

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

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

CPT/HCPCS Codes:

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

Place of Service Codes

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

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

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

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

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

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

Reporting Criteria:

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

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

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

CPT/HCPCS Codes:

Reportable by a Qualified Healthcare Professionals:

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

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

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

Reporting Criteria:

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

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

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

CPT/HCPCS Codes:

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

Reporting Criteria:

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

Documentation Requirements:

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

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

CPT/HCPCS Codes:

Reportable by Qualified Healthcare Professionals:

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

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

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

Reporting Criteria:

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

Documentation Requirements:

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

PAYOR MATRIX

PAYOR	E-VISIT CODES	TELEHEALTH-NO ORIGINATING SITE RESTRICTION	VIRTUAL CHECK-IN CODES	TELEPHONE CODES
AETNA	ALLOWABLE 99421-99423 98970 -98972 G2061-G2063	ALLOWABLE Allowable Codes: Telehealth Eligible Code Professional: Modifier GT, 95, FR, 93 or FQ w/ POS 02. Facility: Modifier GT, 95, FR, 93 or FQ	ALLOWABLE G2010 G2012	ALLOWABLE 99441-99443 98966-98968
ARKANSAS BCBS	ALLOWABLE 99421-99423	ALLOWABLE Allowable Codes: Telehealth Eligible Code Professional: Modifier 95 or GT & POS 02. Facility: Modifier 95 or GT	NOT ALLOWABLE	ALLOWABLE 99441-99443
CIGNA	NOT ALLOWABLE	ALLOWABLE Allowable Codes: Telehealth Eligible Code Professional: Modifier 95 or GT & POS used for in-person visit. Facility: Not Allowable	ALLOWABLE G2010 G2012	ALLOWABLE 99441-99443
MEDICA* *Excludes MHCP Members	ALLOWABLE 99421-99423 98970 -98972 G2061-G2063	ALLOWABLE Allowable Codes: Telehealth Eligible Code Professional: POS 02 or 10 w/ modifier 95, GT, FQ or 93 Facility: Modifier GT, 95, 93, or FQ	ALLOWABLE G2010 G2012	ALLOWABLE 99441-99443 98966-98968
MEDICARE	ALLOWABLE 99421-99423 G2061-G2063 RHC: G0071	ALLOWABLE Allowable Codes: Telehealth Eligible Code Professional: Modifier 95 w/ POS used for in-person visit. Facility: PN or PO modifier w/ DR condition code. Method II: Modifier GT. RHC: G2025. Facility PT/OT/ST: Modifier 95	ALLOWABLE G2010 G2012 G2250-G2252 RHC: G0071	ALLOWABLE 99441-99443 98966-98968 Modifier 95 RHC: G2025
ARKANSAS MEDICAID & PASSE MANGED CARE PAYORS	NOT ALLOWABLE	ALLOWABLE Allowable Codes: Telehealth Eligible Code Professional: POS 02 or 10 Facility: Modifier GT	ALLOWABLE G2012	NOT ALLOWABLE
UHC COMMERICAL	ALLOWABLE 99421-99423 98970 -98972	ALLOWABLE Allowable Codes: Telehealth Eligible Code Professional: 02 or 10	ALLOWABLE G2010 G2012 G2250-G2252	ALLOWABLE 99441-99443

PAYOR GUIDELINES

FEDERAL COVID-19 PHE

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

AETNA

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

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

Remote Patient Monitoring:

Allowable Codes: 99453, 99454, 99457, 99458

Telehealth:

Allowable Services: See table below

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

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

Modifiers/POS:

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

Not Reimbursable:

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

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

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

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

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

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

Cost Share Waiver:

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

AETNA ELIGIBLE TELEHEALTH CODES													
Telehealth Allowable Codes													
90791	90845	90960	92227	96161	99203	99243	99309	99408	G0396	G0442	G2086	90840	G0439
90792	90846	90961	93228	97802	99204	99244	99310	99409	G0397	G0443	G2087	90958	G0513
90832	90847	90963	93229	97803	99205	99245	99354	99495	G0406	G0444	G2088	90970	99453
90833	90853	90964	93268	97804	99211	99231	99355	99496	G0407	G0446	90955	96160	99454
90834	90863	90965	93270	G0270	99212	99232	99356	99497	G0408	G0447	99252	99202	99457
90836	90951	90966	93271	98960	99213	99233	99357	99498	G0425	G0459	99253	99242	99458
90837	90952	90967	93272	98961	99214	99251	99406	97085	G0426	G0506	99254	99308	99418
90838	90954	90968	96040	98962	99215	99255	99407	G0108	G0427	G0508	G0445	G0437	G0316
90839	90957	90969	96116	99201	99241	99307	G0436	G0109	G0438	G0509	G0514	G0296	G0317
G0318	G3002	G3003	96105	97750	C7900	C7901	C7902						
Commercial Codes Effective March 6 th , 2020-End of PHE													
G0410	92002	96170	97164	99217	99235	99307	99344	99476	G0408	G2010	90839	96121	96161
G2061	92012	96171	97165	99218	99236	99308	99345	99477	G0425	G2012	90840	96127	96164
G2062	92065	97110	97166	99219	99238	99309	99347	99478	G0426	G2086	90845	96130	96165
G2063	92526	97112	97167	99220	99239	99310	99348	99479	G0427	G2087	90846	96131	96167
H0015	92601	97116	97168	99221	99281	99315	99349	99480	G0442	G2088	90847	96132	96168
H0035	92602	97150	97530	99222	99282	99316	99350	99483	G0443	97085	90853	96133	97535
H2012	92603	97151	97542	99223	99283	99327	99421	G0108	G0444	90791	90863	96136	97802
H2036	92604	97153	S9443	99224	99284	99328	99422	G0109	G0445	90792	92507	96137	97803
S9480	92606	97155	97755	99225	99285	99334	99423	G0270	G0446	90832	92508	96138	97804
77427	92609	97156	97760	99226	99291	99335	99468	G0296	G0447	90833	92521	96139	G0270
90953	94664	97157	97761	99231	99292	99336	99469	G0396	G0459	90834	92522	96156	98966
90956	96110	97161	98970	99232	99304	99337	99471	G0397	G0506	90836	92523	96158	98967
90959	96112	97162	98971	99233	99305	99341	99472	G0406	G0513	90837	92524	96159	98968
90962	96113	97163	98972	99234	99306	99343	99475	G0407	G0514	90838	96116	96160	99451
99354	99355	99356	99357	99406	99407	G0436	G0437	99441	99442	99443	99446	99447	99448
99449	99497	99498	99452	H0038	G0422	G0423	G0424	99342	90875	93750	93798	95970	95791
95972	95983	95984	90849	96125	97129	97130	92228	94625	94626	96105	96125	97129	97130
92556	92557	92563	92565	92567	92568	92570	92587	92607	92608	92609	92610	92625	92626
92627	90901	97763											
Codes in Blue Require an Audiovisual Connection Codes in Green Can be Performed Over a Telephone or Audiovisual Connection Cells Highlighted in Yellow do NOT Require Modifier GT,95, or FR													



Payor Specific Key Points:

E-Visits/Telephone/Virtual Check 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.

AR BCBS ALLOWABLE TELEHEALTH CODES										
90791	90792	90832	90833	90834	90836	90837	90838	90845	90846	90847
90863	90960	90961	90966	90970	92507	92521	92522	92523	92524	92526
96150	96151	96152	97110	97112	97116	97161	97162	97163	97164	97165
97166	97167	97168	97535	97802	97803	99201	99202	99203	99204	99211
99212	99213	99214	99221	99222	99231	99232	99238	99239	99281	99282
99283	99284	99406	99407	99408	99409	99495	99496	G0180	Q3014	

Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

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

E-Consults:

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

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

Remote Patient Monitoring:

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

- Allowable codes: 99091, 99453, 99454, 99457, 99458, 99473, 99474, S9110

Telehealth Medical:

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

All of the following must also be met:

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

Excluded Services:

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

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

Telehealth Behavioral Health:

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

All of the following must also be met:

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

Excluded Services:

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

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

Modifiers/POS:

- **Professional/1500 Claims:**
 - **During the COVID PHE:** POS for in person visit and modifier 95, GT, or GQ
 - **After COVID PHE:** POS 02 and modifier 95, GT, or GQ, 93 or FQ
 - **Do not bill POS 10 until further notice**
- **Facility/UB Claims:** Modifier 95

- During the COVID-19 PHE, Cigna will temporarily reimburse virtual care services billed on a UB, when the service is:
 - Reasonable to be provided in a virtual setting; reimbursable per a provider's contract; and synchronous audiovisual technology is utilized (except for CPTs 99441-99443)
- Note: Intensive outpatient program (IOP) telehealth services were covered prior to the pandemic, and will continue to be covered

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

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

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

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

CIGNA MEDICAL ELIGIBLE VIRTUAL CODES												
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962	90963
90964	90965	90966	90967	90968	90969	90970	92507	92508	92521	92522	92523	92524
92601	92602	92603	92604	96040	96112	96113	96116	96156	96158	96159	96160	96161
96164	96165	96167	96168	97110	97112	97161	97162	97163	97164	97165	97166	97167
97168	97530	97755	97760	97761	97802	97803	97804	92202	92203	99204	99205	99211
99212	99213	99214	99215	99406	99407	99408	99409	99441	99442	99443	99495	99496
99497	99498	G0108	G0151	G0152	G0153	G0155	G0157	G0158	G0270	G0296	G0299	G0300
G0396	G0397	G0438	G0439	G0442	G0443	G0444	G0445	G0446	G0447	G0493	G0513	G0514
G2012	S9123	S9128	S9129	S9131	S9152	99446	99447	99448	99449	99451	99452	99091
99453	99454	99457	99458	99473	99474	G2010	S9110					

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

CIGNA BEHAVIORAL HEALTH ELIGIBLE VIRTUAL CODES												
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845	0846
90847	90849	90853	90863	90875	90876	90880	96110	96127	916156	96158	96159	96164
96165	96167	96168	96170	96171	97151	97152	97153	97154	97155	97156	97157	97158
99058	99078	99202	99203	99204	99205	99211	99212	99213	99214	99215	99217	99218
99219	99220	99221	99222	99223	99224	99225	99226	99231	99232	99233	99234	99235
99236	99238	99239	99281	99282	99283	99284	99285	99304	99305	99306	99307	99308
99309	99310	99315	99316	99318	99324	99325	99326	99327	99328	99334	99335	99336
99337	99354	99335	99336	99337	93354	99355	99356	99357	99404	99408	99409	99415
99416	99417	99441	99442	99443	99446	99447	99448	99449	99456	994484	99495	99496
0591T	0592T	G0410	H0015	H0035	H0038	H2011	S0201	S9480				

Cost Share Waiver:

Effective March 13th, 2020-End of PHE: Cigna will waive cost sharing for COVID-19 testing-related services, which are medical visits that result in an order for, or administration, of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test or to the evaluation of an individual for purposes of determining the need for such a test.

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

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

E-Visit Exclusions:

- See below “Telehealth Coverage Limitations”

Telehealth:

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

Allowable Codes: See table below for specific codes.

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

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

Modifiers/POS:

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

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

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

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

Originating Sites:

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

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

Telehealth Coverage Limitations: The following are not covered under telemedicine:

- Provider initiated e-mail, refilling or renewing existing prescriptions, scheduling a diagnostic test or appointment, clarification of simple instructions or issues from a previous visit, reporting test results, reminders of scheduled

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

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

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

Cost Share Waiver:

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.

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

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

Modifiers:

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

New patients allowable for COVID-19 PHE

Telehealth:

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

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

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

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

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

Modifiers/POS:

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

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

Patient Location: Through December 31st, 2024, Medicare will pay for office, hospital, and other visits furnished via telehealth across the country, whether urban or rural, and in all settings, including in patients' homes.

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

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

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

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

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

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

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

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

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

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

- Telephone Codes only available for use through December 31st, 2024
- Effective April 1st, 2022: Audio only mental health telehealth will be permanently reimbursable if:
 - The provider has the technical capability, at the time of the service, to use an interactive telecommunications system
 - The patient is incapable of, or fails to consent to, the use of video technology for the service
 - The beneficiary is located at his or her home
 - The practitioner documents the reason for using audio-only technology uses the appropriate service level modifier

Cost Share Waiver:

March 18, 2020 Through the End of the PHE: Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the

following categories of HCPCS evaluation and management codes: Office and other outpatient services, hospital observation services, emergency department services, nursing facility services, domiciliary, rest home, or custodial care services, home services, online digital evaluation, and management services.

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

Use these HCPCS codes for billing:

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

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

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

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.

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

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.

Patient Location: UHC will recognize CMS designated originating sites considered eligible for furnishing telehealth services to a patient located in an originating site.

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

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

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

UHC ELEGIBLE TELEHEALTH CODES											
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845
90846	90847	90853	90863	90951	90952	90953	90954	90955	90956	90957	90958
90959	90960	90961	90962	90964	90965	90966	90967	90968	90969	90970	92227
92228	92507	92521	92522	92523	92524	93228	93229	93268	93270	93271	93272
93797	93798	94625	94626	96040	96116	96121	96130	96131	96132	96133	96136
96137	96138	96139	96156	96158	96159	96160	96161	96164	96165	96167	96168
97110	97112	97116	97161	97162	97163	97164	97165	97166	97167	97168	97530
97535	97750	97755	97760	97761	97802	97803	97804	98960	98961	98962	99202
99203	99204	99205	99211	99212	99213	99214	99215	99217	99224	99225	99226
99231	99232	99233	99238	99239	99281	99282	99283	99284	99285	99291	99292
99307	99308	99309	99310	99315	99316	99334	99335	99336	99337	99347	99348
99349	99350	99354	99355	99356	99357	99395	99396	99397	99406	99407	99408
99409	99469	99472	99476	99478	99479	99480	99483	99495	99496	99497	99498
G0108	G0109	G0270	G0296	G0396	G0397	G0406	G0407	G0408	G0420	G0421	G0422
G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445	G0446	G0447
G0459	G0506	G508	G0509	G0513	G0514	G2086	G2087	G2088	G2211	G2212	G9481
G9482	G9483	G9484	G9485	G9486	G9487	G9488	G9489	G9978	G9979	G9980	G9981
G9982	G9983	G9984	G9985	G9986							
PT/OT/ST											
92507	92521	92522	92523	92524	97110	97112	97116	97161	97162	97163	97164
97165	97166	97167	97168	97535	97750	97755	97760	97761			

Cost Share Waiver:

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

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

Current cost share waivers:

Payor	Cost Sharing Guidelines
Aetna	Effective March 6th, 2020, through End of PHE: Aetna will waive 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
AR BCBS	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..
Cigna	Effective March 13th, 2020 through End of PHE: Cigna will waive member cost sharing for diagnostic testing and office visits/telehealth visits related to assessment and administration of diagnostic testing.
Medica	Effective March 1st, 2020 through End of PHE: Medica will waive cost-sharing for in-network telehealth visits when related to administration of a COVID-19 test.
Medicare	Effective March 18th, 2020-End of PHE: Medicare will waive 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
Arkansas Medicaid	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
UHC	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

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

MEDICARE

Payor Specific Key Points:

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

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

Telehealth:

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

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

Cost Report:

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

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

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

Billing:

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

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

Mental Health Services:

- As of January 1st, 2022, CMS will continue to allow mental health telehealth services, performed by an RHC/FQHC even after the PHE ends
- The service must be either audio visual OR
- Audio-only if the following are present:
 - The patient is incapable of, or fails to consent to, the use of video technology for the service
 - The provider has conducted an in-person visit within the last 6 months of the initial tele-mental service
 - The services are medical necessary
 - After the initial telehealth visit, the provider conducts an in-person visit at least once every 12 months of each tele-mental visit.
 - However, if the patient and provider consider the risks of an in person service and agree that these risks outweigh the benefits, then the annual visit may be skipped.
 - Providers must document the decision
 - Until December 31st, 2024, the initial 6 month visit and the in person visit every 12 month requirement is waived

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cost Share Waiver:

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

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

Use these HCPCS codes for billing:

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

2023 MEDICARE ELEGIBLE TELEHEALTH CODES											
2023 Telehealth Codes											
0362T	90956	92508	92602	95970	96139	97153	97760	99223	99308	99471	G0318
0373T	90957	92521	92603	95971	96156	97154	97761	99231	99309	99472	G0396
77427	90958	92522	92604	95972	96158	97155	97763	99232	99310	99473	G0397
90785	90959	92523	92607	95983	96159	97156	97802	99233	99315	99475	G0406
90791	90960	92524	92608	95984	96160	97157	97803	99234	99316	99476	G0407
90792	90961	92526	92609	96105	96161	97158	97804	99235	99341	99477	G0408
90832	90962	92550	92610	96110	96164	97161	98960	99236	99342	99478	G0410
90833	90963	92552	92625	96112	96165	97162	98961	99238	99344	99479	G0420
90834	90964	92553	92626	96113	96167	97163	98962	99239	99345	99480	G0421
90836	90965	92555	92627	96116	96168	97164	99202	99281	99347	99483	G0422



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

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

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:

- 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.

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:

- **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

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/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)

<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
Aetna	ALLOWABLE	1500 FORM-ALLOWABLE UB FORM-UNCLEAR
Arkansas BCBS	ALLOWABLE	NOT ALLOWABLE

Cigna	CONDITIONAL Allowable on 1500 form only	NOT ALLOWABLE
Medica	ALLOWABLE	1500 FORM-ALLOWABLE UB FORM-UNCLEAR
Medicare	ALLOWABLE	1500 FORM-ALLOWABLE UB FORM-UNCLEAR
Medicaid	ALLOWABLE	NOT ALLOWABLE
UHC	ALLOWABLE	1500 FORM-ALLOWABLE UB FORM-NOT ALLOWABLE

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.arkansasotalcare.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

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-fags-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-fags-covid-19.pdf>

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctst.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/outreachffs/provpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se>

<https://www.cms.gov/files/document/03092020-covid-19-fags-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/>

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