

Prepared for:
South Central Telehealth Resource Center

Virtual Visit & Reimbursement Guide

ARKANSAS

Brought to you by:



University of Arkansas for Medical Sciences

SOUTH CENTRAL
TELEHEALTH RESOURCE CENTER

LearnTelehealth.org

Partnered with:



Virtual Visit Types

- [Telehealth](#)
- [Evisits](#)
- [Virtual Check In](#)
- [Telephone](#)

Payor Matrix

Payor Guidelines

- [Aetna](#)
- [Arkansas Blue Cross Blue Shield](#)
- [Cigna](#)
- [Medica](#)
- [Medicare](#)
- [Arkansas Medicaid](#)
- [United Healthcare](#)

Rural Health Clinic/Federally Qualified Health Center

- [Medicare](#)
- [Medicaid](#)

HIPAA Compliant Software

References and Resources

Definition:

There are three types of telehealth services:

- **Asynchronous Telehealth (Store & Forward)** is the transfer of digital images, sounds, or previously recorded video from one location to another to allow a consulting practitioner (usually a specialist) to obtain information, analyze it, and report back to the referring practitioner. This is a non-interactive telecommunication because the physician or health care practitioner views the medical information without the patient being present.
- **Synchronous Telehealth** is real-time interactive video teleconferencing that involves communication between the patient and a distant practitioner who is performing the medical service. The practitioner sees the patient throughout the communication, so that two-way communication (sight and sound) can take place.

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

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

Modifiers

Synchronous Telehealth Modifiers:

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

Asynchronous Telehealth Modifier:

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

Reporting Criteria:

- 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.
- HIPAA compliant platform

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:

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

Documentation Requirements:

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

Definition:

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

CPT/HCPCS Codes:

- **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
- 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.
- 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

PAOR	E-VISIT	TELEHEALTH	VIRTUAL CHECK-IN	TELEPHONE
AETNA	ALLOWABLE 99421-99423 98970 -98972 G2061-G2063	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 <u>Modifier:</u> GT, 95, FR, 93 or FQ	ALLOWABLE G2010 G2012	ALLOWABLE 99441-99443 98966-98968
BCBS of IL	CONDITIONAL Check contracted fee schedule to see if allowable	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 <u>Modifier:</u> GT or 95	CONDITIONAL Check contracted fee schedule to see if allowable	CONDITIONAL Check contracted fee schedule to see if allowable
CIGNA	NOT ALLOWABLE	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 <u>Modifier:</u> 95, GT, 93, FQ	ALLOWABLE G2012	ALLOWABLE 99441-99443
MEDICA* *Excludes MHCP Members	ALLOWABLE 99421-99423 98970 -98972 G2061-G2063	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 or 10 <u>Modifier:</u> GT, 95, 93, or FQ	ALLOWABLE G2010 G2012	ALLOWABLE 99441-99443 98966-98968
MEDICARE	ALLOWABLE 99421-99423 G2061-G2063 RHC: G0071	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> Same as in-person visit <u>Modifier:</u> 95 <u>Method II:</u> Modifier GT <u>RHC:</u> G2025	ALLOWABLE G2010 G2012 G2250-G2252 RHC: G0071	ALLOWABLE 99441-99443 98966-98968 Modifier 95 RHC: G2025
MEDICAID	NOT ALLOWABLE	ALLOWABLE <u>Allowable Codes:</u> Medically Necessary Code <u>POS:</u> 02 or 10	NOT ALLOWABLE	NOT ALLOWABLE
UHC COMMERICAL	ALLOWABLE 99421-99423 98970 -98972	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 or 10 <u>Modifier:</u> 95 or GT	ALLOWABLE G2010 G2012 G2250-G2252	ALLOWABLE 99441-99443

PAYOR GUIDELINES

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*, G2250-G2252*

*Coverage ending December 1st, 2023

Remote Patient Monitoring:

Allowable Codes:

99453, 99454, 99457, 99458

Telehealth:

Allowable Services:

See table below for allowable code set

Modifiers/POS:

- **POS 02**
- **Modifier** GT, 95, FR, G0
 - If audio only allowable code, POS 02 with modifier FQ or 93

Not Reimbursable:

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

*Exceptions listed in telehealth codes table, available through December 1st, 2023

Patient Location:

Patient can be located at any location, including their home

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.

AETNA ELIGIBLE TELEHEALTH CODES

Telehealth Allowable Codes

90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845	90846	90847	90853
90849	90863	90951	90952	90954	90955	90957	90958	90960	90961	90963	90964	90965	90966
90967	90968	90968	90970	92227	92228	93228	93229	93268	93270	93271	93272	96040	96105
96116	96160	96161	97750	97802	97803	97804	G0270	98960	98961	98962	99202	99203	99204
99205	99211	99212	99213	99214	99215	99231	99232	99233	99251	99252	99253	99254	99255
99307	99308	99309	99310	99354	99355	99356	99357	G2212	99417	99418	G0316	G0317	G0318
99406	99407	99408	99409	99495	99496	99497	99498	90785	C7900	C7901	C7902	G0108	G0109
G0296	G0396	G0397	G0406	G0407	G0408	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444
G0445	G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G3002	G3003

Temporary Commercial Codes Effective Until December 1st 2023

98966	98967	98968	98970	98971	98972	99421	99422	99423	99441	99442	99443	G2010	G2012
G2061	G2062	G2063	G2250	G2251	G2252	77427	90901	90953	90956	90959	90962	92002	92012
92065	92606	92609	93750	93798	94625	94626	95970	95971	95972	95983	95984	97129	9710
97150	97151	97153	97155	97156	97157	97163	97167	97164	97168	97542	97763	99221	99222
99223	99234	99235	99236	99238	99239	99281	99282	99283	99284	99285	99291	99292	99304
99305	99306	99315	99316	99341	99342	99344	99345	99347	99348	99349	99350	99468	99469
99471	99472	99475	997476	99477	99478	99479	99480	G0410	G0422	G0423	H0015	H0035	H2012
H2036	S9480	90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845
90846	90847	90853	90863	92507	92508	92521	9252	92523	92524	96116	96121	96130	96131
96132	96133	96136	96137	96138	96139	96156	96158	96159	96164	96165	96167	96168	97535
97804	99497	99498	C7900	C7901	C7902	G0109	G0443	G0445	G0446	G0447	G0506	G0513	G0514
G2086	G2087	G2088	G2212										

Codes in Blue Allowable Audio Only

Cells Highlighted in Yellow do **NOT** Require a Modifier

Payor Specific Key Points

E-Visits/Telephone/Virtual Check-In:

Allowable Codes:

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

POS/Modifier

- POS 02

Telehealth:

Allowable Services:

See below table for 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.

Asynchronous: Allowed, utilize GQ modifier

Modifiers/POS:

- **Place of Service** 02
- **Modifier** 95 or GT

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 will allow HCPCS Q3014 (originating site fee) but will 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.

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:** G2012

Interprofessional Consultations:

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

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

Remote Patient Monitoring:

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

- **Allowable codes:** 99091, 99453, 99454, 99457, 99458, 99473, 99474, S9110
- [Detailed Medical Policy for Conditions Allowed via RPM](#)

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.

Modifiers/POS:

- **POS 02**
 - Do not bill POS 10 until further notice
- **Modifier 95, GT, GQ, 93 or FQ**
- Virtual care billed by facilities on a UB-04 claim form continues to be reimbursable until further notice, with an expectation that it will move to permanently reimbursable for certain services as part of our R31 Virtual Care Reimbursement Policy at a later date

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	99381	99382	99833	99384	99385	99386	99387
99391	99392	99393	99394	99395	99396	99397	99401	99402	99403	99404	99411	99412

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

CIGNA BEHAVIORAL HEALTH ELIGIBLE VIRTUAL CODES												
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845	90846
90847	90849	90853	90863	90875	90876	90880	96110	96127	916156	96158	96159	96164
96165	96167	96168	96170	96171	97151	97152	97153	97154	97155	97156	97157	97158
99058	99078	99202	99203	99204	99205	99211	99212	99213	99214	99215	99217	99218
99219	99220	99221	99222	99223	99224	99225	99226	99231	99232	99233	99234	99235
99236	99238	99239	99281	99282	99283	99284	99285	99304	99305	99306	99307	99308
99309	99310	99315	99316	99318	99324	99325	99326	99327	99328	99334	99335	99336
99337	99354	99335	99336	99337	93354	99355	99356	99357	99404	99408	99409	99415
99416	99417	99441	99442	99443	99446	99447	99448	99449	99456	994484	99495	99496
0591T	0592T	G0410	H0015	H0035	H0038	H2011	S0201	S9480				

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

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

Telehealth:

Synchronous Telehealth Allowable Codes:

See table below for specific codes.

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

Store and Forward Telehealth:

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

Modifiers/POS:

- **POS** 02 or 10 OR POS code used for an in-person visit
- **Modifier** 95, 93, FQ, G0, GQ, or GT

Provider Type:

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

Reimbursement:

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

Originating Sites:

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

Transmission & Originating Site Fees:

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

Coverage Limitations:

Provider initiated e-mail, refilling or renewing existing prescriptions, scheduling a diagnostic test or appointment, clarification of simple instructions or issues from a previous visit, reporting test results, reminders of scheduled office visits, requests for a referral, non-clinical communication, educational materials, brief follow-up of a medical procedure without indication of complication or new condition including, but not limited to, routine global surgical follow-up, brief discussion to confirm stability of the patient's without change in current treatment, when information is exchanged and the

patient is subsequently asked to come in for an office visit, a service that would similarly not be charged for in a regular office visit, consultative message exchanges with an individual who is seen in the provider's office immediately afterward, communication between two licensed health care providers that consists solely of a telephone conversation, email or facsimile, communications between a licensed health care provider and a patient that consists solely of an e-mail or facsimile.

Video Component:

Interactive audio and video communications that permit real-time communication between the distant site physician or practitioner and the member. The services must be of sufficient audio and visual fidelity with clarity and function equivalent to a face-to-face encounter. Audio-only technology on Telehealth Services Code List will be available through December 31, 2024.

MEDICA ALLOWABLE TELEHEALTH CODES											
0362T	0373T	77427	90785*	90791*	90792*	90832*	90833*	90834*	90836*	90837*	90838*
90839*	90840*	90845*	90846*	90847*	90853*	90901	90951	90952	90953	90954	90955
90956	90957	90958	90959	90960	9061	90962	90963	90964	90965	90966	90967
90968	90969	90970	92002	92004	92012	92014	92507*	92521*	92522*	92523*	92524*
92526	92550	92552	92553	92555	92556	92557	92563	92565	92567	92568	92570
92587	92588	92601	92602	92603	92604	92607	92608	92609	92610	92625	92626
92627	93750	93797	93798	94002	94003	94004	94625	94626	94464	95970	95971
95972	95983	95984	96105	96112	96113	96116*	96121*	96125	96127*	96130*	96131*
96132*	96133*	96136*	96137*	96138*	96139*	96156*	96158*	96159*	96160*	96161*	96164*
96165*	96167*	96168*	97110	97112	97116	97129	97130	97150	97151	97152	97153
97154	97155	97156	97157	97158	97161	97162	97163	97164	97165	97166	97167
97168	97530	97535*	97537	97542	97750	97755	97760	97761	97763	97802*	97803*
97804*	98966*	98967*	98968*	99202	99203	99204	99205	99211	99212	99213	99214
99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238	99239
99281	99284	99285	99291	9992	99304	99305	99306	99307	99308	99309	99310
99315	99316	99341	99342	99344	99345	99347	99348	99349	99350	99406*	99407*
99441*	99442*	99443*	99468	99469	99471	99472	99473	99475	99476	99477	99478
99479	99480	99483	99495	99496	99497*	99498*	G0108*	G0109*	G0270*	G0296*	G0317
G0318	G0396*	G0397*	G0406*	G0407*	G0408*	G0420*	G0421*	G0422	G0423	G0425*	G0426*
G0427*	G0438*	G0439*	G0442*	G0443*	G0444*	G0445*	G0446*	G0447*	G0459*	G0447*	G0459*
G0506*	G0508	G0509	G0513*	G0514*	G2086*	G2087*	G2088*	G2212*	G3002	G3003	G9685
Codes With An * Can Be Performed via an Audio only (Telephone) or Audiovisual Connection											

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

Payor Specific Key Points:

E-Visits/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-G2252

Modifiers:

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

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*

- Asynchronous Telehealth is not allowable outside of Alaska or Hawaii
- Home Health: G0320-G0322

Consent:

Providers may get patient consent at the same time they initially provide the services. Direct supervision isn't required to get consent. In general, auxiliary personnel under general supervision of the billing practitioner can get patient consent for these services. The person getting consent can be an employee, independent contractor, or leased employee of the billing practitioner.

Modifiers/POS:

- **POS:**
 - **Through December 31st, 2023:** POS that would have been used if the visit were provided in person
 - **After December 31st, 2023:** POS 02 or 10
- **Modifier:**
 - **Through December 31st, 2023:** 95
 - **After December 31st, 2023:** Optional as long as POS is 02 or 10
- **Mental Health Claims:** POS 02 or 10
 - **Modifier 93** if performed over audio only
 - **RHC/FQHC:** Modifier FQ
- **CAH Method II (UB) Claims:** Modifier GT

Patient Location:

Through December 31st, 2024, all patients can get telehealth wherever they're located. They don't need to be at an originating site, and there aren't any geographic restrictions.

- **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:

Physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals

- Through December 31st, 2024, all providers who are eligible to bill Medicare for professional services can provide distant site telehealth

Reimbursement:

In the 2023 Physician Fee Schedule Final Rule, CMS extended payment parity for telehealth in non-facility settings through the end of 2023

- Absent further rulemaking, beginning Jan. 1, 2024, distant-site practitioners would again be reimbursed based only on facility rates, resulting in reimbursement for some telehealth services reverting to lower pre-PHE levels.

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
- 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

2023 MEDICARE ELEGIBLE TELEHEALTH CODES											
2023 Telehealth Codes											
0362T	0373T	77427	90785	90791	90792	90832	90833	90834	90836	90837	90838
90839	90840	90845	90846	90847	90853	90875	90901	90951	90952	90953	90954
90955	90956	90957	90958	90959	90960	90961	90962	90963	90964	90965	90966
90967	90968	90969	90970	92002	92004	92012	92014	92507	92508	92521	92522
92523	92524	92526	92550	92552	92553	92555	92556	92257	92563	92565	92567
92563	92565	92567	92568	92570	92587	92588	92601	92602	92603	92604	92607
92608	92609	92610	92625	92626	92627	93750	93797	93798	94002	94003	94004
94005	94625	94626	94664	95970	95971	95972	95983	95984	96105	96110	96112
96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138
96139	96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171
97110	97112	97116	97129	97130	97150	97151	97152	97153	97154	97155	97156
97157	97158	97161	97162	97163	97164	97165	97166	97167	97168	97530	97535
97537	97542	97750	97755	97760	97761	97763	97802	97803	97804	98960	98961

98962	98966	98967	98968	99202	99203	99204	99205	99211	99212	99213	99214
99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238	99239
99281	99282	99283	99284	99285	99291	99292	99304	99305	99306	99307	99308
99309	99310	99315	99316	99341	99342	99344	99345	99347	99348	99349	99350
99406	99407	99441	99442	99443	99468	99469	99471	99472	99473	99475	99476
99477	99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0270
G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0420	G0421
G0422	G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445	G0446
G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211	G2212
G3003	G9685	S9152									

Codes Highlighted in Blue-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-In:** Not Allowed

Telehealth:***Allowed Services:***

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.

Modifiers/POS:

- **POS** 02 or 10

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 be 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.

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.

Payor Specific Key Points:**E-Visits/Telephone/Virtual Check Ins:*****Allowable Codes:***

- **E-Visits:** 99421-99423, 98970-98972
- **Interprofessional Consultation:** 99446-99449, 99451-99454
- **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, 98975-98978, 98980-98981,

POS/Modifier:

POS utilized if visit would have in person and no modifier

Interprofessional Assessment Codes:

- **Allowable Codes:** 99446-99449, 99451-99454

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 vid-eos and discussing or reviewing by phone is not reimbursable.

Modifiers/POS:

- **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.

Provider Type:

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

Reimbursement:

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

Patient Location:

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

- Examples of CMS originating sites with a telepresenter: the office of a physician or practitioner, hospital, critical access hospital (CAH), rural health clinic (RHC), federally qualified health center (FQHC), hospital based renal dialysis center, skilled nursing facility (SNF), community mental health center (CMHC), mobile stroke unit, patient home-for monthly end stage renal, ESRD-related clinical assessments, for purposes of treatment of a substance use disorder or a co-occurring mental health disorder.

- UHC will also recognize home as an originating site for telehealth services (no telepresenter present)

Transmission & Originating Site Fees:

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

Video Component:

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

- UHC will align with the AMA and will consider for reimbursement the services included in Appendix T of the CPT code set, which are appropriate for reporting real-time, interactive audio-only tele-health, when appended with modifier 93, and reported with POS 02 or 10
- All PT/OT/ST Telehealth visits must be performed using live, interactive video conferencing that in-volves 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 vid-eos and discussing or reviewing by phone is not reimbursable.

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			

AUDIO ONLY CODES											
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845
90846	90847	92507	92508	92521	92522	92523	92524	96040	96110	96116	96121
96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171	97802
97803	97804	99406	99407	99408	99409	99497	99498				

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.

Billing:

- **HCPCS:** G2025
- **POS:**
 - **Through December 31st, 2023:** POS that would have been used if the visit were provided in person
 - **After December 31st, 2023:** POS 02 or 10
- **Modifier:** 95 (Optional)
- **Mental Health Claims:** POS 02 or 10 and modifier FQ if performed via audio only

Mental Health Services:

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

Provider Type:

Physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals

- Through December 31st, 2024, all providers who are eligible to bill Medicare for professional services can provide distant site telehealth

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.

Transmission/ Originating Site Fees:

Medicare does not reimburse 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.

- 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.

2023 MEDICARE ELEGIBLE TELEHEALTH CODES											
2023 Telehealth Codes											
0362T	0373T	77427	90785	90791	90792	90832	90833	90834	90836	90837	90838
90839	90840	90845	90846	90847	90853	90875	90901	90951	90952	90953	90954
90955	90956	90957	90958	90959	90960	90961	90962	90963	90964	90965	90966
90967	90968	90969	90970	92002	92004	92012	92014	92507	92508	92521	92522
92523	92524	92526	92550	92552	92553	92555	92556	92257	92563	92565	92567
92563	92565	92567	92568	92570	92587	92588	92601	92602	92603	92604	92607
92608	92609	92610	92625	92626	92627	93750	93797	93798	94002	94003	94004

94005	94625	94626	94664	95970	95971	95972	95983	95984	96105	96110	96112
96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138
96139	96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171
97110	97112	97116	97129	97130	97150	97151	97152	97153	97154	97155	97156
97157	97158	97161	97162	97163	97164	97165	97166	97167	97168	97530	97535
97537	97542	97750	97755	97760	97761	97763	97802	97803	97804	98960	98961
98962	98966	98967	98968	99202	99203	99204	99205	99211	99212	99213	99214
99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238	99239
99281	99282	99283	99284	99285	99291	99292	99304	99305	99306	99307	99308
99309	99310	99315	99316	99341	99342	99344	99345	99347	99348	99349	99350
99406	99407	99441	99442	99443	99468	99469	99471	99472	99473	99475	99476
99477	99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0270
G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0420	G0421
G0422	G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445	G0446
G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211	G2212
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-In:** Not Allowed

Telehealth:

Allowed Services:

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.

Modifiers/POS:

- **POS** 02 or 10

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.

HIPAA COMPLIANT SOFTWARE

On April 11, 2023, OCR announced that the HIPAA compliant software enforcement discretion will expire at 11:59 p.m. on May 11, 2023, due the expiration of the COVID-19 PHE. OCR will continue to support the use of telehealth after the PHE by providing a 90-calendar day transition period for covered health care providers to make any changes to their operations that are needed to provide telehealth in a private and secure manner in compliance with the HIPAA Rules. During this transition period, OCR will continue to exercise its enforcement discretion and will not impose penalties on covered health care providers for noncompliance with the HIPAA Rules in connection with the good faith provision of telehealth. The transition period will be in effect beginning on May 12, 2023, and will expire at 11:59 p.m. on August 9, 2023.

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.arkansastotalcare.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-faqs-31720.pdf>

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

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

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

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

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

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

Empower Healthcare Solutions:

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

Medica:

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

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

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

NARHC:

<https://narhc.org/>

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

Summit Community Care:

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

UHC:

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

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

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

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

Other:

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

Document Prepared By:

Hayley Prosser, Director of Revenue Cycle Services

ruralMED Revenue Cycle Resources

Email: hprosser@ruralmed.net