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Prepared for:
South Central Telehealth Resource Center

Virtual Visit & Reimbursement Guide

MISSISSIPPI

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Definition:

There are two 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:

Synchronous Audio/Video CPT Codes:

- **98000:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
- **98001:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98002:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
- **98003:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded
- **98004:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded
- **98005:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
- **98006:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98007:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded

Other CPT/HCPCS are often eligible to be reported via synchronous audio/video telehealth (refer to payor guidelines section for specific code sets)

Synchronous Audio-Only CPT Codes:

- **98008:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
- **98009:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98010:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
- **98011:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of

medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded

- **98012:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded
- **98013:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
- **98014:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98015:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded

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:

- Must be initiated by the patient
- Communication must be a direct interaction between the patient and the healthcare professional
- HIPAA compliant platform must be utilized

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, and the length of the call. Obtain 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**: Nonphysician qualified healthcare professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- **G2062/98971**: Nonphysician qualified healthcare professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
- **G2063/98972**: Nonphysician qualified healthcare professional online digital assessment and management, for an established patient, for up to 7 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
- 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:

- **98016**: Brief communication technology-based service (eg, 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 evaluation and management service provided within the previous 7 days nor leading to an evaluation and management 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 assessment and management service provided by a nonphysician qualified health care professional via audio telecommunication

CPT/HCPCS Codes:

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

Reporting Criteria:

- Call must be initiated by the patient
- 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
- The patient must be established

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 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- AUDIO/VIDEO	TELEHEALTH- AUDIO ONLY	VIRTUAL CHECK-IN
AETNA	CONDITIONAL Check Contracted Fee Schedule	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 Modifier: GT, 95, FR	ALLOWABLE Allowable Codes: Audio Only Telehealth Eligible Code POS: 02 or 10 Modifier: 93, FQ	CONDITIONAL Check Contracted Fee Schedule
BCBS	ALLOWABLE 99421-99423 98970 -98972	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: GT or 95	CONDITIONAL Check Contracted Fee Schedule to Determine if CPT 98008-98015 are Allowable	ALLOWABLE G2010 98016
CIGNA	NOT ALLOWABLE	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 Modifier: 95, GT	ALLOWABLE Allowable Codes: CPT 98008-98015 POS: 02 Modifier: Not Required	ALLOWABLE 98016
MEDICA* ***Excludes MHCP Members**	ALLOWABLE 99421-99423 98970 -98972 G2061-G2063	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: GT, 95	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: 93, FQ	ALLOWABLE G2010 98016
MEDICARE	ALLOWABLE 99421-99423 G2061-G2063	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: Hospital Based Provider-95 Method II: Modifier GT RHC: G2025	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: 93 Method II: Modifier GT RHC: G2025	ALLOWABLE 98016 G2010 G2250-G2252
MEDICAID	NOT ALLOWABLE	ALLOWABLE Allowable Codes: Medically Necessary Code POS: 02 Modifier: GT	NOT ALLOWABLE	NOT ALLOWABLE
UHC COMMERCIAL	ALLOWABLE 99421-99423 98970 -98972	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: 95 or GT	ALLOWABLE Allowable Codes: Audio Only Telehealth Eligible Code POS: 02 or 10 Modifier: 93	ALLOWABLE 98016 G2010 G2250-G2252

AETNA

Payor Specific Key Points

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: Check Contracted Fee Schedule
- **Virtual Check-Ins**: Check Contracted Fee Schedule

Remote Patient Monitoring:

Allowable Codes:

- 98975, 98976, 98977, 98978, 98980, 98981, 99453, 99454, 99445, 99470, 99457, 99458

Interprofessional Codes:

Allowable Codes:

- 99446-99449, 99451, 99452, G9037, G0546-G0551

Modifier:

- No telehealth modifier required

Telehealth:

Allowable Services:
See table below for allowable code set

Audio Only Services:
Designated codes, highlighted in blue in the below “Telehealth Allowable Codes” matrix, can be performed via an audio only connection

Modifiers/POS:

- **POS** 02 or 10
- **Modifiers**
  - **Audio-Visual:** GT, 95, FR
  - **Audio-Only**: 93, FQ (only for codes that explicitly allow them)
  - **Asynchronous:** GQ
  - **Tele-Stroke**: G0

Direct Patient Contact:
Unless listed as a covered service, medical services that do not include direct in-person patient contact are not payable

Reimbursement:
Refer to contracted fee schedule

Not Reimbursable:.

- Care Plan Oversight (Except if authorized by Patient Management)
- Concierge Medicine (boutique medicine)
- Missed appointments

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.

AETNA ELIGIBLE TELEHEALTH CODES													
Telehealth Allowable Codes													
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845	90846	90847
90849	90853	90863	90951	90952	90954	90955	90957	90958	90960	90961	90963	90964	90965
90966	90967	90968	90969	90970	92227	92228	92507	92508	92521	92522	92523	92524	92526
92601	92602	92603	92604	93228	93229	93268	93270	93271	93272	94664	96041	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	97151	97153	97155	97156	97157	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	99231	99232	99233	99252	99253	99254
99255	99307	99308	99309	99310	99406	99407	99408	99409	99417	99418	99446	99447	99448
99449	99451	99452	99483	99495	99496	99497	99498	C7900	C7901	C7902	G0108	G0109	G0270
G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0425	G0426	G0427	G0438
G0439	G0442	G0443	G0444	G0445	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087
G2088	G2212	G3002	G3003	H0015	H0035	H0038	H2012	H2036	S9443	S9480	97152	97154	97158
97542	98000	98001	98002	98003	98004	98005	98006	98007					
Cells Highlighted in Yellow do **NOT** Require a Modifier Codes in Blue are Allowable via an audio-only connection													

Reference:

- Telemedicine and Direct Patient Contact Payment Policy available on Availity

Payor Specific Key Points

E-Visits/Virtual Check-In:

Allowable Codes:

- **E-Visits:** 99421-99423, 98970-98972
- **Virtual Check-In:** G2010, 98016

Remote Patient Monitoring:

Requirements:

- All Remote Patient Monitoring Services must be prior authorized and are subject to the Care Management provisions of the member's Benefit Plan. Remote Patient Monitoring Services will only be prior authorized for coverage if the following criteria are met:
    - Must be ordered by a Physician
    - Must be performed by a Mississippi-licensed Provider affiliated with a Mississippi health care facility
    - Services must be provided using HIPAA-compliant equipment and protocols necessary for delivery of Remote Patient Monitoring services via Telemedicine
    - Must meet all requirements in the Prior Authorization Requirements for Remote Patient Monitoring Services
    - Must meet all requirements in the Provider Requirements and Delivery of Remote Patient Monitoring Services

Episode of Care:

- An initial episode of remote patient monitoring will be allowed for up to 31 days if all coverage criteria is met.
- Coverage of additional monitoring beyond 31 days will only be allowed if an updated plan of care signed and dated by the prescribing physician and documentation to support that the medical data from the previous 31-day episode was used in the management of the patient's care is submitted for re-authorization.
- Coverage of Remote Patient Monitoring will not be provided beyond a six-month period.
- Services will no longer be considered medically necessary if the patient is hospitalized or is receiving duplicative services while under a Remote Patient Monitoring plan of care.

Allowable Codes:

- 98975, 98976, 98977, 98980, 98981, 99091, 99453, 99454, 99457, 99458, 0650T, G0071, S5185, S9110

Interprofessional Services:

Allowable Codes:

- Interprofessional Services are **NOT** allowed, including 99446, 99447, 99448, 99449, 99451, 99452, G0546, G0547, G0548, G0549, G0550, G0551

Store and Forward

Requirements:

- Both the Originating Site and Distant Site Providers must be licensed in the state where the Member is located and have the appropriate equipment necessary to provide Store-and-Forward Telemedicine services, AND
- A physician-patient relationship must be established. The Originating Site Provider must obtain the patient's informed consent before providing Store-and-Forward Telemedicine Services. In addition to the informed consent, including risks and benefits associated with Store-and-Forward Telemedicine, the patient is to be informed of his/her right to receive follow-up care or assistance if there is an adverse treatment reaction or failure in telemedicine equipment, AND
- The Distant Site Provider using Store-and-Forward Telemedicine must be able to offer patients the option of interactive communication upon the patient's request. If requested by the patient, interactive communication with the distant site Provider may occur at the time of the consultation or within thirty (30) days of the patient's notification of

the request of the consultation. Providers unable to offer interactive consultation shall not be reimbursed for Store-and-Forward Telemedicine services, AND

- The telemedicine equipment must be HIPAA-compliant and sufficient to provide a review and evaluation of the data to the same standard of care required as if viewed in person, AND
- A specialty service for Store-and-Forward is considered inaccessible to the patient, if that specialty service is unavailable to 100% of the Subscribers within a 60 mile radius of the specialty service location(s).

Medical Necessity

- Store-and-Forward Telemedicine services are considered medically necessary between a patient and a distant site or originating site Provider for the purpose of diagnostic and therapeutic assistance in the care of patients who otherwise have no access to specialty care, as described in Section I.E. Accordingly, such specialty Store-and-Forward services are limited currently to the following specialties in the identified counties:
    - Dermatology (Coahoma, Attala, Winston, Leake)

Allowable Codes:

- CPTs 99202-99205, 99211-99215, G2010, G2250

Modifier/POS:

Place of Service 02 or 10
Store and Forward: FQ, GQ, 93

Telehealth

Allowable Services:

- **Telehealth Services:** Defined by BCBS as real-time clinical healthcare diagnosis, consultation and treatment provided through interactive electronic and telecommunication technologies linking Originating Site Telemedicine Network Providers to a Distant Site Telemedicine Network Provider who has a higher level of care, specialty or other advanced degree/training.
    - **Allowable Codes**: See table below for allowable codes

Audio Only:

Review fee schedule to determine if audio-only telehealth E/M codes, 98008-98015, are allowable

Modifier/POS:

- **Place of Service** 02 or 10
- **Modifier:**
    - **Audio Visual**: 95, FR, GT

Provider Type:

Provider eligible to perform services

Reimbursement:

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

Transmission & Originating Site Fees:

Originating site (HCPCS Q3014) is allowable if the patient presents to a healthcare facility. Transmission fees (T1014) are not allowable.

BCBS MS ELIGIBLE TELEHEALTH CODES										
0650T	0702T	0703T	0704T	0705T	0706T	0733T	0734T	77427	90785	90791
90792	970832	90833	90834	90836	90837	90838	90839	90840	90845	90846
90847	90853	90863	90875	90951	90952	90954	90955	90957	90958	90960
90961	90963	90964	90965	90966	90967	90968	90969	90970	92227	92228
93228	93229	93268	93270	93271	93272	93298	93299	96040	96116	96121

96150	96151	96152	96153	96154	96156	96158	96159	96160	96161	96164
96165	96167	96168	97802	97803	97804	98966	98967	98968	98969	98970
98971	98972	98980	98981	99091	99201	99202	99203	99204	99205	99211
99212	99213	99214	99215	99231	99232	99233	99234	99235	99236	99242
99243	99244	99245	99252	99253	99254	99255	99307	99308	99309	99310
99347	99348	99406	99407	99408	99409	99417	99421	994422	99423	T1014
S9152	99444	99446	99447	99448	99449	99451	99452	99453	99454	99457
99458	99483	99495	99496	99497	99498	0177T	0188T	0189T	D9995	D9996
G0071	G0108	G0109	G0270	G0296	G0316	G0317	G0318	G0396	G0397	G0406
G0407	G0408	G0420	G0421	G0424	G0425	G0426	G0427	G0438	G0439	G0442
G0443	G0444	G0445	G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514
G2010	98016	G2025	G2061	G2062	G2063	G2086	G2087	G2088	G2211	G2212
G3002	G3003	G9006	G9481	G9482	G9483	G9484	G9485	G9486	G9487	G9488
G9489	G9978	G9979	G9980	G9981	G9982	G9983	G9984	G9985	G9986	G9868
G9869	G9870	S5185	S9110							

References:

Blue Cross & Blue Shield of Mississippi Telehealth Coding Policy

Telehealth: Store-and-Forward Telemedicine Services

Telehealth: Remote Patient Monitoring Services

Payor Specific Key Points

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits:** Not Allowable
- **Virtual Check-Ins:** 98016

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, G0322
- Coverage Policy 0563- Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM)

Telehealth Medical:

Allowable Services:

See below table for allowable medical telehealth codes

Audio Only:

An audiovisual connection is required, except for audio-only telehealth E/M CPT 98008-98015

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
  - Exception for CPT 98008-98015
- 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**
    - **Audio-Visual**: GT, 95
    - **Audio-Only**: 93
    - **Asynchronous**: GQ

Provider Type:

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

Reimbursement:
Refer to contracted fee schedule

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	96041	96112	96113	96116	96156	96158	96159	96160	96161
96164	96165	96167	96168	97110	97112	97161	97162	97163	97164	97165	97166	97167
97168	97530	97755	97760	97761	97802	97803	97804	99202	99203	99204	99205	99211
99212	99213	99214	99215	99406	99407	99408	99409	99404	99411	99412	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
98016	S9123	S9128	S9129	S9131	S9152	99446	99447	99448	99449	99451	99452	99381
99382	99383	99384	99385	99386	99387	99391	99392	99393	99394	99395	99396	99397
99401	99402	99403	98000	98001	98002	98003	98004	98005	98006	98007	98008	98009
98010	98011	98012	98018	98014	98015							

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	96156	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	99354	99355	99356	99357	99404	99408	99409	99415
99416	99417	H2011	S0201	S9480	99446	99447	99448	99449	99456	99484	99495	99496
0591T	0592T	G0410	H0015	H0035	H0038							

References:

- Reimbursement Policy- R31- Virtual Care

Payor Specific Key Points:

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 99421-99423, 98970-98972, G2061-G2063
- **Virtual Check-In:** G2010, 98016

Telehealth:

Telehealth Allowable Codes:

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

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:**
  - For more information regarding telemental health refer to the Telemental Health Services - Commercial

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).

Audio Only:

Audio only allowable codes defined in the below *Medica Eligible Telehealth Code list*

Modifiers/POS:

- **POS** 02 or 10
- **Modifier**
  - **Audio-Visual:** GT, 95
  - **Audio-Only**: 93, FQ
  - **Asynchronous:** GQ
  - **Tele-Stroke**: G0

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:

Refer to contracted fee schedule

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

References:

- Reimbursement Policy: Telehealth excluding Minnesota Health Care Program (MHCP) Members
- Reimbursement Policy: Telephone and Virtual Care Services

MEDICA ELIGIBLE TELEHEALTH CODE LIST											
0362T	0373T	0591T	0592T	0593T	77427	87633	90785	90791	90792	90832	90833
90834	90836	90837	90838	90839	90840	90845	90846	90847	90853	90863	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	92227	92228	92507	92508	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	93228	93229
93268	93750	93270	93271	93272	93298	93797	93798	94002	94003	94004	94005
94625	94626	94664	95970	95971	95972	95983	95984	96040	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
99242	99243	99244	99245	99252	99253	99254	99255	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	99408	99409
99417	99418	99441	99442	99443	99468	99469	99471	99472	99473	99475	99476
99477	99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0136
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	G3002	G3003	G9685	Q3014							
Codes in blue may be performed via an audio-only connection											

Payor Specific Key Points:

E-Visits/ Virtual Check Ins:

Allowable Codes:

- **E-Visits:** 99421-99423, G2061-G2063
- **Virtual Check-In**: G2010, 98016, G2250-G2252

Modifiers: None

Telehealth:

Consolidated Appropriations Act, 2026

Extends certain telehealth flexibilities for Medicare patients through December 31st, 2027

- **Medicare Beneficiary Location**: Patients can receive Medicare telehealth services, regardless of patient location in the United States
- **Medicare Telehealth Practitioners Type**: An extended range of practitioners may bill for telehealth services, including physical therapists, occupational therapists, speech-language pathologists, and audiologists
- **Hospital-Based Outpatient Therapy, Diabetes Self-Management Training, and Medical Nutrition Therapy:** Hospitals may bill for certain outpatient therapy services, diabetes self-management training, and medical nutrition therapy services furnished remotely by hospital staff
- **In-Person Mental Health Visit Requirements:** Delayed in-person visit requirements for behavioral health services provided via telehealth
- **RHC & FQHC Distant Site:** RHCs and FQHCs may continue to bill for non-behavioral health services furnished through interactive telehealth

Allowable Codes:

See table below for codes allowable via telehealth

- Effective January 1st, 2026, CMS permanently removed the application of telehealth frequency limits on subsequent inpatient and nursing facility visits and critical care consultations

Audio Only:

Beneficiaries may continue to receive audio-only telehealth services in their homes through December 31, 2027

- Audio-only can be used for both new and established patients
- Utilized when the patient is not capable of or does not consent to using audio-video communication technology
- Provider must be technically capable of using audio-video communication technology
- Beneficiaries who are receiving remote mental health services, as defined in the CY 2023 and 2024 OPPS Final Rules, furnished by hospital-employed staff in their homes may also receive these services via audio-only communication technology
- Starting January 1, 2028, providers may only use audio-only communication technology for behavioral health services furnished to a patient in their home

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.

***Hospital Based Providers*:**

Hospitals and other providers of PT, OT, SLP, diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services can continue to bill for telehealth services through December 31st, 2027

- For outpatient hospitals, patients' homes no longer need to be registered as provider-based entities to allow for hospitals to bill for these services
- The 95 modifier is required on claims from all providers, except for Critical Access Hospitals (CAHs) electing Method II (which utilize a GT modifier)

Medicare Shared Savings Program Accountable Care Organizations (ACOs)

- The Bipartisan Budget Act of 2018 allows clinicians participating in certain Medicare Shared Savings Program (MSSP) ACOs to provide and receive payment for covered telehealth services without geographic restrictions, including services furnished in the beneficiary's home
    - These flexibilities apply only to applicable ACOs with prospective beneficiary assignment in the ENHANCED track or BASIC track Levels C–E, and services must be billed under the ACO participant's TIN for assigned beneficiaries
    - ACOs using retrospective assignment and non-risk ACOs do not qualify and must follow standard Medicare fee-for-service telehealth rules

Modifiers/POS:

- **Professional Claims:**
    - **POS:** 02 or 10
- **Institutional Claims:**
    - Modifier 95 is for outpatient therapy services provided via telehealth by qualified physical
    - therapists, occupational therapists, or speech language pathologists employed by hospitals
    - Modifier GT is required for CAH Method II (UB) Claims

Patient Location:

Through December 31st, 2027, there is no originating site or geographic restriction

Mental Health Place of Service:

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 the decision in the patient's medical record
- Through December 31st, 2027, the initial 6 month visit requirement and the in person visit every 12 month requirement, is waived

Provider Type:

Allowable telehealth providers are physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, marriage and family therapists, mental health counselors, and nutrition professionals

- Through December 31st, 2027, physical therapists, occupational therapists, speech-language pathologists, and audiologists to provide Medicare telehealth services

Provider Location:

Practitioners who furnish telehealth services from their homes but have a physical practice location are not required to report their home address on their Medicare enrollment application. Practitioners can enroll and bill from their physical practice location as if they furnished the telehealth service in person. Virtual-only telehealth practitioners whose only physical practice location is their home address will need to enroll their home address as a practice location.

Reimbursement:

When telehealth services are provided to people in their homes (POS 10), the service will be reimbursed at the non-facility rate. If the telehealth service is provided when the patient is not in their home, and POS 02 is utilized, then the service will be reimbursed at the facility rate.

Rural Health Clinics & Federally Qualified Health Centers:

See the RHC and FQHC section for specific billing regulations

Supervision:

Effective January 1, 2026, the presence of the physician (or other practitioner) required for direct supervision may include virtual presence through audio/video real-time communications technology (excluding audio-only) for services without a 010 or 090 global surgery indicator

- Applies to services where direct supervision is required which do not have a 010 or 090 global surgery indicator
    - Includes most incident-to services under § 410.26, many diagnostic tests under § 410.32, pulmonary rehabilitation services under § 410.47, cardiac rehabilitation and intensive cardiac rehabilitation services under § 410.49, and certain hospital outpatient services as provided under § 410.27(a)(1)(iv)

Teaching Physicians:

CMS will allow teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service was furnished virtually, on a permanent basis

Transmission/ Originating Site Fees:

Medicare will reimburse an originating site fee (HCPCS Q3014) if the patient is present at a healthcare facility. Medicare does not reimburse for transmission fees. Modifier 95 not required when billing Q3014.

MEDICARE ELIGIBLE TELEHEALTH CODES											
2026 Telehealth Codes											
0362T	0373T	0591T	0592T	0593T	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	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
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	97550	97551	97552	99468	99469	99471	99472	99473	99475	99476
99477	99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0136
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	G3002	G3003	G9685	96202	96203	G0011	G0013	G0539	G0540	G0541	G0542
G0543	G0560	90849	92622	92623	G0473	G0545					

References:

MLN Matters-Telehealth Services
SE22001 Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers
CMS Telehealth FAQ 2026
Consolidated Appropriations Act, 2026
CMS Telehealth Services List

Payor Specific Key Points:

E-Visits/ Virtual Check Ins:

Allowable Codes:

- **E-Visits**: Not Allowed
- **Virtual Check-In:** Not Allowed

Telehealth:

Allowable Codes:

The Division of Medicaid covers medically necessary health services as a substitution for an in-person visit for consultation, office visit, and/or outpatient visit when all the required medically appropriate criteria is met which aligns with the description of the CPT E&M and HCPCS guidelines. If a service is not covered in an in-person setting, it is not covered if provided through telehealth.

- The Division of Medicaid requires that providers utilize telehealth technology sufficient to provide real-time interactive communications that provide the same information as if the telehealth visit was performed in-person. Equipment must also be compliant with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA)

Audio Only:

Telehealth must be live, interactive, and audiovisual

Documentation:

Must be the same information as for a comparable in-person service and be maintained at both the originating and distant site of the telehealth services provided including, but not limited to:

- Signed consent for treatment using telehealth
- Medically appropriate reason telehealth was utilized to provide services
- Beneficiary's presenting diagnosis and symptoms
- Specific name/type of all diagnostic studies and results/findings of the studies
- Plan of Care

Modifier/POS:

- **Professional (1500) claims**: Modifier GT and POS 02
- **Facility (UB) Claims**: Modifier GT

Non-Covered Services:

- Telehealth service if that same service is not covered in an in-person setting.
- Separate reimbursement for the installation or maintenance of telehealth hardware, software and/or equipment, videotapes, and transmissions.
- Early and periodic screening, diagnosis, and treatment (EPSDT) well child visits through telehealth.
- Physician or other practitioner visits through telehealth for non-established beneficiaries
- Physician or other practitioner visits through telehealth for Level VI or V visits.
- Telephone conversations, chart reviews, electronic mail messages, facsimile transmission, internet services for online medical evaluations, communication through social media or any other communication made in the course of usual business practices (calling prescription refill or performing a quick virtual triage).
- The installation or maintenance of any telecommunication devices or systems

Provider Type:

Providers must be an enrolled Mississippi Medicaid provider acting within their scope-of-practice and license or medical certification or Mississippi Department of Health (MDSH) certification and in accordance with state and federal guidelines, including but not limited to, authorization of prescription medications.

- **Approved Originating Site Providers**: Office of a physician or practitioner, Outpatient Hospital (including a Critical Access Hospital (CAH), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), Private Mental Health Centers, Therapeutic Group Homes, Indian Health Service Clinic, School-based clinics, School which Employs a School Nurse, Inpatient hospital, and Beneficiary Home.
    - The Division of Medicaid requires a telepresenter who meets the requirements of Miss. Admin Code Part 225, Rule 1.1.C. at the originating site as determined by the Division.
- **Approved Distant Site Providers**: Physicians, Physician Assistants, Nurse Practitioners, Psychologists, Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), Licensed Marriage and Family Therapists (LMFTs), Board Certified Behavior Analysts (BCBAs), Board Certified Behavior Analyst-Doctorals (BCBA-Ds), Speech Therapists, Occupational Therapists, Physical Therapists, Rural Health Clinics, Federally Qualified Health Centers, Community Mental Health Centers, Mississippi State Department of Health (MSDH) clinics, and Private Mental Health Centers.

Reimbursement:

The current applicable Mississippi Medicaid fee-for-service rate or encounter for the service provided.

- Providers delivering simultaneous distant and originating site services to a beneficiary are reimbursed:
    - The current applicable Mississippi Medicaid fee-for-service rate for the medical service(s) provided, and either the originating or distant site facility fees, not both, except for RHC, FQHC and CMHC when such services are appropriately provided by the same organization.

Transmission & Originating Site Fees:

Mississippi Medicaid reimburses the provider at the originating site the originating site facility fee for telehealth services per completed transmission, in addition to a separately identifiable covered service if performed

- Providers elgible to receive the originating site facility fee for telehealth services per transmission: the office of a physician, an outpatient hospital, RHC, FQHC Community Mental health/Private Mental Health Center, Therapeutic Group Home, Indian Health Service Clinic, School Based Clinic, School that Employes a Nurse
- The inpatient hospital originating site fee is included in the APR-DRG payment.
- There is no originating site fee paid when the originating site is the beneficiary's home
- The originating site provider may not bill for an encounter or Evaluation and Management (E&M) visit unless a separately identifiable service is performed.
- Providers delivering simultaneous distant and originating site services to a beneficiary are reimbursed
    - The current applicable Mississippi Medicaid fee-for-service rate for the medical service(s) provided, AND
    - Either the originating or distant site facility fees, not both, except for RHC, FQHC and CMHC when such services are appropriately provided by the same organization.

MISSISSIPPI MEDICAID ELIGIBLE TELEHEALTH CODES											
0362T	0373T	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	90961	90962	90963	90964	90965	90966	90967	90968
90969	90970	92012	92014	92507	92521	92522	92523	92524	92550	92552	92553
92553	92555	92556	92557	92563	92565	92567	92568	92570	92587	92588	92601
92625	92626	92627	93797	93798	94625	94626	95970	95983	95984	96105	96112
96113	96116	96121	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	99211	99212	99213	99214	99215
99231	99232	99233	99234	99235	99238	99239	99244	99245	99254	99255	99281
99282	99283	99284	99291	99292	99304	99305	99307	99308	99309	99310	99315

99316	99345	99347	99348	99349	99350	99406	99407	99469	99472	99473	99476
99478	99479	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0270
G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0420	G0421	G0422
G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445	G0446	G0447
G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2212	G3002	G3003
G9481	G9482	G9483	G9484	G9485	G9486	G9487	G9488	G9489	G9978	G9979	G9980
G9981	G9982	G9983	G9984	G9985	G9986						

References:

Mississippi Division of Medicaid- Administrative Code- Part 225- Telemedicine

Payor Specific Key Points:

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 98970-98972, 99421-99423
- **Virtual Check-In**: 98016, G2010, G2250-G2252

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

Remote Patient Monitoring Codes:

Allowable Codes:

- 98975-98978, 98980-98981, 99091, 99457, 99458, 99473-99474

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

Interprofessional Assessment Codes:

Allowable Codes:

- 99446-99449, 99451-99454, G0546-G0551

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
- Consistent with CMS, UHC will not recognize CPT 98000-98015, as they are assigned to status code “I” on the NPFS Relative Value File, indicating another code (replacement code) is used to report the procedure or service and that replacement code has an assigned RVU

Physical Health, Occupational, and Speech Therapy:
UHC will reimburse certain physical, occupational, and speech therapy (PT/OT/ST) Telehealth services provided by QHPs rendered via interactive audio and video technology.
Services submitted on a CMS 1500 form should include:

- Code(s) from the list of specific physical, occupational and speech therapy Telehealth services (see the PT/OT/ST Telehealth Eligible Services Code List in the Attachments section)
- The appropriate place of service code 02 or 10 in Box 24B

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.

Modifiers/POS:

- **POS** 02 or 10
- **Modifiers**

- **Audio Visual:** 95, GT, GQ, and G0 are not required to identify telehealth services but are accepted as informational if reported on claims
- **Audio-Only**: 93

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.

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)

Reimbursement:

Refer to contracted fee schedule

Transmission & Originating Site Fees:

Claims for Originating Site services may be reported using HCPCS code Q3014 (Telehealth Originating Site facility fee) on either a professional (CMS-1500) or a facility (UB-04) claim when a Telepresenter is present at an Originating Site location other than the patient's home. Q3014 is not reimbursable when the Distant Site claim is reported with a POS 10 indicating the patient is located at home and not receiving any Originating Site services from a Telepresenter. T1014 is not eligible for payment, UHC considers these services as incidental to the charges associated with the E/M.

Audio Only Services:

Telehealth services must be performed over an audiovisual connection, unless an 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 telehealth, when appended with modifier 93, and reported with POS 02 or 10.

UHC ELIGIBLE TELEHEALTH CODES											
0362T	0373T	0591T	0592T	0593T	77427	90785	90791	90792	90832	90833	90834
90836	90837	90838	90839	90840	90845	90846	90847	90853	90863	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
92227	92228	92507	92508	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	93228	93229	93268
93270	93271	93272	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	96202	96203	97110
97112	97129	97130	97150	97151	97152	97153	97154	97155	97156	97157	97158
97161	97162	97163	97164	97165	97166	97167	97168	97530	97535	97537	97542
97550	97551	97552	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	99408	99409	99417	99418	99468	99469	99471	99472	99473
99475	99476	99477	99478	99479	99480	99483	99495	99496	99497	99498	G0011
G0013	G0108	G0109	G0136	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
G0539	G0540	G0541	G0542	G0543	G0560	G2086	G2087	G2088	G2211	G2212	G3002
G3003	G9685	90482	90483	90484	90849	92622	92623	96041	97116	99497	99498
G0473	G0545										

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	96041	96110	96116	96121
96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171	97802
97803	97804	99406	99407	99408	99409	99497	99498	90482	90483	90484	90853
96130	96131	96132	96133	96136	96137	96138	96139	96202	96203		

Reference:

- Reimbursement Policy-Telehealth/Virtual Health Policy, Professional

Payor Specific Key Points:

Virtual Communication Services:

Effective Jan 1, 2026, RHCs are required to report the individual remote evaluation service codes previously billed under G0071 (G0071 is no longer reportable)

Allowable Codes:

Virtual Check-In: G2010, 98016, G2250

Care Coordination Services

Starting Jan 1, 2025, CMS required RHCs & FQHCs to report the individual CPT/HCPCS care coordination codes instead of G0511; CMS allowed billing G0511 during a transition period, but G0511 was no longer billable after Sept 30, 2025

Telehealth:

RHC/FQHC Distant Site Provider Extension:

RHCs and FQHCs may continue to bill for non-behavioral health services furnished through interactive telehealth through December 31st, 2027, utilizing G2025

Allowable Codes:

RHCs and FQHCs may furnish allowable RHC/FQHC services via telehealth utilizing G2025 for medical telehealth claims and the appropriate behavioral health CPT/HCPCS for behavioral health claims.

Audio Only:

Beneficiaries may continue to receive audio-only telehealth services in their homes through December 31, 2027

- Audio-only can be used for both new and established patients
- Utilized when the patient is not capable of or does not consent to using audio-video communication technology
- Provider must be technically capable of using audio-video communication technology
- Beneficiaries who are receiving remote mental health services, as defined in the CY 2023 and 2024 OPPS Final Rules, furnished by hospital-employed staff in their homes may also receive these services via audio-only communication technology
- Starting January 1, 2028, providers may only use audio-only communication technology for behavioral health services furnished to a patient in their home

Billing:

- **Medical Claims**
  - **HCPCS**: G2025
  - **UB**: 52X revenue code
  - **Modifier:**
    - **Audio/Video:** None Required
    - **Audio Only:** FQ
- **Mental Health Claims**:
  - **CPT/HCPCS**: Appropriate Behavioral Health CPT/HCPCS
  - **UB**: 900 revenue code
  - **Modifier:**
    - **Audio/Video:** CG & 95
    - **Audio Only:** FQ

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 medically 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, 2027, the initial 6 month visit and the in person visit every 12 month requirement is waived

Provider Type:

Physicians, Nurse practitioners (NPs), Physician assistants (PAs), Certified nurse-midwives (CNMs), Clinical psychologists (CPs), Clinical social workers (CSWs), Marriage and family therapists (MFTs), Mental health counselors ((MHCs)

Reimbursement:

Medical:

- 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 2026 the rate is $97.53

Mental Health:

- RHC AIR rate or FQHC PPS rate

Supervision:

CMS permanently adopted a definition of direct supervision, for RHC and FQHC services, that allows the physician or supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only)

Transmission/ Originating Site Fees:

Medicare will reimburse an originating site fee (HCPCS Q3014) if the patient is present at a healthcare facility. Medicare does not reimburse for transmission fees.

References:

MLN Matters-Telehealth Services
SE22001 Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers
CMS Telehealth FAQ 2026
Consolidated Appropriations Act, 2026
CMS Telehealth Services List

Payor Specific Key Points:

E-Visits/ Virtual Check Ins:

Allowable Codes:

- **E-Visits**: Not Allowed
- **Virtual Check-In:** Not Allowed

Telehealth:

Allowable Codes:

The Division of Medicaid covers medically necessary health services as a substitution for an in-person visit for consultation, office visit, and/or outpatient visit when all the required medically appropriate criteria is met which aligns with the description of the CPT E&M and HCPCS guidelines. If a service is not covered in an in-person setting, it is not covered if provided through telehealth.

- The Division of Medicaid requires that providers utilize telehealth technology sufficient to provide real-time interactive communications that provide the same information as if the telehealth visit was performed in-person. Equipment must also be compliant with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA)

Audio Only:

Telehealth must be live, interactive, and audiovisual

Documentation:

Must be the same information as for a comparable in-person service and be maintained at both the originating and distant site of the telehealth services provided including, but not limited to:

- Signed consent for treatment using telehealth
- Medically appropriate reason telehealth was utilized to provide services
- Beneficiary's presenting diagnosis and symptoms
- Specific name/type of all diagnostic studies and results/findings of the studies
- Plan of Care

Modifier/POS:

- **Professional (1500) claims**: Modifier GT and POS 02
- **Facility (UB) Claims**: Modifier GT

Non-Covered Services:

- Telehealth service if that same service is not covered in an in-person setting.
- Separate reimbursement for the installation or maintenance of telehealth hardware, software and/or equipment, videotapes, and transmissions.
- Early and periodic screening, diagnosis, and treatment (EPSDT) well child visits through telehealth.
- Physician or other practitioner visits through telehealth for non-established beneficiaries
- Physician or other practitioner visits through telehealth for Level VI or V visits.
- Telephone conversations, chart reviews, electronic mail messages, facsimile transmission, internet services for online medical evaluations, communication through social media or any other communication made in the course of usual business practices (calling prescription refill or performing a quick virtual triage).
- The installation or maintenance of any telecommunication devices or systems

Provider Type:

Providers must be an enrolled Mississippi Medicaid provider acting within their scope-of-practice and license or medical certification or Mississippi Department of Health (MDSH) certification and in accordance with state and federal guidelines, including but not limited to, authorization of prescription medications.

- **Approved Originating Site Providers**: Office of a physician or practitioner, Outpatient Hospital (including a Critical Access Hospital (CAH), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), Private Mental Health Centers, Therapeutic Group Homes, Indian Health Service Clinic, School-based clinics, School which Employs a School Nurse, Inpatient hospital, and Beneficiary Home.
    - The Division of Medicaid requires a telepresenter who meets the requirements of Miss. Admin Code Part 225, Rule 1.1.C. at the originating site as determined by the Division.
- **Approved Distant Site Providers**: Physicians, Physician Assistants, Nurse Practitioners, Psychologists, Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), Licensed Marriage and Family Therapists (LMFTs), Board Certified Behavior Analysts (BCBAs), Board Certified Behavior Analyst-Doctorals (BCBA-Ds), Speech Therapists, Occupational Therapists, Physical Therapists, Rural Health Clinics, Federally Qualified Health Centers, Community Mental Health Centers, Mississippi State Department of Health (MSDH) clinics, and Private Mental Health Centers.

Reimbursement:

The current applicable Mississippi Medicaid fee-for-service rate or encounter for the service provided.

- Providers delivering simultaneous distant and originating site services to a beneficiary are reimbursed:
    - The current applicable Mississippi Medicaid fee-for-service rate for the medical service(s) provided, and either the originating or distant site facility fees, not both, except for RHC, FQHC and CMHC when such services are appropriately provided by the same organization.

Transmission & Originating Site Fees:

Mississippi Medicaid reimburses the provider at the originating site the originating site facility fee for telehealth services per completed transmission, in addition to a separately identifiable covered service if performed

- Providers elgible to receive the originating site facility fee for telehealth services per transmission: the office of a physician, an outpatient hospital, RHC, FQHC Community Mental health/Private Mental Health Center, Therapeutic Group Home, Indian Health Service Clinic, School Based Clinic, School that Employes a Nurse
- The inpatient hospital originating site fee is included in the APR-DRG payment.
- There is no originating site fee paid when the originating site is the beneficiary's home
- The originating site provider may not bill for an encounter or Evaluation and Management (E&M) visit unless a separately identifiable service is performed.
- Providers delivering simultaneous distant and originating site services to a beneficiary are reimbursed
    - The current applicable Mississippi Medicaid fee-for-service rate for the medical service(s) provided, AND
    - Either the originating or distant site facility fees, not both, except for RHC, FQHC and CMHC when such services are appropriately provided by the same organization.

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92625	92626	92627	93797	93798	94625	94626	95970	95983	95984	96105	96112
96113	96116	96121	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	99211	99212	99213	99214	99215
99231	99232	99233	99234	99235	99238	99239	99244	99245	99254	99255	99281
99282	99283	99284	99291	99292	99304	99305	99307	99308	99309	99310	99315

99316	99345	99347	99348	99349	99350	99406	99407	99469	99472	99473	99476
99478	99479	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0270
G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0420	G0421	G0422
G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445	G0446	G0447
G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2212	G3002	G3003
G9481	G9482	G9483	G9484	G9485	G9486	G9487	G9488	G9489	G9978	G9979	G9980
G9981	G9982	G9983	G9984	G9985	G9986						

References:

Mississippi Division of Medicaid- Administrative Code- Part 225- Telemedicine

HIPAA COMPLIANT SOFTWARE

As of the end of the COVID PHE in May of 2023, all payors require a HIPAA compliant software

Document Prepared By:

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