting of test results and provision of educational materials.
- Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.
• Urgent Care centers will not be reimbursed for virtual care*
  *Cigna will reimburse urgent care centers for virtual care services provided on and before March 12, 2022.
• Specific Excluded CPT Codes: 98966, 98967, 98968, 98970, 988971, 99421, 99422, 99423, G0406, G0407, G0408, G0409, G0425, G0426, G0427, G0459, G0508, G0509, G2025, S0320.

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

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

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

Reimbursement: Reimbursement will be at the same rate as in-person face-to-face visits, refer to your Cigna contract for allowable rates.

Video Component: An audiovisual connection is required except for telephone codes.

Transmission & Originating Site Fees: Cigna will not reimburse an originating site of service fee/facility fee for telehealth visits (HCPCS Q3014). Cigna will also not reimburse transmission fees; transmission of digitalized data is considered integral to the procedure performed and is not separately reimbursable.

<table>
<thead>
<tr>
<th>CIGNA ELIGIBLE VIRTUAL CODES</th>
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<tr>
<td>90951</td>
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Cost Share Waiver:
Effective March 13th, 2020-End of PHE: Cigna will waive cost sharing for COVID-19 testing-related services, which are medical visits that result in an order for, or administration, of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test or to the evaluation of an individual for purposes of determining the need for such a test.
E-Visits/Telephone/Virtual Check Ins:

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

E-Visit Exclusions:
- See below “Telehealth Coverage Limitations”

Telehealth:
Medica has extended their coverage for their telemedicine reimbursement policies at least through January 31, 2023

**Allowable Codes**: See table below for specific codes.
- **Wellness Visits**: During the COVID-19 PHE Medica will allow preventive visits to be provided via telehealth utilizing CPTs 99381-99387 and 99391-99397.
  - Providers may perform all or portions of a preventive visit that can be done appropriately via telehealth.
  - Services that require face-to-face interaction may be provided later, however, providers may only bill one preventive medicine code to cover both portions.

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

**Modifiers/POS**:
- **Professional (1500) Claims**: POS 02 or 10 with modifier GT or 95
- **Facility (UB) Claims**: GT or 95
- **Audio Only**: 93 or FQ
- **COVID-19 Related**: For services relating to the order for or administration of a COVID-19 test or for services related to the evaluation for purposes of determining the need for diagnostic testing, append modifier CS.

**Provider Type**: Audiologist, Certified Genetic Counselor, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist, Licensed Drug & Alcohol Counselor, Dentist, Nurse Midwife, Nurse Practitioner, Occupational Therapist, Physical Therapist, Physician, Physician Assistant, podiatrist, Registered Dietitian or Nutrition Professional, and Speech Therapist.

**Reimbursement**: Reimbursement will be at the same rate as in-person face-to-face visits, refer to your Medica contract for allowable rates.

**Store and Forward Telehealth**: Medica allows both synchronous (interactive audiovisual communication) and asynchronous (store and forward). Utilize modifier GQ.

**Originating Sites**:
- Allowable originating sites: Office of physician or practitioner; hospital (inpatient or outpatient); home; critical-access hospital (CAH); rural health clinic (RHC) and federally qualified health center (FQHC); hospital-based or CAH-based renal dialysis center (including satellites); skilled nursing facility (SNF); end-stage renal disease (ESRD) facilities; community mental health center; Residential Substance Abuse Treatment Facility; and other eligible medical facilities.

**Transmission & Originating Site Fees**: Transmission fees (HCPCS T1014) are not eligible for payment, however Medica will allow an originating site fee (HCPCS Q3014) to be billed by an originating site facility.

**Telehealth Coverage Limitations**: The following are not covered under telemedicine:
- Provider initiated e-mail, refilling or renewing existing prescriptions, scheduling a diagnostic test or appointment, clarification of simple instructions or issues from a previous visit, reporting test results, reminders of scheduled
office visits, requests for a referral, non-clinical communication, educational materials, brief follow-up of a medical procedure without indication of complication or new condition including, but not limited to, routine global surgical follow-up, brief discussion to confirm stability of the patient’s without change in current treatment, when information is exchanged and the patient is subsequently asked to come in for an office visit, a service that would similarly not be charged for in a regular office visit, consultative message exchanges with an individual who is seen in the provider’s office immediately afterward, communication between two licensed health care providers that consists solely of a telephone conversation, email or facsimile, communications between a licensed health care provider and a patient that consists solely of an e-mail or facsimile.

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

<table>
<thead>
<tr>
<th>MEDICA ALLOWABLE TELEHEALTH CODES</th>
<th>Codes Highlighted in Blue -Require an Audiovisual Connection</th>
<th>Codes Highlighted in Green -Can Be Performed via an Audio only (Telephone) or Audiovisual Connection</th>
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Cost Share Waiver:
Effective March 1st, 2020, through End of PHE: Medica will waive cost-sharing for in-network telehealth visits when related to administration of a COVID-19 test. Utilize the Medica provider portal for details regarding cost-share waivers for specific patients, as the cost share waiver for telehealth may vary by plan.

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

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:
- E-Visits: 99421-99423, G2061-G2063
- Telephone: 99441-99443, 98966-98968
  - Allowed only through PHE +151 days only
- Virtual Check-In: G2010, G2012, G2250-G2251, G2252

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

New patients allowable for COVID-19 PHE

Telehealth:

Consolidated Appropriations Act: Extends certain telehealth flexibilities for Medicare patients for 151 days after the official end of the federal public health emergency (PHE), including:
- Originating site restriction waiver
- Expanded list of allowable telehealth practitioners
- Audio only telehealth services
- In person requirement for mental health services via telehealth
- Extension of FQHC/RHC to serve as originating site

Allowable Codes: See table below for codes allowable via telehealth.
- Temporary telehealth code coverage will be removed once the PHE expires +151 days
- Category 3 codes will be available through the end of 2023
- Note - Telehealth rules do not apply when the beneficiary and the practitioner are in the same location and are utilizing telehealth to reduce exposure risks, even if audio/video technology assists in furnishing a service.

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

Modifiers/POS:
- Professional (1500) Claims:
  - During PHE +151 Days: POS that would have been used if the visit were provided in person with modifier 95
  - After PHE +151 Days: POS 02 or 10
  - Modifier: FR if applicable
- Mental Health Claims: After PHE Ends: POS 02 or 10 and modifier 93 if performed over audio only
  - RHC/FQHC: Modifier FQ
  - MACs have instructed providers not to use modifier FQ, 93, or FR during the PHE
- CAH Method II (UB) Claims: Modifier GT
- CAH & PPS PT/OT/Speech UB Claims: Modifier 95
- PPS Facility (UB) Claims: PN or PO modifier with condition code DR. Appropriate use of the PN and PO modifier is dependent on your specific services and locations. See the “hospital” section for details.
- COVID-19 Related: For services relating to the order for or administration of a COVID-19 diagnostic test or for services related to the evaluation of an individual for purposes of determining the need for diagnostic testing, append modifier CS

Patient Type: Through the end of the PHE, telehealth services can be provided to both new and established patients.
Patient Location: During the COVID-19 PHE, Medicare will pay for office, hospital, and other visits furnished via telehealth across the country, whether urban or rural, and in all settings, including in patients’ homes.

- **151 Days Post PHE:** Originating site restriction will once again be enforced, except for tele-mental health
- **Mental Health:** CMS permanently added a patient’s home as an originating site for patients receiving mental health services via telehealth. “Home” includes temporary lodging. Must meet the following requirements:
  - The provider (or another provider in the same practice and subspecialty) has conducted an in-person (non-telehealth) visit within 6 months
  - After the initial tele-mental health visit, the provider must conduct an in-person visit at least once every 12 months
    - However, this visit is not required if the patient and provider consider the risks of an in-person visit and agree that the risks outweigh the benefits
    - Provider should document decision in the patient’s medical record
  - During the PHE +151 days, the initial 6 month visit and the in person visit every 12 month requirement is waived

Provider Type: During the PHE +151 days, 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.
- **151 Days Post PHE:** Allowable provider types will revert back to only physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals

Reimbursement: During the PHE +151 days, reimbursement will be at the same rate as in-person face-to-face visits, refer to the Medicare fee schedule for allowable rates.

- **151 Days Post PHE:** Site of service differential will once again apply

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

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

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

Transmission/ Originating Site Fees: Medicare does not reimburse for transmission fees. If applicable, Medicare will reimburse an originating site fee (HCPCS Q3014).

- Hospitals may bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home.

Video Component: When providers are providing an E/M service that would otherwise be reported as an in-person or telehealth visit, using audio-only technology, providers should utilize the appropriate telephone E/M code (99441-99443), not the in person or telehealth visit code.

- Telephone Codes only available for use during the PHE +151 days
- **Effective April 1st, 2022:** Audio only mental health telehealth will be permanently reimbursable if:
  - The provider has the technical capability, at the time of the service, to use an interactive telecommunications system
The patient is incapable of, or fails to consent to, the use of video technology for the service
The beneficiary is located at his or her home
The practitioner documents the reason for using audio-only technology uses the appropriate service level modifier

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


  **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).

<table>
<thead>
<tr>
<th>2023 MEDICARE ELEGIBLE TELEHEALTH CODES</th>
<th>2023 Standard Telehealth Codes</th>
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**Codes Available up Through December 31st, 2023**

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**Codes Available for the COVID-19 PHE + 151 Days**
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<tr>
<td>G0410</td>
<td>Statutory exclusion</td>
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<tr>
<td>G2211</td>
<td>Bundled code</td>
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Codes Highlighted in **Green** - Can Be Performed via an Audio only

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

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Disclaimer: Although the data found here has been produced and processed from payer sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability or usefulness of any information.
Have a referral from the designated PCP of the minor patient.

**HIPPA 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 between patient and provider via audio-only communication should be placed in the medical record addressing the problem, content of the conversation, medical decision-making, and plan of care.

**Cost Share Waiver:**

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

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**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
- **Telephone**: 99441-99443
- **Virtual Check-In**: G2010, G2012, G2250-G2252

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

Remote Patient Monitoring Codes:

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

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

Interprofessional Assessment Codes:

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

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

Telehealth:

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

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

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

Modifiers/POS:
- **Professional (1500) claims**: POS 02 or 10. Modifiers 95, GT, GQ, and G0 are not required to identify telehealth services but are accepted as information if reported on claims.
- **Facility (UB) claims**: Revenue code 780 (allowable during the PHE only)

Provider Type: Physician, nurse practitioner, physician assistant, nurse-midwife, clinical nurse specialist, registered dietitian or nutrition professional, clinical psychologist, clinical social worker, certified registered nurse anesthetists, physical therapists, occupational therapists, and speech therapists.

Reimbursement: Reimbursement will be at the same rate as in-person face-to-face visits, refer to your UHC contract for allowable rates.

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Patient Location: UHC will recognize CMS designated originating sites considered eligible for furnishing telehealth services to a patient located in an originating site.
- Examples of CMS originating sites with a telpresenter: the office of a physician or practitioner, hospital, critical access hospital (CAH), rural health clinic (RHC), federally qualified health center (FQHC), hospital based renal dialysis center, skilled nursing facility (SNF), community mental health center (CMHC), mobile stroke unit, patient home-for monthly end stage renal, ESRD-related clinical assessments, for purposes of treatment of a substance use disorder or a co-occurring mental health disorder.
- UHC will also recognize home as an originating site for telehealth services (no telepresenter present)

Transmission & Originating Site Fees: UHC will allow the originating site to submit a claim for services of the telepresenter using HCPS Q3014. T1014 is not eligible for payment, UHC considers these services as incidental to the charges associated with the E/M.

Video Component: Telehealth services must be performed over an audiovisual connection.

### UHC ELEGIBLE TELEHEALTH CODES

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Cost Share Waiver:

Duration of COVID-19 PHE: UHC will waive cost sharing for COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test
Current cost share waivers:

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<th>Cost Sharing Guidelines</th>
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<td>Aetna</td>
<td>Effective March 6th, 2020, through End of PHE: Aetna will waive cost sharing for COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test</td>
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<tr>
<td>AR BCBS</td>
<td>Duration of PHE: AR BCBS will waive cost sharing for COVID-19 testing-related services, which are medical visits that result in an order for, or administration, of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test or to the evaluation of an individual for purposes of determining the need for such a test. Note that the cost share waiver for COVID-19 visits for treatment (beyond the initial evaluation visit for a COVID-19 test) expired on July 31st, 2022.</td>
</tr>
<tr>
<td>Cigna</td>
<td>Effective March 13th, 2020 through End of PHE: Cigna will waive member cost sharing for diagnostic testing and office visits/telehealth visits related to assessment and administration of diagnostic testing.</td>
</tr>
<tr>
<td>Medica</td>
<td>Effective March 1st, 2020 through End of PHE: Medica will waive cost-sharing for in-network telehealth visits when related to administration of a COVID-19 test.</td>
</tr>
<tr>
<td>Medicare</td>
<td>Effective March 18th, 2020-End of PHE: Medicare will waive COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in a specified set of HCPCS E/M codes</td>
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<tr>
<td>Arkansas Medicaid</td>
<td>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</td>
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<td>UHC</td>
<td>Duration of COVID-19 PHE: Cost share is waived on COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test</td>
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Payor Specific Key Points:

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

• Once the PHE ends, plus 151 days, RHCs & FQHCs will no longer be allowed to act as a distant site

Telehealth:

Consolidated Appropriations Act: Extends certain telehealth flexibilities for Medicare patients for 151 days after the official end of the federal public health emergency (PHE), including:

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

Cost Report:

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

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

• Temporary telehealth code coverage will be removed once the PHE expires +151 days
• Category 3 codes will be available through the end of 2023
• Note: Telehealth rules do not apply when the beneficiary and the practitioner are in the same location and are utilizing telehealth to reduce exposure risks, even if audio/video technology assists in furnishing a service.

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

Billing:

• HCPCS: G2025
• Professional (1500) Claims:
  o During PHE +151 Days: POS that would have been used if the visit were provided in person with modifier 95
  o 151 Days Post PHE: RHC/FQHC no longer allowed to be originating site
  o Modifier: FR if applicable
• Mental Health Claims: After PHE Ends: POS 02 or 10 and modifier FQ if performed via audio only
  o MACs have instructed providers not to use modifier FQ, 93, or FR during the PHE
• COVID-19 Related: For services relating to the order for or administration of a COVID-19 diagnostic test or for services related to the evaluation of an individual for purposes of determining the need for diagnostic testing, append modifier CS

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

- As of January 1st, 2022, CMS will continue to allow mental health telehealth services, performed by an RHC/FQHC even after the PHE ends
- The service must be either audio visual OR
- Audio-only if the following are present:
  - The patient is incapable of, or fails to consent to, the use of video technology for the service
  - The provider has conducted an in-person visit within the last 6 months of the initial tele-mental service
  - The services are medical necessary
  - After the initial telehealth visit, the provider conducts an in-person visit at least once every 12 months of each tele-mental visit.
    - However, if the patient and provider consider the risks of an in person service and agree that these risks outweigh the benefits, then the annual visit may be skipped.
    - Providers must document the decision
  - During the PHE +151 days, the initial 6 month visit and the in person visit every 12 month requirement is waived

Provider Type: During the PHE +151 days, 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.
- **151 Days Post PHE:** Allowable provider types will revert back to only physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals

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

Reimbursement: The RHC/FQHC telehealth payment rate is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS. For 2023 the rate is $95.88.

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

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

Transmission/Originating Site Fees: Medicare does not reimburse for transmission fees. If applicable, Medicare will reimburse an originating site fee (HCPCS Q3014).

- Hospitals may bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home.

Video Component: When providers are providing an E/M service that would otherwise be reported as an in-person or telehealth visit, using audio-only technology, providers should utilize the appropriate telephone E/M code (99441-99443), not the in person or telehealth visit code.

- Effective April 1st, 2022: Audio only mental health telehealth will be permanently reimbursable if:
o The provider has the technical capability, at the time of the service, to use an interactive telecommunications system
o The patient is incapable of, or fails to consent to, the use of video technology for the service
o The beneficiary is located at his or her home
o The practitioner documents the reason for using audio-only technology uses the appropriate service level modifier

**Telephone Services:** During the COVID-19 PHE +151 days, RHC/FQHCs can perform audio only telephone E/M services utilizing CPT codes 99441, 99442, and 99443.

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

- **151 Days Post PHE:** Telephone services will no longer be allowed

**Virtual Check-Ins & E-Visits:** During the COVID-19 PHE +151 days, RHC/FQHCs can perform E-Visits (CPT codes 99421-99423), which are online digital E/M services that utilize a secure patient portal. Medicare will also allow RHC/FQHCs to perform Virtual Check Ins (HCPCS G2012 and G2010).

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

**Cost Share Waiver:**

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


**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).

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**2023 MEDICARE ELEGIBLE TELEHEALTH CODES**

<table>
<thead>
<tr>
<th>2023 Standard Telehealth Codes</th>
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<tbody>
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Disclaimer: Although the data found here has been produced and processed from payer sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability or usefulness of any information.
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<thead>
<tr>
<th>CPT/HCPCS</th>
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<tr>
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<tr>
<td>94005</td>
<td>Bundled code</td>
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<tr>
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<td>Non-covered service</td>
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<tr>
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<td>Non-covered service</td>
</tr>
<tr>
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<td>Non-covered service</td>
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<td>Bundled code</td>
</tr>
<tr>
<td>98962</td>
<td>Bundled code</td>
</tr>
<tr>
<td>S9152</td>
<td>Not valid for Medicare purposes</td>
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<tr>
<td>G0410</td>
<td>Statutory exclusion</td>
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<tr>
<td>G2211</td>
<td>Bundled code</td>
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</tbody>
</table>

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

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.

- **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:
o Be the designated Primary Care Provider (PCP) for the minor patient.
o Have a cross-coverage arrangement with the designated PCP of the minor patient; or
o 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:**
- **HCPCS Code:** G2025
- **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 between patient and provider via audio-only communication should be placed in the medical record addressing the problem, content of the conversation, medical decision-making, and plan of care.

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

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**HOSPITAL OUTPATIENT**

The following list is a summary of telehealth services that some payors are allowing – see payor’s allowable telehealth code list in the payor’s section.
- **Professional Fees** such as emergency department visits, initial and subsequent observation and observation discharge day management, initial and subsequent hospital care and hospital discharge day management, critical care services, initial and continuing intensive care services, etc.
- **Diabetes management training** (individual & group) and **individual medical nutritional** (initial and subsequent) are allowed by most payors. CMS, along with many other payors, considers Registered Dietitians and Nutritional Professionals as eligible telehealth clinicians.
- **Facility Fees:** If the patient is not coming into the hospital, you cannot bill your normal facility fee, except for Medicare.
  - Effective April 30th, 2020, Medicare is allowing hospitals to bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home.

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

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

- **Method II CAH (UB Form):** Utilize modifier GT when a physician performs services within the hospital outpatient department.

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

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

- **Medicare FAQ:**
  - **Question:** When hospital clinical staff furnish a service using telecommunication technology to the patient who is a registered outpatient of the hospital and the hospital makes the 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](https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf)

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

- **Medicare FAQ:**
  - **Question:** How do hospitals bill for outpatient therapy services furnished by employed or contracted therapists using telecommunications technology on the UB-04 claim form during the COVID-19 PHE?
  - **Answer:** There are two options available to hospitals and their therapists.
    1.) A hospital could choose to bill for services furnished by employed/contracted PTs, OTs, or SLPs through telehealth, meaning that they would identify furnished services on the telehealth list ([https://www.cms.gov/Medicare/Medicare-GeneralInformation/Telehealth/Telehealth-Codes](https://www.cms.gov/Medicare/Medicare-GeneralInformation/Telehealth/Telehealth-Codes)), they would bill these services on a UB-04 with a “-95” modifier on each line for which the service was delivered via telehealth. No POS code is required (and there is no location for it on the UB-04).
    2.) A hospital could, instead, use the flexibilities available under the Hospital Without
Walls initiative. The hospital would register the patient as a hospital outpatient, where the patient’s home acts as a provider-based department of the hospital. The hospital's employed/contracted PT, OT, SLP would furnish the therapy care that the hospital believed could be furnished safely and effectively through telecommunications technology. The hospital is not limited to services included on the telehealth list (since these would not be considered telehealth services), but must ensure the care can be fully furnished remotely using telecommunications technology. The hospital would bill as if the therapy had been furnished in the hospital and the applicable PO/PN modifier would apply for the patient’s home since it would be serving as an off-campus department of the hospital. The option to bill for telehealth services, along with the -95 modifier, furnished by employed/contracted PTs, OTs, and SLPs using applicable audio-visual telecommunications technology applies to the following types of hospitals and institutions:
- Hospital – 12X or 13X (for hospital outpatient therapy services);
- Skilled Nursing Facility (SNF) – 22X or 23X (SNFs may, in some circumstances, furnish Part B PT/OT/SLP services to their own long-term residents);
- Critical Access Hospital (CAH) – 85X (CAHs may separately provide and bill for PT, OT, and SLP services on 85X bill type);
- Comprehensive Outpatient Rehabilitation Facility (CORF) – 75X (CORFs provide ambulatory outpatient PT, OT, SLP services);
- Outpatient Rehabilitation Facility (ORF) – 74X (ORFs, also known as rehabilitation agencies, provide ambulatory outpatient PT and SLP, as well as OT services); and
- Home Health Agency (HHA) – 34X (agencies may separately provide and bill for outpatient PT/OT/SLP services to persons in their homes only if such patients are not under a home health plan of care)


- **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.

<table>
<thead>
<tr>
<th>Payor</th>
<th>Telehealth Codes</th>
<th>E-Visits</th>
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</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>ALLOWABLE</td>
<td>1500 FORM-ALLOWABLE</td>
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<tr>
<td></td>
<td></td>
<td>UB FORM-UNCLEAR</td>
</tr>
<tr>
<td>Arkansas BCBS</td>
<td>ALLOWABLE</td>
<td>NOT ALLOWABLE</td>
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</tbody>
</table>

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

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

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

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


REFERENCES & RESOURCES

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

Arkansas BCBS:
https://www.arkansasbluecross.com/providers/medical-providers/providers-news

Arkansas Department of Human Services:
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Other:
https://www.ahip.org/covid-19-coverage-frequently-asked-questions/

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