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Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.
Definition: There are three types of telehealth services:
- **Asynchronous Telehealth (Store & Forward)** is the transfer of digital images, sounds, or previously recorded video from one location to another to allow a consulting practitioner (usually a specialist) to obtain information, analyze it, and report back to the referring practitioner. This is a non-interactive telecommunication because the physician or health care practitioner views the medical information without the patient being present.
- **Synchronous Telehealth** is real-time interactive video teleconferencing that involves communication between the patient and a distant practitioner who is performing the medical service. The practitioner sees the patient throughout the communication, so that two-way communication (sight and sound) can take place.
- **Remote Patient Monitoring** is use of digital technologies to collect health data from individuals in one location and electronically transmit that information to providers in a different location for assessment.

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

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

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

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

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

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

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

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

**CPT/HCPCS Codes:**

Reportable by a Qualified Healthcare Professionals:

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

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

- **G2061/G98970:** 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/G98971:** 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/G98972:** Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.

**Reporting Criteria:**

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

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

**CPT/HCPCS Codes:**

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

**Reporting Criteria:**

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

**Documentation Requirements:**

Documentation should include medical decisions made, names and roles of any persons participating in the evaluation, and the communication method (telephone, video/audio software, etc.). Obtain verbal consent at the start of the visit and ensure the consent is documented. Maintain a permanent record of the telehealth visit in the patient’s medical record.
**Definition:** A telephone visit is an evaluation and management service provided by a qualified healthcare professional or an assessment and management service provided by a qualified nonphysician health care professional via audio telecommunication.

**CPT/HCPCS Codes:**

Reportable by Qualified Healthcare Professionals:

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

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

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

**Reporting Criteria:**

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

**Documentation Requirements:**

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

<table>
<thead>
<tr>
<th>PAYOR</th>
<th>E-VISIT</th>
<th>TELEHEALTH- NO ORIGINATING SITE RESTRICTION</th>
<th>VIRTUAL CHECK-IN</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANTHEM BCBS</td>
<td>CONDITIONAL</td>
<td>Check contracted fee schedule to see if E-Visit codes are allowable</td>
<td>ALLOWABLE</td>
<td>CONDITIONAL</td>
</tr>
<tr>
<td>CIGNA</td>
<td>NOT ALLOWABLE</td>
<td>Coverage: Effective: March 19th, 2020 Patient Type: New or Established Patients Billing: Telehealth Eligible Code Professional: Modifier 95 or GT &amp; POS used for in-person visit. Facility: Not Allowable</td>
<td>ALLOWABLE</td>
<td>ALLOWABLE</td>
</tr>
<tr>
<td>MEDICA*</td>
<td>ALLOWABLE</td>
<td>*Excludes MHCP Members Coverage: Effective: March 6th, 2020 Patient Type: Established Only Billing: 99421-99423, 98970-98972, G2061-G2063.</td>
<td>ALLOWABLE</td>
<td>ALLOWABLE</td>
</tr>
<tr>
<td>WI MEDICAID</td>
<td>ALLOWABLE</td>
<td>Coverage: Effective: March 1st, 2020 Patient Type: Established Billing: 99421-99423, 98970-98972</td>
<td>ALLOWABLE</td>
<td>NOT ALLOWABLE</td>
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</table>

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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
- **Effective Date:** March 6th, 2020-Further Notice
- **Modifier:** None
- **Patient Type:** Established
- **Telephone Reimbursement:** Telephone services (99441-99443) provided March 5th, 2020 through September 30th, 2020 were reimbursed at the same rate as a 99212-99214 E/M office visit (ex. 99441 equaled a 99212 E/M reimbursement). After September 30, 2020, telephone-only services resumed to pre-March 5, 2020 rates.

Telehealth:

- **Allowable Codes:** See table below
  - Wellness: Appropriate E/M codes with a wellness diagnosis for wellness aspects of the visit done via telehealth will be covered. Preventative visit codes should be billed when routine in-office visits can resume, and the remaining parts of the well visit can be completed. Both services will be fully reimbursed, and the patient will not incur a cost share.
- **Effective Date:**
  - Expanded telehealth code set: March 6th, 2020-Further Notice
  - Original telehealth code set: N/A
- **HIPAA Compliant Platform:** Non-HIPAA compliant, non-public facing software can be utilized for telehealth visits, such as Skype & FaceTime.
- **Modifiers/POS:**
  - Commercial:
    - 1500: POS 02 with modifier GT for CMS recognized CPTs or modifier 95 for AMA Appendix P.
    - UB: Modifier GT or 95
  - Medicare Advantage:
    - 1500: POS that would have been used if the service were performed in person (e.g. POS 11) with modifier 95.
    - UB: Modifier 95
- **Not Reimbursable:**
  - Asynchronous Telemedicine Services (services reported w/ GQ modifier).
  - Services that do not include direct patient contact, such as physician standby services.
- **Provider Type:** Not specified
  - Aetna will allow physicians to provide care from any location, including the provider’s home.
- **Reimbursement:** Reimbursement will be at the same rate as in-person face-to-face visits, refer to your Aetna contract for allowable rates.
- **Capitation:** Telemedicine will be covered within the capitation agreement, similar to an in-office visit
- **Transmission & Originating Site Fees:** For their commercial product, T1014 and Q3014 are not eligible for payment, Aetna considers these services as incidental to the charges associated with the E/M. For their Medicare Advantage product Aetna will allow an originating site fee (Q3014) as appropriate.
- **Video Component:** The telehealth video component is required, except on codes indicated below that can be provided over audio only.

**Cost Share Waiver:**
Both Commercial & Medicare Advantage:

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

<table>
<thead>
<tr>
<th>AETNA ELIGIBLE TELEHEALTH CODES</th>
<th>Original Telehealth Allowable Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0410   92002  96170   97164   99217   99235   99307   99344   99476   G0408  G2010  90839  96121  96164</td>
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<tr>
<td>G2061   92012  96171   97165   99218   99236   99308   99345   99477   G0425  G2012  90840  96127  96164</td>
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<tr>
<td>G2062   92065  97110   97166   99219   99238   99309   99347   99478   G0426  G2086  90845  96130  96165</td>
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<tr>
<td>G2063   92526  97112   97167   99220   99239   99310   99348   99479   G0427  G2087  90846  96131  96167</td>
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<td>H0015   92601  97116   97168   99221   99281   99315   99349   99480   G0442  G2088  90847  96132  96168</td>
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<tr>
<td>H0035   92602  97150   97530   99222   99282   99316   99350   99483   G0443  G7085  90853  96133  97535</td>
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<tr>
<td>H2012   92603  97151   97542   99223   99283   99327   99421   G0108  G0444  90791  90863  96136  97802</td>
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<tr>
<td>H2036   92604  97153   97443   99224   99284   99328   99422   G0109  G0445  90792  92507  96137  97803</td>
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<tr>
<td>S9480   92606  97155   97755   99225   99285   99334   99423   G0270  G0446  90832  92508  96138  97804</td>
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<tr>
<td>S7742   92609  97156   97760   99226   99291   99335   99468   G0296  G0447  90833  92521  96139  92070</td>
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<tr>
<td>90953   94664  97157   97761   99231   99292   99336   99469   G0396  G0459  90834  92522  96156  98966</td>
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<td>90956   96110  97161   98970   99232   99304   99337   99471   G0397  G0506  90836  92523  96158  98967</td>
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<td>90959   96112  97162   98971   99233   99305   99341   99472   G0406  G0513  90837  92524  96159  98968</td>
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<td>90962   96113  97163   98972   99234   99306   99343   99475   G0407  G0514  90838  96116  96160  99451</td>
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<tr>
<td>99354   99355   99356   99357   99406   99407   G0436  G0437  94941   99442   99443   99446   99447   99448</td>
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<tr>
<td>99449   99497   99498   99452   H0038   G0422   G0423   G0424   99342   90875   93750   93798   95970   95791</td>
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<tr>
<td>95972   95983   95984   90849   96125   97129   97130   92228</td>
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</tbody>
</table>

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

**E-Visits/Telephone/Virtual Check-In:**

- **Allowable Codes:**
  - **E-Visits:** Check provider’s fee schedule
  - **Telephone:** 99441-99443, 98966-98968
  - **Virtual Check-In:** Check provider’s fee schedule

- **Effective Date:**
  - **E-Visit/Virtual Check-In:** N/A
  - **Telephone:** March 19th, 2020-December 31st, 2021

- **Modifier/POS:** POS for in person service, no modifier.

- **Patient Type:** Seeking Clarification

**Telehealth:**

- **Allowable Codes:** Anthem has not published a specific allowable telehealth allowable code list, except for PT/OT/ST and some behavioral health services. Providers should report the applicable CPT/HCPCS code on the provider’s fee schedule.
  - **Therapy Specific Allowable Codes:**
    - **Physical Therapy:** 97161, 97162, 97163, and 97164
    - **Occupational Therapy:** 97165, 97166, 97167, and 97168
    - **PT/OT Treatment Codes** 97110, 97112, 97530, and 97535
    - **Speech Therapy:** 92521, 92522, 92523, and 92524
    - **ST Treatment Codes** 92507, 92526, 92606, and 92609
    - **PT/OT codes that require equipment and/or direct physical hands-on interaction and therefore are not appropriate via telehealth include:** 97010-97028, 97032-97039, 97113-97124, 97139-97150, 97533, and 97537-97546.
  - **Behavioral Health:** Anthem will allow IOP, PHP, ABA, and psychological testing services to be provided via telehealth. These services will still need to be provided within benefits limits, authorization limits, medical necessity criteria, and within state and federal regulatory requirements and licensure requirements, including HIPAA compliance and the regulations regarding how substance use information is handled. Services must be provided over an audiovisual connection, except for the CPTs that are designated as allowable over an audio only connection.
    - **IOP/PHP:** Bill with applicable revenue code (905, 906, 912, 913) and appropriate behavioral health CPT code. IOP and PHP services delivered telehealth must meet specific requirements, see the detailed list at the following link:
    - **Mental Health and Substance Abuse:**
      - Psychiatric Diagnostic Evaluation: CPT 90791-90792
      - Psychotherapy: 90832-90838, 90839-90840, 90845-90847
      - Medication Management: 90863
      - E&M codes: 99211-99215
    - **ABA Therapy:**
      - Functional Behavior Assessment (FBA): CPT 97151
      - Adaptive Behavioral Treatment by Protocol or Protocol Modification: CPT 97153, 97155
      - Telehealth Caregiver Training: CPT 97156, 97157
    - **Telephonic Only Behavioral Health Codes:**
      - Telephone codes (see above section)
Anthem will also recognize telephonic-only services for diagnostic evaluation (90791-90792), psychotherapy (90832-90838, 90839-90840, 90845-90847), and medication management (90863) with place of service (POS) 02 and modifier 95 or GT.

- **Effective Date:** March 19th, Further Notice
- **HIPAA Compliant Platform:** Seeking Clarification
- **Modifiers/POS:**
  - Professional (1500) Claims: POS 02 with modifier 95 or GT
  - Facility (UB) Claims: Applicable in-person revenue code with modifier 95 or GT
  - COVID-19 Related: Append the CS modifier to line items in which COVID-19 evaluation or testing services where performed.
- **Patient Type:** Seeking Clarification
- **Patient Location:** Patient can be located at home or at an allowable originating site facility.
- **Provider Type:**
  - Providers do not need to notify Anthem of a temporary address for providing health care services. Providers should continue to submit claims with their primary service address, not their temporary address.
- **Reimbursement:** Seeking Clarification
- **Transmission & Originating Site Fees:** Seeking clarification
- **Video Component:** The video component has not been waived for telehealth codes, per Anthem if a telephonic-only visit is performed providers should utilize the telephone codes, CPT 99441-99443 and 98966-98968.

**Cost Share Waiver:**
- Effective March 17th, 2020 through September 30th, 2020, Anthem waived cost sharing for all telehealth visits for fully insured and individual plan members, regardless of DX.
- Effective March 18th, 2020 through January 31st, 2021, Anthem waived cost sharing for COVID-19 treatment related telehealth visits from in-network providers.
- Effective March 19th, 2020-December 31st, 2021, Anthem will waive cost sharing for telephonic-only in-network visits. Both Commercial & Medicare Advantage:
- Effective March 17th, 2021, through End of PHE: Anthem will waive COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test.
Payor Specific Key Points
Effective January 1st, 2021

E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes:**
  - E-Visits: Not Allowable
  - Telephone: 99441-99443
  - Virtual Check-Ins: G2012-temporary reimbursable until further notice
- **Effective Date:** Effective January 1st, 2021 Cigna implemented a permanent Virtual Care Policy.
- **Modifier:** None
- **POS:** Utilize POS 02
- **Patient Type:** Established

E-Consults:

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

- **Allowable Codes:** 99446-99452
- **Effective Date:** March 2nd, 2020- further notice
- **Modifier:** No modifier, unless COVID-19 related, then utilize modifier CS.
- **POS:** Utilize POS 02
- **Patient Type:** New or Established
- **Non-Billable:**
  - If the consultation to a transfer of care or other face-to-face service (e.g., a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes should not be billed.
  - If the consultation lasted less than 5 minutes.
  - If the consultation was for the sole purpose to arrange transfer of care or a face to face visit.

Telehealth:

- **Allowable Codes:** See below table for allowable telehealth codes.
  - Cigna will reimburse telehealth when ALL of the following are met:
    - Services must be provided over an interactive audiovisual connection.
      - Services rendered via telephone only are considered interactive and will be reimbursed when the appropriate telephone only code is billed.
    - Service would be reimbursable if the service were provided face-to-face.
    - The patient and/or actively 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 of the customer is maintained as part of the customer’s 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 as defined in the 1997 Centers for Medicare and Medicaid Services (CMS) Documentation guidelines for codes outside of the 99202 through 99215 range and the 2021 CPT E/M documentation guidelines outlined by the American Medical Association for codes within the range 99202 through 99215.
- 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.
- Services must be provided by a health care professional who is licensed, registered, or otherwise acting within the scope of his/her licensure.
- Services must be billed on a 1500 form or electronic equivalent.

- **Effective Date:** Effective January 1st, 2021 Cigna implemented a permanent Virtual Care Policy.
- **Excluded Services:**
  - Service occurs on the same day as a face to face visit, when performed by the same provider and for the same condition.
  - Services billed within the post-operative period of a previously completed major or minor surgical procedure will be considered part of the global payment for the procedure and not reimbursed separately.
  - Services performed via asynchronous communications systems (e.g., fax).
  - Store and forward telecommunication [transferring data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation] whether an appropriate virtual care modifier is appended to the procedure code or not.
  - Communications are incidental to E/M services, counseling, or medical services included in this policy, including, but not limited to reporting of test results and provision of educational materials.
  - Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.
  - Urgent Care centers will not be reimbursed for virtual care under the Cigna's virtual care policy.

- **HIPAA Compliant Platform:** All technology used must be secure and meet or exceed federal and state privacy requirements.
  - However, until further notice providers may use non public facing, non-HIPAA compliant platforms, such as FaceTime, Skype, Zoom, etc.

- **Modifiers/POS:**
  - **Announced October 2021:**
    - Professional/1500 Claims: POS 02 and modifier 95
    - Facility/UB Claims: Modifier 95
      - Services billed on a UB-04 claim will not be reimbursed under Cigna's virtual care policy. However, Cigna will temporarily reimburse virtual care services billed on a UB-04 through December 31st, 2021.
      - Note: Intensive outpatient program (IOP) telehealth services were covered prior to the pandemic, and will continue to be covered
  - **Prior to October 2021:**
    - Professional/1500 Claims: POS that would have been used if the service were performed in person (e.g. POS 11) and modifier 95 or GT.
    - Facility/UB Claims: Services billed on a UB-04 claim will not be reimbursed under Cigna’s virtual care policy. However, Cigna will temporarily reimburse virtual care services billed on a UB-04, until further notice, when the service is:
      - Reasonable to be provided in a virtual setting; and
      - Reimbursable per a provider's contract; and
      - Synchronous audiovisual technology is utilized (except for CPTs 99441-99443)

- **COVID-19 Related Telehealth Care:**
  - Suspected or Likely COVID-19 Exposure: ICD-10 Z03.818, Z20.822 or Z20.828, CS modifier, and GT or 95 modifier.
  - Confirmed COVID-19 Case: ICD-10 U07.1, J12.82, M35.81, M35.89, and 95 modifier

- **Patient Type:** New or established patients.
- **Provider Type:** Providers who are licensed, registered, or otherwise acting within the scope of their licensure may provide telehealth services.
- **Reimbursement:** Reimbursement will be at the same rate as in-person face-to-face visits, refer to your Cigna contract for allowable rates.
• Video Component: An audiovisual connection is required except for telephone codes.
• Transmission & Originating Site Fees: Cigna will not reimburse an originating site of service fee or facility fee for telehealth visits (HCPCS Q3014). Cigna will also not reimburse transmission fees; transmission of digitalized data is considered integral to the procedure performed and is not separately reimbursable.

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<th>CIGNA ELIGIBLE TELEHEALTH CODES</th>
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Cost Share Waiver:
Effective March 13th, 2020 through January 15th, 2022, Cigna will waive member cost sharing for diagnostic testing and office visits/telehealth visits related to assessment and administration of diagnostic testing. Cigna will also waive member cost sharing for all virtual screening telephone consults (regardless of DX).
Effective March 13th, 2020 until further notice, Cigna will also waive member cost sharing for all virtual screening telephone consults (regardless of DX).
Effective January 1st, 2022 cost sharing will apply to e-consults

Effective March 2nd, 2020-December 31st, 2020

E-Visits/Telephone/Virtual Check Ins:

• Allowable Codes:
  o E-Visits: Check Provider Fee Schedule
  o Telephone: Check Provider Fee Schedule
  o Virtual Check-Ins: G2012 (Cigna classifies a Virtual Check-In as “5-10-minute virtual screening telephone consult”
• Effective Date: March 2nd, 2020-January 21st, 2021
• Modifier: None
• Patient Type: Established

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

• Allowable Codes: 99446-99452
• Effective Date: March 2nd, 2020-January 21st, 2021
• Modifier & POS: No modifier, unless COVID-19 related, then utilize modifier CS. POS used if visit was performed in person.
• Patient Type: New or Established
• Non-Billable:
  o 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.
  o If the consultation lasted less than 5 minutes.
Telehealth:

- **Allowable Codes**: Cigna will allow any existing face-to-face service on a provider’s fee schedule to be performed and billed via telehealth.
  - **Level Four & Five Codes**: Cigna has encouraged providers to bill the appropriate E/M code that was performed; however providers should be cognizant when billing level four and five codes for virtual services. Cigna will reimburse these services consistent with face-to-face rates but will monitor the use of level 4 and 5 codes and audit as necessary.
  - **Inappropriate Virtual Services**: Cigna will closely monitor and audit claims for inappropriate services that should not be performed virtually (including but not limited to: acupuncture, all surgical codes, anesthesia, radiology services, laboratory testing, administration of drugs and biologics, infusions or vaccines, and EEG or EKG testing).
  - **Urgent Care Centers**: Virtual care services are covered, including S9083 for services that require a more complex telephone call. Cigna will reimburse the full face to face rate of insured and NON-ERISA ASO providers where telehealth parity laws exist. For all other providers, Cigna will reimburse urgent care centers a flat rate of $88.00 per visit.
- **Effective Date**: March 2nd, 2020-December 31st, 2020.
- **HIPAA Compliant Platform**: Telehealth visits can be performed via non-compliant HIPAA platforms, such as FaceTime, Facebook Messenger, Skype, and Google Hangouts.
- **Modifiers/POS**:
  - **Professional/1500 Claims**: Modifiers GT or 95 with POS that would have been used if service had been provided in-person. DO NOT use POS 02 for virtual visits, as that will result in reduced payment or denied claims.
  - **Facility/UB Claims**: Appropriate revenue code and modifiers GT or 95
  - **COVID-19 Related Telehealth Care**:
    - Suspected or Likely COVID-19 Exposure: ICD-10 Z03.818 or Z20.828, CS modifier, and GT or 95 modifier.
    - Confirmed COVID-19 Case: ICD-10 U07.1
  - **DX Code Placement**:
    - Cigna does not require any specific placement for COVID-19 DX codes, however they recommend providers place the COVID-19 DX code for confirmed or suspected cases in the first position when the primary reason for the visit is to determine if the patient has COVID-19.
    - For services where COVID-19 is not the reason for visit (ex.-labor/delivery), but the patient is also tested for COVID-19, the provider should bill the DX code specific to the primary reason for visit in the first position, and the COVID-19 DX code in any position after the first.
- **Patient Type**: New or established patients.
- **Provider Type**: If the provider can deliver the service in a clinic/facility setting, then they can also provide the service virtually. Providers should bill virtual visits on the same form they usually do (UB/1500) for in-person visits.
- **Reimbursement**: Reimbursement will be allowed at 100% of the provider’s contracted rate, refer to your Cigna contract for allowable rates.
- **Video Component**: Telehealth codes can be performed over an audiovisual or audio only connection.
- **Transmission & Originating Site Fees**: Cigna will not reimburse an originating site of service fee or facility fee for telehealth visits (HCPCS Q3014). Cigna will also not reimburse for transmission fees.

**Cost Share Waiver**:

- Effective March 13th, 2020 through January 21st, 2021, Cigna will waive member cost sharing for diagnostic testing and office visits/telehealth visits related to assessment and administration of diagnostic testing. Cigna will also waive member cost sharing for all virtual screening telephone consults (regardless of DX).
- Effective March 30th, 2020 through December 31st, 2020, Cigna will waive member cost sharing for all COVID-19 related treatment.

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

E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes:**
  - E-Visits: 99421-99423, 98970-98972, G2061-G2063.
  - Telephone: 98966-98968, 99441-99443
  - Virtual Check-In: G2010, G2012
- **Effective Date:** March 6th, 2020-Permanent Policy
- **Modifier:** None
- **Patient Type:**
  - Telephone & Virtual Check-In: Established
  - E-Visits: New & Established
- **E-Visit Exclusions:**
  - Provider initiated email, appointment scheduling, refilling or renewing existing prescriptions without substantial change in clinical situation, scheduling diagnostic tests, reporting test results, updating patient information, providing educational materials, brief follow-up of a medical procedure to confirm stability of the patient’s condition without indication of complication or new condition including, but not limited to, routine global surgical follow-up, brief discussion to confirm stability of the patient’s chronic condition without change in current treatment, when information is exchanged and the patient is subsequently asked to come in for an office visit, a service that would similarly not be charged for in a regular office visit, reminders of scheduled office visits, requests for a referral, consultative message exchanges with an individual who is seen in the provider’s office immediately afterward, clarification of simple instructions or issues from a previous visit.

Telehealth:

- **Allowable Codes:** See table below for specific codes. Medica has provided a list of examples of allowable telehealth services, including, but not limited to the following:
  - Consultations
  - Telemedicine consults: emergency department or initial inpatient care
  - Subsequent hospital care services
  - Subsequent nursing facility care services
  - End stage renal disease services
  - Individual medical nutrition therapy
  - Individual and group diabetes self-management training
  - Smoking cessation
  - Alcohol and substance abuse (other than tobacco) structured assessment and intervention services
  - Individual psychotherapy
  - Psychiatric diagnostic interview examinations
  - Family psychotherapy with or without patient present
- **Wellness Visits:** Effective June 1st, 2020, Medica is allowing preventive visits to be provided via telehealth utilizing CPTs 99381-99387 and 99391-99397. Providers may perform all or portions of a preventive visit that can be done appropriately and effectively via telehealth. Services that require face-to-face interaction may be provided at a later date, however, providers may only bill one preventive medicine code to cover both the portion done via telehealth and any necessary face-to-face interaction associated with the preventive care service.
- **Effective Date:** March 6th, 2020- January 31st, 2021
- **HIPAA Compliant Platform:** Telehealth visits can be performed via non-compliant HIPAA platforms, such as FaceTime, Facebook Messenger, and Skype.
- **Modifiers/POS:**
  - Professional (1500) Claims:
**Commercial**: POS 02 with modifier GT for CMS recognized CPTs or modifier 95 for AMA Appendix P CPTs.

**Medicare Advantage** POS that would have been used if the visit were performed in person with modifier 95.

  - **Facility (UB) Claims**: Utilize modifier GT or 95.
  - **COVID-19 Related**: For services relating to the order for or administration of a COVID-19 diagnostic test or for services related to the evaluation of an individual for purposes of determining the need for diagnostic testing, append modifier CS.

**Patient Type**: Not Specified.

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

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

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

**Originating Sites**:

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

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

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

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

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

### Cost Share Waiver:

  - Effective March 1st, 2020 through January 31st, 2021 Medica will waive cost-sharing for in-network telehealth visits when related to administration of a COVID-19 test. Utilize the Medica provider portal for details regarding cost-share waivers for specific patients, as the cost share waiver for telehealth may vary by plan.

### MEDICA ALLOWABLE TELEHEALTH CODES

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E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes:**
  - **E-Visits:** 99421-99423, G2061-G2063
  - **Telephone:** 99441-99443, 98966-98968
  - **Virtual Check-In:** G2010, G2012, G2250-G2251, G2252

- **Effective Date:**
  - **E-Visits & Virtual Check-Ins:** Permanently Allowed
  - **Telephone:** March 6th, 2020-End of PHE

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

- **Patient Type:** New & Established (New patients allowable only for COVID-19 PHE)

- **Provider Type:**
  - **E-Visits (99421-99423), Telephone (99441-99443), Virtual Check-In (G2010, G2012, G2250 & G2251):** Qualified Healthcare Professional.
  - **E-Visits (G2061-G2063) Virtual Check-In (G2250 & G2251):** Effective January 1st, 2021 Medicare clarified that licensed clinical social workers, clinical psychologists, physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) can furnish E-visits (G2061-G2063) and Virtual Check-Ins. Medicare created two new HCPCS codes, G2250 & G2251, for virtual check-ins for these provider types.

- **Telephone Services Reporting:** 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 Reimbursement Change:** Effective March 1st, 2020, CMS has increased payments for telephone visits to match payments for similar office and outpatient visits.

**Telehealth:**

- **Allowable Codes:** See table below for all codes allowable via telehealth.
  - **Note:** Telehealth rules do not apply when the beneficiary and the practitioner are in the same location and are utilizing telehealth to reduce exposure risks, even if audio/video technology assists in furnishing a service.

- **Effective Date:**
  - **Effective March 6th, 2020-End of COVID-19 PHE:**
    - CMS implemented an 1135 blanket waiver for Medicare telehealth services. This waiver allows for additional flexibilities in Medicare telehealth services. Specifically, Medicare will pay for office, hospital, and other visits furnished via telehealth across the country, whether urban or rural, and in all settings, including in patients’ homes. Prior to this waiver, Medicare required telehealth to originate from a healthcare facility within a rural area.
  - **Effective January 1st, 2022-Permenant Policy:**
    - CMS 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
      - The services are medically necessary
      - 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
• **HIPAA Compliant Platform:** Effective March 17th, 2020-End of COVID-19 PHE, the HHS Office for Civil Rights (OCR) will waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime.

• **Hospitals-CAH & PPS:** See “Hospital” section for details on Medicare telehealth hospital regulations.

• **Modifiers/POS:**
  - **Professional (1500) Claims:** POS that would have been used if the visit were provided in person with modifier 95.
  - **CAH Method II (UB) Claims:** Modifier GT
  - **CAH & PPS PT/OT/Speech UB Claims:** Modifier 95
  - **PPS Facility (UB) Claims:** PN or PO modifier with condition code DR. Appropriate use of the PN and PO modifier is dependent on your specific services and locations. See the “hospital” section for details.
  - **COVID-19 Related:** If COVID-19 Part B related services were performed also append a CS modifier to applicable line items.
  - **DR Condition Code & CR Modifier:** For all services relating to a COVID-19 waiver, except telehealth services, append the “DR” condition code (UB claims) or “CR” modifier (1500 claims).

• **Patient Type:** As part of the CARES Act, practitioners can provide telehealth services to both new and established patients.

• **Provider Type:** All health care practitioners who are authorized to bill Medicare for their professional services may also furnish and bill for telehealth services. This allows health care professionals who were not previously authorized under the statute to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.
  - There are no payment restrictions on distant site providers furnishing Medicare telehealth services from their home during the PHE. Report the place of service code that would have been reported had the service been furnished in person.
  - Direct supervision may be provided using real-time, interactive audio and video technology through the later of the end of the calendar year in which the PHE ends or December 31, 2021.

• **Reimbursement:** Reimbursement will be at the same rate as in-person face-to-face visits, refer to the Medicare fee schedule for allowable rates.
  - **Site of Service Differential:** Prior to CMS-1744-IFC, services that had a site differential (facility versus office), were paid on the facility payment rate when services were furnished via telehealth. Effective March 1st, 2020, CMS now allows physicians’ offices to be paid at the office rate.
    - Providers should report the POS code that would have been reported had the service been furnished in person.
    - CMS is maintaining the facility payment rate for services billed using the POS code 02 if providers choose to not change their current billing practices.

• **Removal of Frequency Limitations on Medicare Telehealth:** Per CMS, the following services no longer have limitations on the number of times they can be provided by telehealth:
  - A subsequent inpatient visit can be furnished via telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233).
  - A subsequent skilled nursing facility visit can be furnished via telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310).
    - Effective January 1st, 2021 Medicare has permanently changed the frequency limitation of subsequent skilled nursing visits to one visit every 14 days.
  - Critical care consult codes may be furnished by telehealth beyond the once per day limitation (CPT codes G0508-G0509).

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

• **Transmission/ Originating Site Fees:** Medicare does not reimburse for transmission fees. If applicable, Medicare will reimburse an originating site fee (HCPCS Q3014).
  - Effective April 30th, 2020 through the end of the PHE.
- Hospitals may bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home.

- **Video Component:** See the “Medicare Telehealth Allowable Codes” below for codes that can be performed via an audio only connection during the COVID-19 PHE only.
  - Effective January 1st, 2022:
    - Medicare redefined “interactive telecommunications system” definition to include interactive, real-time, two way audio-only technology for telehealth services for mental health disorders
    - Audio only mental health telehealth will be reimbursable if:
      - The provider has the technical capability, at the time of the service, to use an interactive telecommunications system
      - The patient is incapable of, or fails to consent to, the use of video technology for the service
      - The beneficiary is located at his or her home
      - The practitioner documents the reason for using audio-only technology uses the appropriate service level modifier

**Cost Share Waiver:**
- The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible). Therefore, cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the PHE that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following categories of HCPCS evaluation and management codes: Office and other outpatient services, hospital observation services, emergency department services, nursing facility services, domiciliary, rest home, or custodial care services, home services, online digital evaluation, and management services.

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<th>Use these HCPCS codes for billing:</th>
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<td>Physicians and non-physician practitioners</td>
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<td>Outpatient Prospective Payment System (OPPS)</td>
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<td>RHCs and FQHCs</td>
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<td>CAHs: use OPPS codes</td>
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<tr>
<td>Method II CAHs: use the OPPS list or the physician and non-physician practitioner list, as appropriate.</td>
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- Cost-sharing does not apply to the above medical visit services for which payment is made to:
  - Hospital Outpatient Departments paid under the Outpatient Prospective Payment System, Physicians and other professionals under the Physician Fee Schedule, Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs).
  - Providers who bill for Medicare Part B services should use CS modifier on applicable claim lines.
  - Providers should NOT charge Medicare patients any co-insurance and/or deductible amounts for these services.

### 2020 MEDICARE ELEGIBLE TELEHEALTH CODES

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<th>2020 Standard Telehealth Codes</th>
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<td>90785 90840 90961 96156 97804 99215 99356 G0109 G0425 G0445 G2087</td>
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Temporarily Added Telehealth Codes for the COVID-19 Pandemic - Effective March 1st 2020

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Codes Highlighted in Blue - Require an Audiovisual Connection

Codes Highlighted in Green - Can Be Performed via an Audio only (Telephone) or Audiovisual Connection

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

### 2021 MEDICARE ELEGIBLE TELEHEALTH CODES

#### 2021 Standard Telehealth Codes

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#### Codes Available up Through the Year in Which the PHE Ends

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#### Codes Available for the COVID-19 PHE Only

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Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.
| Codes Highlighted in **Blue** - Require an Audiovisual Connection |
| Codes Highlighted in **Green** - Can Be Performed via an Audio only (Telephone) or Audiovisual Connection during the COVID-19 PHE ONLY |
| Codes Highlighted in **Yellow** - Have a Medicare Payment Limitation (See Table Below) |

### 2022 Medicare Elegible Telehealth Codes

#### 2022 Standard Telehealth Codes

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#### Codes Available for the COVID-19 PHE

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### Medicare Telehealth Codes Payment Limitations

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
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<td>Non-covered service</td>
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<td>Non-covered service</td>
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<td>S9152</td>
<td>Not valid for Medicare purposes</td>
</tr>
<tr>
<td>G0410</td>
<td>Statutory exclusion</td>
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</tbody>
</table>
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**Payor Specific Key Points**

**E-Visits/Telephone/Virtual Check Ins:**
- **Allowable Codes:**
  - **E-Visits:** 99421-99423, 98970-98972
  - **Telephone:** 99441-99443, 98966-98968
  - **Virtual Check-In:** Not Allowed
- **Effective Date:** WI Medicaid made e-visit and telephone E/M codes permanently allowable on March 1st, 2020, except for CPT 98966-98968, which are considered temporary codes only available during the PHE.
- **Modifier:** None
- **Patient Type:** Not specified

**Interprofessional Consultations:**
- **Allowable Codes:** 99446-99449, 99451, 99452. Providers are expected to follow CPT guidelines including, but not limited to, the following:
  - CPT 99446–99449 and 99451 may be billed by the consulting provider.
  - CPT 99452 may be billed by the treating provider.
  - CPT 99446–99449, 99451, and 99452 are not covered if the consultation leads to a transfer of care or other face-to-face service within the next 14 days or next available date of the consultant.
  - If the only purpose of the consultation is to arrange a transfer of care or other face-to-face service, then an interprofessional consultation code cannot be billed.
  - The CPT procedure codes should not be submitted if the consulting provider saw the member in a face-to-face encounter within the previous 14 days.
  - CPT 99446–99449 and 99451 are covered once in a seven-day period.
  - CPT 99452 is covered once in a 14-day period.
- **Documentation:** The following is required to be documented in the patient’s medical record:
  - The consulting provider's opinion.
  - The written or verbal request for a consultation by the treating provider.
  - Verbal consent for each consultation, including assurance that the member is aware of any applicable cost-sharing
- **Effective Date:** September 1st, 2020-Further Notice
- **Modifier:** None Required
- **Provider Requirements:**
  - The treating provider must be a physician, nurse practitioner, physician assistant, or podiatrist
  - The consulting provider must be a physician, nurse practitioner, or physician assistant.
  - Both the consulting and treating providers must be enrolled in WI Medicaid as eligible rendering providers.

**Remote Physiologic Monitoring:**
- **Allowable Codes:** 99091, 99453, 99454, 99457, 99458, 99473, 99474. Providers must follow the CPT guidelines, including, but not limited to:
  - CPT 99453–99458: the members’ physiologic data must be wirelessly synced so it can be evaluated by the physician, nurse practitioner, or physician assistant. Transmission can be synchronous or asynchronous (data does not have to be transmitted in real time if it is automatically updated on an ongoing basis for the provider to review).
  - CPT 99453 and 99454: can be used for blood pressure remote physiologic monitoring if the device used to measure blood pressure meets remote monitoring requirements. If the member self-reports blood pressure readings, the provider must instead submit self-measured blood pressure monitoring CPT procedure codes 99473–99474.
Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

CPT 99457 should be used when the physician, APRN, or PA uses medical decision making based on interpreted data received from a remote monitoring device to assess the member’s clinical stability, communicate the results to the member, and oversee the management and/or coordination of services as needed.

Remote monitoring services are not separately reimbursable if bundled or covered by other procedure codes (for example, continuous glucose monitoring is covered under CPT procedure code 95250 and should not be submitted under CPT procedure codes 99453–99454).

Providers must also follow the additional CPT specific guidelines, including but not limited to, the guidelines found in the table at the following link: https://www.forwardhealth.wi.gov/kw/pdf/2020-36.pdf

**Documentation:** The following must be documented in the patient’s medical record:

- The consulting provider’s opinion.
- The written or verbal request for a consultation by the treating provider.
- Verbal consent for each consultation, including assurance that the patient is aware of any applicable cost-sharing.

**Effective Date:** September 1st, 2020—Further Notice

**Modifier:** None Required

**Provider Type:** Physicians, nurse practitioners, and physician assistants enrolled in with WI Medicaid.

**Telehealth:**

- On January 1, 2022, WI Medicaid will transition to permanent telehealth coverage policy for synchronous (telehealth services. The list of permanent telehealth procedure codes has been updated on the maximum allowable fee schedule.
  - To facilitate the transition from temporary to permanent telehealth coverage policy, between July 1, 2021, and December 31, 2021, WI Medicaid will allow providers to submit claims for services identified as permanent telehealth procedure codes under either the temporary or permanent telehealth billing guidelines.

**Allowable Codes:**

- **Temporary Telehealth Services:** WI Medicaid will temporarily allow any currently covered Medicaid service that can be delivered with functional equivalency to the face-to-face service to be performed over interactive synchronous (real-time) telehealth technology or audio-only phone communication.
  - WI Medicaid has specified some requirements for the following temporary allowable services:
    - **Group Services:** Telehealth-based group services will be temporarily allowed, which includes benefit areas listed as “for individual services only” in the Telehealth topic (topic #510) of the Online Handbook. These services can be provided via an audiovisual or audio only connection.
      - WI Medicaid has stated that group leaders are obligated to provide information about issues of privacy and confidentiality to their members at the beginning of telehealth-based meetings. Members should confirm their understanding of the risks and acceptance of telehealth-based group services in writing or verbally. Group leaders should direct group members to participate in telehealth group sessions in ways that prevent violating one another’s privacy, without disclosing group members’ faces, names, identifying details, or circumstances. Providers should make individual services available to the greatest extent possible for members who elect not to participate in telehealth-based group treatment due to privacy concerns.
    - **Face to Face Mental Health Requirement:** WI Medicaid will allow mental health screenings to be conducted via telehealth. When possible, face-to-face technology is preferred for screening and initial assessment.
    - **Community Health Services:** The following HCPS may be billed for Community Health Services provided via telehealth: H0038, H0043, U8, H2023.
    - **Behavioral Treatment:** The services and provider types noted below may be reimbursed for services delivered via telehealth.
• **Targeted Case Management Services**: The services noted below may be reimbursed for services delivered via telehealth. WI Medicaid has stated that face-to-face technology is preferred for the initial assessment, when possible.

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<thead>
<tr>
<th>SERVICE</th>
<th>PROCEDURE CODE</th>
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<td>Family treatment guidance</td>
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<td>TG or TF with AM</td>
<td>Licensed supervisor or treatment therapist</td>
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<tr>
<td>Targeted case management</td>
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<td>Case management for children with medical complexity</td>
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• **Narcotic Treatment Services**: WI Medicaid will allow real-time audio only communication in place of face-to-face daily dosing contact by registered nurses or licensed practical nurses working in an opioid treatment program clinic. Utilize CPT 98966-98968.

• **Therapy Provided as Part of the Birth to 3 Program**: WI Medicaid will reimburse therapy providers supplying services as part of the Birth to 3 Program at an enhanced rate when occupational therapy, physical therapy, and/or speech therapy is performed using telehealth and the member is located in their natural environment as defined in both 34 C.F.R. Part 303 and Wis. Admin. Code § DHS 90.03(25). To receive this reimbursement, therapy providers must meet all other requirements and indicate modifier TL (Early intervention/individualized family service plan [IFSP]) when submitting claims.

• **Permanent Telehealth Services Prior to July 1st, 2021**:  
  o WI Medicaid is NOT expanding their coverage policy for services allowable under their permanent telehealth coverage policy as outlined in the Telehealth topic (#510) of the ForwardHealth Online Handbook  
  o Under their permanent telehealth services policy, group services are not covered, however they are covered within the temporary policy.  
  o Below are the allowable permanent telehealth services.

• **Permanent Telehealth Services AFTER July 1st, 2021**:  
  o Procedure codes for services allowed under permanent telehealth policy have POS code 02 (Telehealth) listed as an allowable POS. Effective January 1, 2022, if POS code 02 is not listed as an allowable POS for a procedure code, the service will not be reimbursed under permanent telehealth policy.
• **Documentation:** All services provided via telehealth must be thoroughly documented in the member's medical record in the same manner as services provided face-to-face. As a reminder, documentation for originating sites must support the member's presence to submit a claim for the originating site facility fee.

• **Effective Date:**
  - **Temporary Policy:** March 1st, 2020-December 31st, 2021.
  - **Permanent Policy:** January 1st, 2022

• **HIPAA Compliant Platform:** Per WI Medicaid, “Providers are reminded that HIPAA confidentiality requirements apply to telehealth services. When a covered entity or provider utilizes a telehealth service that involves PHI, the entity or provider will need to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to PHI confidentiality, integrity, and availability.”

• **Modifiers/POS:**
  - **Permanent Telehealth Services:**
    - Professional (1500) Claims: POS 02
    - Facility (UB) Claims: Modifier GT
  - **Temporary Telehealth Services:**
    - Professional (1500) Claims: POS utilized for in person visit with modifier 95
    - Facility (UB) Claims: Modifier 95
  - **COVID-19 Related:** Apply a CS modifier to COVID-19 testing related services, which are medical visits that result in an order for, or administration of, a COVID-19 test, are related to furnishing or administering such a test, or to the evaluation of an individual for purposes of determining the need for such a test.
  - **Audio Only Permanent Telehealth Services:** When audiovisual services listed as allowable in the telehealth topic (#510) in the Online Provider Manual are provided as audio only (phone) services, providers have three billing options:
    - Report the service as instructed for temporary services with informational modifier 95 and the POS of where the distant site provider is located. Distant site providers working remotely should use the POS that they are connecting to. For example, a provider working remotely from their clinic should use POS code 11 (Office).
    - Follow the billing policies in the Telehealth topic (#510), with modifier GT included and POS 02 (Telehealth), adding the informational modifier 95 after modifier GT.
    - Follow the billing policies in the Telehealth topic (#510), with modifier GT included and POS 02. In the documentation of the visit, note that the service was performed with audio only as allowed by Executive Order 72.
- **Medicaid Managed Care**: The managed care organizations are required to provide at least the same benefits as those provided under fee for-service arrangements. BadgerCare Plus and Medicaid SSI HMOs, as well as special managed care programs including Children Come First, Wraparound Milwaukee, and Care4Kids are expected to extend the same considerations to allowable telehealth services.

- **Non-Covered Services**: The following are not covered as telehealth services:
  - Store and forward services (defined as the asynchronous transmission of medical information to be reviewed later by a provider at a distant site).
  - Services that are not covered when delivered face-to-face.
  - Services or activities that require physical interaction or for goals that require hands-on support or physical prompting.

- **Patient Location**: Effective March 1st, 2020 the patient may be located at their home, an originating site, or any other location.

- **Patient Type**: New and established patients.

- **Provider Type**:
  - **Permanent Telehealth Services**:
    - Audiologists, Individual mental health and substance abuse practitioners not in a facility certified by the DQA, Nurse midwives, Nurse practitioners, Ph.D. psychologists, Physician assistants, Physicians, Psychiatrists, Professionals providing services in mental health or substance abuse programs certified by the DQA.
  - **Ancillary Providers**: Telehealth provided by ancillary providers should be submitted under the supervising physician's NPI using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT code for the service performed. These services must be provided under the direct on-site supervision of a physician who is located at the same physical site as the ancillary provider and must be documented in the same manner as services that are provided face to face.
  - **Pediatric and Health Professional Shortage Area-Eligible Services**: Telehealth services provided by distant site providers may qualify for pediatric (services for members 18 years of age and under) or HPSA-enhanced reimbursement. Pediatric and HPSA-eligible providers should report the applicable pediatric or HPSA modifier, with a POS 02 and GT modifier, when submitting claims that qualify for enhanced reimbursement.
Temporary Telehealth Services:

- All enrolled professionals and paraprofessional providers can provide services via telehealth.
  - Paraprofessional providers are providers who do not hold a license to practice independently but are providing services under the direction of a licensed provider. Paraprofessional providers are subject to supervision requirements, which may include face-to-face supervision. Supervision requirements can be met via telehealth, but this flexibility does not change or replace licensure or certification requirements of the provider’s supervising body or other regulatory authorities. When possible, face-to-face supervision requirements should be met via audio-visual technologies. Supervision must be documented according to existing benefit policy.
  - All providers are required to act within their scope of practice. Providers must make a good faith effort to provide direct oversight of treatment, but the required minimum hours of supervision will be relaxed during the Wisconsin public health emergency.

- Reimbursement: Reimbursement will be at the same rate as in-person face-to-face visits, refer to the WI Medicaid fee schedule for allowable rates.

- Transmission & Originating Site Fees: An eligible originating site can bill an originating site fee (HCPCS Q3014). WI Medicaid does not provide guidance on transmission fees.
  - Originating sites eligible for a facility fee reimbursement:
    - Hospitals, including emergency departments
    - Office/clinic
    - Skilled nursing facility
  - Providers who bill on a professional claim should utilize the POS code that represents where the member was located during the service along with Q3014. Providers who bill on an institutional claim should bill Q3014 as a separate line item with the appropriate revenue code.

- Video Component: WI Medicaid will allow remote services utilizing interactive synchronous (real-time) technology, including audio-only phone communication, for services that can be delivered with functional equivalency to the face-to-face service. This applies to both permanent telehealth services listed in the Telehealth topic (#510) of the Online Handbook and temporarily allowed telehealth services.
  - Temporarily Covered Telehealth Services: Any services that is currently covered by WI Medicaid and delivered through audio-only methods (phone) should be billed the same way as interactive video services, which is with the POS code for an in-person visit and modifier 95.
  - Permanent Covered Telehealth Services: When audiovisual services listed as allowable in the telehealth topic (#510) in the Online Provider Manual are provided as audio only (phone) services, providers have three billing options:
    - Report the service as instructed for temporary services with informational modifier 95 and the POS of where the distant site provider is located. Distant site providers working remotely should use the POS that they are connecting to. For example, a provider working remotely from their clinic should use POS code 11 (Office).
    - Follow the billing policies in the Telehealth topic (#510), with modifier GT included and POS 02 (Telehealth), adding the informational modifier 95 after modifier GT.
    - Follow the billing policies in the Telehealth topic (#510), with modifier GT included and POS 02. In the documentation of the visit, note that the service was performed with audio only as allowed by Executive Order 72.

Cost Share Waiver:

- Effective March 18th, 2020-December 31st, 2020, WI Medicaid has waived cost sharing for medical visits that result in an order for, or administration of, a COVID-19 test, are related to furnishing or administering a test, or related to the evaluation of an individual for purposes of determining the need for a test.
- Effective July 1st, 2020-December 31st, 2020, WI Medicaid has waived cost sharing for any treatment services related to COVID-19 care.
- Effective January 1st, 2021-End of PHE, WI Medicaid will waive cost sharing for COVID related testing and related services.
**Payor Specific Key Points:**

**Effective January 1st, 2021**

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

- **Allowable Codes:**
  - E-Visits: 99421-99423, 98970-98972
  - Interprofessional Consultation: 99446-99449, 99451, 99452
  - Remote Patient Monitoring: 99091, 99453, 99454, 99457-99458, 99473-99474
  - Telephone: Check Fee Schedule
  - Virtual Check-In: G2010, G2012, G2250-G2252

- **Effective Date:**
  - E-Visits, Interprofessional Consultations, Remote Patient Monitoring, Virtual Check-Ins: Permanently allowable per UHC Telehealth/Telemedicine Policy effective 01/01/2021
  - Telephone: N/A

- **Modifier/POS:** None

- **Patient Type:** CPT code specific

**Telehealth:**

- **Allowable Codes:** See Telehealth Allowable Codes table below for allowable code sets. UHC will also allow any code on CMS’ Covered Telehealth Services list during the national PHE.
  - PT/OT/ST Services: All PT/OT/ST Telehealth visits must be performed using live, interactive video conferencing that involves the presence of both parties at the same time and a communication link between them that allows a real-time audio and visual interaction to take place. E-mailing “stored” exercise videos and discussing or reviewing by phone is not reimbursable.

- **Effective Date:** UHC’s permanent Telehealth/Telemedicine Policy is effective 01/01/2021
  - Out of Network:
    - COVID-19 Testing Related Visits: March 18th, 2020-End of PHE

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

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

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

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

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

**Cost Share Waiver:** Telehealth services must be performed over an audiovisual connection.

**COVID-19 Testing Related Telehealth:**

- **In & Out of Network:** February 4th, 2020-End of PHE

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**Effective March 18th, 2020-December 31st, 2020**

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

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

- **Effective Date:**
  - E-Visits: Previously Allowable
  - Virtual Check-In & Telephone:
    - In-Network:
      - In-Network: March 18th, 2020 through December 31st, 2020
    - Out of Network:
      - COVID-19 Visits:
        - Out-of-Network for COVID-19 Testing: March 18th, 2020-End of PHE
Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

  - As of October 23rd, 2020, telehealth services will be covered according to the member’s benefit plan and UHC’s standard telehealth reimbursement policy.

- Non-COVID-19 Visits:
  - As of July 25th, 2020, telehealth services are covered according to the member’s benefit plan and UHC’s standard telehealth reimbursement policy.

- Modifier: None
- Patient Type:
  - E-Visits: Established Only
  - Virtual Check-Ins & Telephone: New & Established

Telehealth:
- Allowable Codes: UHC will allow any code on the Medicare covered telehealth code list to be billed. Any code on UHC’s telehealth eligible code list can still also be used. See table below for allowable code set.
- Effective Date: UHC has waived the originating site requirement (allowing the patient to be at home) and has waived the telehealth video requirement with effective and term dates as listed below.
  - In-Network:
    - In-Network: March 18th, 2020 through December 31st, 2020
  - Out of Network:
    - COVID-19 Visits:
      - Out-of-Network for COVID-19 Testing: March 18th, 2020-End of PHE
        - As of October 23rd, 2020, telehealth services will be covered according to the member’s benefit plan and UHC’s standard telehealth reimbursement policy.
  - Non-COVID-19 Visits:
      - As of July 25th, 2020, telehealth services are covered according to the member’s benefit plan and UHC’s standard telehealth reimbursement policy.
- HIPAA Compliant Platform: Telehealth visits can be performed via non-compliant HIPAA platforms, such as FaceTime, Facebook Messenger, Skype, Google Hangouts and WhatsApp.
- Modifiers/POS:
  - Professional (1500) claims:
    - Commercial: Utilize modifier GT for CMS recognized CPTs, modifier 95 for AMA Appendix P CPTs, and modifier G0 for telehealth services for diagnosis, evaluation, or treatment, of an acute stroke with POS that would have been used if visit were furnished in person.
    - Medicare Advantage: Utilize modifier 95 and POS that would have been used if visit were furnished in person.
  - Facility (UB) claims: Utilize revenue code 780.
- Provider Type: UHC follows CMS’ policies on the types of care providers eligible to deliver telehealth services. These include physician, nurse practitioner, physician assistant, nurse-midwife, clinical nurse specialist, registered dietitian or nutrition professional, clinical psychologist, clinical social worker, certified registered nurse anesthetists. UHC will also allow physical therapists, occupational therapists, speech therapists, and chiropractic providers to provide limited services via telehealth.
- Reimbursement: Reimbursement will be at the same rate as in-person face-to-face visits, refer to your UHC contract for allowable rates.
- Transmission & Originating Site Fees: T1014 and Q3014 are not eligible for payment, UHC considers these services as incidental to the charges associated with the E/M.
- Video Component: The video component requirement for telehealth services has been waived, except in cases where UHC has specifically stated audiovisual is required, which includes PT/OT/ST, chiropractic therapy, home health, and hospice.
  - Medicare Advantage plans, including DSNP plans, still require an audiovisual connection, except for CMS indicated audio only codes.
Cost Share Waiver:

Commercial:
- **Non COVID-19 Telehealth**: March 31st, 2020 -September 30th, 2020, UHC waived member cost sharing for all in-network telehealth visits for medical, outpatient behavioral, PT/OT/ST, chiropractic therapy, home health and hospice, and remote patient monitoring services, regardless of DX.
  - Effective October 1st, 2020, benefits will be adjudicated in accordance with the member’s benefit plan.
- **COVID-19 Testing Related Telehealth**:
  - In & Out of Network: February 4th, 2020-End of PHE
- **COVID-19 Treatment Related Telehealth**:
  - **In-Network**: February 4th, 2020-December 31st, 2020
  - **Out of Network**: February 4th, 2020-October 22nd, 2020

Medicare Advantage:
- **Non COVID-19 Telehealth**:
  - March 31st, 2020 -September 30th, 2020, UHC waived member cost sharing for all in-network telehealth visits for medical, outpatient behavioral, PT/OT/ST, chiropractic therapy, home health and hospice, and remote patient monitoring services, regardless of DX.
  - October 1st, 2020-December 31st, 2020, UHC will waive the cost share for in-network and covered out-of-network primary care telehealth services only.
    - Effective October 1st, 2020 UHC will adjudicate in accordance with the member’s benefit plan for non-primary care telehealth services.
- **COVID-19 Testing Related Telehealth**:
  - In & Out of Network: February 4th, 2020-End of PHE
- **COVID-19 Treatment Related Telehealth**:
  - In & Out of Network: February 4th, 2020-December 31st, 2020

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**Preventive Medicine and Applied Behavior Analysis**

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All major insurance companies have issued statements that costs will be waived for physician ordered diagnostic testing related to COVID-19 provided at approved locations in accordance with CDC guidelines. Self-insured plan sponsors are not required to implement the same policy. Other payors have gone a step further and issued waivers for other services.

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<th>Cost Sharing Guidelines</th>
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<td>Aetna</td>
<td>Effective March 6th, 2021, through End of PHE: Aetna will waive COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test.</td>
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<td>Anthem BCBS</td>
<td>Effective March 6th, 2021, through End of PHE: Anthem will waive COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test. Effective March 19th, 2020-December 31st, 2021, Anthem will waive cost sharing for telephonic-only in-network visits.</td>
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<td>Cigna</td>
<td>Effective March 13th, 2020 through January 15th, 2022: Cigna will waive member cost sharing for diagnostic testing and office visits/telehealth visits related to assessment and administration of diagnostic testing. Cigna will also waive member cost sharing for all virtual screening telephone consults (regardless of DX).</td>
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<td>Medicare</td>
<td>Effective March 18th, 2020-End of PHE: Medicare will waive cost sharing for COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in a specified set of HCPCS E/M codes.</td>
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<tr>
<td>WI Medicaid</td>
<td>Effective January 1st, 2021-End of PHE, WI Medicaid will waive cost sharing for COVID related testing and related services.</td>
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</table>
On March 27th, 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law. As part of the CARES Act, Congress has authorized RHCs to be a “distant site” for telehealth visits, therefore allowing RHC practitioners to provide telehealth services.

- **Allowable Telehealth Codes:** During the COVID-19 PHE, providers can provide any telehealth service that is approved as a Medicare telehealth service under the Medicare Professional Fee Schedule (PFS) (see the Medicare Allowable Telehealth Code Table in the Medicare section).

- **Billing:**
  - **Telehealth Services Provided January 27, 2020- June 30, 2020:** RHCs must report HCPCS code G2025 on their claims with the CG modifier. Modifier “95” may also be appended but is not required.
    - Claims will be paid at the RHC’s all-inclusive rate (AIR).
    - Claims will automatically reprocess in July when the Medicare claims processing system is updated with the new payment rate.
    - RHCs do not need to resubmit these claims for the payment adjustment.
  - **Telehealth Services Provided July 1, 2020 and Forward:** RHCs will no longer need to append the CG modifier on claims with HCPCS code G2025. Modifier “95” may be appended but is not required.

- **COVID-19 Related Care:** Append modifier CS

| RHC Claims for Telehealth Services from January 27, 2020 through June 30, 2020 |
|-----------------------------|-----------------|----------------|
| Revenue Code | HCPCS Code | Modifiers |
| 052X | G2025 | CG (required) 95 (optional) |

| RHC Claims for Telehealth Services starting July 1, 2020 |
|-----------------------------|-----------------|----------------|
| Revenue Code | HCPCS Code | Modifiers |
| 052X | G2025 | 95 (optional) |

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

- **Cost Share Waiver:** Effective March 18th-the end of the COVID-19 PHE, Medicare is waiving cost sharing for specified categories of E/M services if they result in an order for or an administration of a COVID-19 test and relate to the furnishing or administration of such test or to the evaluation of an individual for purposes of determining the need for such test.
  - RHCs must waive collection of co-insurance from beneficiaries.
  - Apply CS modifier to the service item.
  - Claims with CS modifier will automatically reprocess July 1st, 2020.

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

- **Mental Health Services:**
  - As of January 1st, 2022, CMS will continue to allow mental health telehealth services, performed by an RHC/FQHC even after the PHE ends
    - The service must be either audio visual OR
    - Audio-only, IF the following are present:
      - The patient is incapable of, or fails to consent to, the use of video technology for the service

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

• **Reimbursement:** The RHC telehealth payment rate is set at $92.03 per visit, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS. This rate will apply to telehealth visits performed by independent or provider based RHCs.

• **Telephone Services:** Effective March 1st, 2020 RHCs can perform audio only telephone E/M services utilizing CPT codes 99441, 99442, and 99443.
  • RHCs can furnish and bill for these services using HCPCS code G2025.
  • At least 5 minutes of telephone E/M by physician or other qualified health care professional who may report E/M services must be provided to an established patient, parent, or guardian.
  • Cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

• **Virtual Check-Ins & E-Visits:** Medicare will allow RHCs to perform E-Visits (CPT codes 99421-99423), which are online digital E/M services that utilize a secure patient portal. Medicare will also allow RHCs to perform Virtual Check Ins (HCPCS G2012 and G2010).
  o RHCs should bill HCPCS G0071 if E-Visit or Virtual Check-In services are performed.
  o For claims submitted with G0071 on or after March 1, 2020, and for the duration of the COVID-19 PHE, payment for G0071 is set at the average of the national non-facility PFS payment rates for the 5 E-visits and Virtual Check-In codes, which is $24.76.
  o MACs will automatically reprocess any claims with G0071 for services furnished on or after March 1 that were paid at the CY 2020 rate of $13.53 before the claims processing system was updated.
  o 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.

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**WISCONSIN MEDICAID**

**Payor Specific Key Points**

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

• **Allowable Codes:**
  o E-Visits: 99421-99423, 98970-98972
  o Telephone: 99441-99443, 98966-98968
  o Virtual Check-In: Not Allowed

• **Effective Date:** WI Medicaid made e-visit and telephone E/M codes permanently allowable on March 1st, 2020, except for CPT 98966-98968, which are considered temporary codes only available during the PHE.

• **Modifier:** None

• **Patient Type:** Not specified

**Interprofessional Consultations:**

• **Allowable Codes:** 99446-99449, 99451, 99452. Providers are expected to follow CPT guidelines including, but not limited to, the following:
  o CPT 99446-99449 and 99451 may be billed by the consulting provider.
  o CPT 99452 may be billed by the treating provider.
Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.

- CPT 99446–99449, 99451, and 99452 are not covered if the consultation leads to a transfer of care or other face-to-face service within the next 14 days or next available date of the consultant.
- If the only purpose of the consultation is to arrange a transfer of care or other face-to-face service, then an interprofessional consultation code cannot be billed.
- The CPT procedure codes should not be submitted if the consulting provider saw the member in a face-to-face encounter within the previous 14 days.
- CPT 99446–99449 and 99451 are covered once in a seven-day period.
- CPT 99452 is covered once in a 14-day period.

- **Documentation**: The following is required to be documented in the patient’s medical record:
  - The consulting provider’s opinion.
  - The written or verbal request for a consultation by the treating provider.
  - Verbal consent for each consultation, including assurance that the member is aware of any applicable cost-sharing.

- **Effective Date**: September 1st, 2020
- **Modifier**: None Required
- **Provider Requirements**:
  - The treating provider must be a physician, nurse practitioner, physician assistant, or podiatrist.
  - The consulting provider must be a physician, nurse practitioner, or physician assistant.
  - Both the consulting and treating providers must be enrolled in WI Medicaid as eligible rendering providers.

**Remote Physiologic Monitoring**:

- **Allowable Codes**: 99091, 99453, 99454, 99457, 99458, 99473, 99474. Providers must follow the CPT guidelines, including, but not limited to:
  - CPT 99453–99458: the members’ physiologic data must be wirelessly synced so it can be evaluated by the physician, nurse practitioner, or physician assistant. Transmission can be synchronous or asynchronous (data does not have to be transmitted in real time if it is automatically updated on an ongoing basis for the provider to review).
  - CPT 99453 and 99454: can be used for blood pressure remote physiologic monitoring if the device used to measure blood pressure meets remote monitoring requirements. If the member self-reports blood pressure readings, the provider must instead submit self-measured blood pressure monitoring CPT procedure codes 99473–99474.
  - CPT 99457 should be used when the physician, APRN, or PA uses medical decision making based on interpreted data received from a remote monitoring device to assess the member’s clinical stability, communicate the results to the member, and oversee the management and/or coordination of services as needed.
  - Remote monitoring services are not separately reimbursable if bundled or covered by other procedure codes (for example, continuous glucose monitoring is covered under CPT procedure code 95250 and should not be submitted under CPT procedure codes 99453–99454).
  - Providers must also follow the additional CPT specific guidelines, including but not limited to, the guidelines found in the table at the following link: [https://www.forwardhealth.wi.gov/kw/pdf/2020-36.pdf](https://www.forwardhealth.wi.gov/kw/pdf/2020-36.pdf)

- **Documentation**: The following must be documented in the patient’s medical record:
  - The consulting provider’s opinion.
  - The written or verbal request for a consultation by the treating provider.
  - Verbal consent for each consultation, including assurance that the patient is aware of any applicable cost-sharing.

- **Effective Date**: September 1st, 2020
- **Modifier**: None Required
- **Provider Type**: Physicians, nurse practitioners, and physician assistants enrolled in with WI Medicaid.

**Telehealth**:

- **Allowable Codes**: 
Temporary Telehealth Services: WI Medicaid will temporarily allow any currently covered Medicaid service that can be delivered with functional equivalency to the face-to-face service to be performed over interactive synchronous (real-time) telehealth technology or audio-only phone communication. WI Medicaid has specified some requirements for the following temporary allowable services:

- **Group Services**: Telehealth-based group services will be temporarily allowed, which includes benefit areas listed as “for individual services only” in the Telehealth topic (topic #510) of the Online Handbook. These services can be provided via an audiovisual or audio only connection.
  - WI Medicaid has stated that group leaders are obligated to provide information about issues of privacy and confidentiality to their members at the beginning of telehealth-based meetings. Members should confirm their understanding of the risks and acceptance of telehealth-based group services in writing or verbally. Group leaders should direct group members to participate in telehealth group sessions in ways that prevent violating one another’s privacy, without disclosing group members’ faces, names, identifying details, or circumstances. Providers should make individual services available to the greatest extent possible for members who elect not to participate in telehealth-based group treatment due to privacy concerns.

- **Face to Face Mental Health Requirement**: WI Medicaid will allow mental health screenings to be conducted via telehealth. When possible, face-to-face technology is preferred for screening and initial assessment.

- **Community Health Services**: The following HCPS may be billed for Community Health Services provided via telehealth: H0038, H0043, U8, H2023.

- **Behavioral Treatment**: The services and provider types noted below may be reimbursed for services delivered via telehealth.

- **Targeted Case Management Services**: The services noted below may be reimbursed for services delivered via telehealth. WI Medicaid has stated that face-to-face technology is preferred for the initial assessment, when possible.

- **Narcotic Treatment Services**: WI Medicaid will allow real-time audio only communication in place of face-to-face daily dosing contact by registered nurses or licensed practical nurses working in an opioid treatment program clinic. Utilize CPT 98966-98968.

- **Therapy Provided as Part of the Birth to 3 Program**: WI Medicaid will reimburse therapy providers supplying services as part of the Birth to 3 Program at an enhanced rate when occupational therapy, physical therapy, and/or speech therapy is performed using telehealth and the member is located in their natural environment as defined in both 34 C.F.R. Part 303 and Wis.
Admin. Code § DHS 90.03(25). To receive this reimbursement, therapy providers must meet all other requirements and indicate modifier TL (Early intervention/individualized family service plan [IFSP]) when submitting claims.

- **Permanent Telehealth Services:**
  - WI Medicaid is NOT expanding their coverage policy for services allowable under their permanent telehealth coverage policy as outlined in the Telehealth topic (#510) of the ForwardHealth Online Handbook
  - Under their permanent telehealth services policy, group services are not covered, however they are covered within the temporary policy.
  - Below are the allowable permanent telehealth services.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health Day Treatment Services</td>
<td>H2012 (for individual services only)</td>
</tr>
<tr>
<td>Audiology Services</td>
<td>92550, 92585, 92586, 92587, 92588</td>
</tr>
<tr>
<td>Child/Adolescent Day Treatment Services (HealthCheck “Other Services”)</td>
<td>H2012 (for individual services only)</td>
</tr>
<tr>
<td>Community Support Program Services</td>
<td>H0039 (for individual services only)</td>
</tr>
<tr>
<td>Comprehensive Community Services</td>
<td>H2017 (for individual services only)</td>
</tr>
<tr>
<td>Crisis Intervention Services</td>
<td>99484</td>
</tr>
<tr>
<td>End-Stage Renal Disease-Related Services</td>
<td>90951-90952, 90954-90958, 90960-90961, 90967-90970</td>
</tr>
<tr>
<td>E-Visits</td>
<td>98970-98972, 99421-99423</td>
</tr>
<tr>
<td>Health and Behavior Assessment/Intervention</td>
<td>96156, 96158-96159, 96167, 96170-96171</td>
</tr>
<tr>
<td>Initial Inpatient Consultations</td>
<td>99251-99255</td>
</tr>
<tr>
<td>Inpatient Consultations</td>
<td>99231-99233, 99356-99357</td>
</tr>
<tr>
<td>Nursing Facility Service Assessments</td>
<td>99307-99310</td>
</tr>
<tr>
<td>Office or Other Outpatient Services</td>
<td>99201-99205, 99211-99215*</td>
</tr>
<tr>
<td>Office or Other Outpatient Consultations</td>
<td>99241-99245*</td>
</tr>
<tr>
<td>Outpatient Mental Health Services (Evaluation,</td>
<td>90785, 90791-90792, 90832-90834, 90836-90840, 90845-90847, 90849, 90875, 90876, 90887</td>
</tr>
<tr>
<td>Psychotherapy)</td>
<td></td>
</tr>
<tr>
<td>Outpatient Substance Abuse Services</td>
<td>H0022, H0047, T1006</td>
</tr>
<tr>
<td>Phone Services, Qualified Health Professional</td>
<td>99441-99443</td>
</tr>
<tr>
<td>Substance Abuse Day Treatment</td>
<td>H2012 (for individual services only)</td>
</tr>
</tbody>
</table>

* Telehealth services that are medical in nature and would otherwise be coded as an office visit or consultation evaluation and management visit are covered for members residing in a skilled nursing facility. Some Nursing Facility Service Assessments are not covered as telehealth services (e.g. 99304-99318). Domiciliary, Rest Home, or Custodial Care Services and Oversight Services (codes 99324-99340) are not allowable as telehealth services.

- **Documentation:** All services provided via telehealth must be thoroughly documented in the member's medical record in the same manner as services provided face-to-face. As a reminder, documentation for originating sites must support the member’s presence to submit a claim for the originating site facility fee.
- **Effective Date:** March 1st, 2020-Further notice.
- **HIPAA Compliant Platform:** Telehealth visits can be performed via non-public facing, non-compliant HIPAA platforms, such as FaceTime, Facebook Messenger, and Skype. WI Medicaid encourages providers to let patients know that these third-party applications can introduce privacy risks. Providers should also enable all available encryption and privacy functions when using such applications.
- **Modifiers/POS:**
  - For dates of service on and after March 1, 2020, WI Medicaid will allow RHC services billed with modifier GT to be considered under the per encounter reimbursement methodology.
    - Services billed with modifier GT will be considered under the PPS reimbursement method.
    - Billing HCPCS procedure code T1015 (Clinic visit/encounter, all-inclusive) with a telehealth procedure code will result in a PPS rate for fee-for-service encounters.
  - **COVID-19 Related:** Apply a CS modifier to COVID-19 testing related services, which are medical visits that result in an order for, or administration of, a COVID-19 test, are related to furnishing or administering such a test, or to the evaluation of an individual for purposes of determining the need for such a test.
  - **Audio Only Permanent Telehealth Services:** When audiovisual services listed as allowable in the telehealth topic (#510) in the Online Provider Manual are provided as audio only (phone) services, providers have three billing options:*
    - Report the service as instructed for temporary services with informational modifier 95 and the POS of where the distant site provider is located. Distant site providers working remotely should
use the POS that they are connecting to. For example, a provider working remotely from their clinic should use POS code 11 (Office).

- Follow the billing policies in the Telehealth topic (#510), with modifier GT included and POS 02 (Telehealth), adding the informational modifier 95 after modifier GT.
- Follow the billing policies in the Telehealth topic (#510), with modifier GT included and POS 02. In the documentation of the visit, note that the service was performed with audio only as allowed by Executive Order 72.

*Seeking clarification if the three options apply to RHC providers.

- WI Medicaid has provided the below flow chart to assist providers in selecting the correct code, modifier, and POS.

**Medicaid Managed Care:** The managed care organizations are required to provide at least the same benefits as those provided under fee for-service arrangements. BadgerCare Plus and Medicaid SSI HMOs, as well as special managed care programs including Children Come First, Wraparound Milwaukee, and Care4Kids are expected to extend the same considerations to allowable telehealth services.

**Non-Covered Services:** The following are not covered as telehealth services:
  - Store and forward services (defined as the asynchronous transmission of medical information to be reviewed later by a provider at a distant site).
  - Services that are not covered when delivered face-to-face.
  - Services or activities that require physical interaction or for goals that require hands-on support or physical prompting.

**Patient Location:** Effective March 1st, 2020 the patient may be located at their home, an originating site, or any other location.

**Patient Type:** New and established patients.

**Provider Type:**
  - **Permanent Telehealth Services:**
    - Audiologists, Individual mental health and substance abuse practitioners not in a facility certified by the DQA, Nurse midwives, Nurse practitioners, Ph.D. psychologists, Physician assistants, Physicians, Psychiatrists, Professionals providing services in mental health or substance abuse programs certified by the DQA.
  - **Ancillary Providers:** Telehealth provided by ancillary providers should be submitted under the supervising physician's NPI using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT code for the service performed. These services must be provided
under the direct on-site supervision of a physician who is located at the same physical site as the ancillary provider and must be documented in the same manner as services that are provided face to face.

- **Pediatric and Health Professional Shortage Area-Eligible Services**: Telehealth services provided by distant site providers may qualify for pediatric (services for members 18 years of age and under) or HPSA-enhanced reimbursement. Pediatric and HPSA-eligible providers should report the applicable pediatric or HPSA modifier, with a POS 02 and GT modifier, when submitting claims that qualify for enhanced reimbursement.

  o **Temporary Telehealth Services**:
    - All enrolled professionals and paraprofessional providers can provide services via telehealth.
      - Paraprofessional providers are providers who do not hold a license to practice independently but are providing services under the direction of a licensed provider. Paraprofessional providers are subject to supervision requirements, which may include face-to-face supervision. Supervision requirements can be met via telehealth, but this flexibility does not change or replace licensure or certification requirements of the provider’s supervising body or other regulatory authorities. When possible, face-to-face supervision requirements should be met via audio-visual technologies. Supervision must be documented according to existing benefit policy.
    - All providers are required to act within their scope of practice. Providers must make a good faith effort to provide direct oversight of treatment, but the required minimum hours of supervision will be relaxed during the Wisconsin public health emergency.

  - **Reimbursement**: For dates of service on and after March 1, 2020, WI Medicaid will allow RHC services billed with modifier GT to be considered under the per encounter reimbursement methodology.
    - RHCs may report services provided via telehealth on the cost settlement report when the RHC served as the distant site and the member is an established patient of the RHC at the time of the telehealth service.

  - **Transmission & Originating Site Fees**: An eligible originating site can bill an originating site fee (HCPCS Q3014). WI Medicaid does not provide guidance on transmission fees.
    - Originating sites eligible for a facility fee reimbursement:
      - Hospitals, including emergency departments
      - Office/clinic
      - Skilled nursing facility
    - The originating site facility fee is not an RHC reportable encounter on the cost report. Any reimbursement for the originating site facility fee must be reported as a deductive value on the cost report.

  - **Video Component**: WI Medicaid will allow remote services utilizing interactive synchronous (real-time) technology, including audio-only phone communication, for services that can be delivered with functional equivalency to the face-to-face service. This applies to both permanent telehealth services listed in the Telehealth topic (#510) of the Online Handbook and temporarily allowed telehealth services.
    - **Temporarily Covered Telehealth Services**: Any services that is currently covered by WI Medicaid and delivered through audio-only methods (phone) should be billed the same way as interactive video services, which is with the POS code for an in-person visit and modifier 95.
    - **Permanent Covered Telehealth Services**: When audiovisual services listed as allowable in the telehealth topic (#510) in the Online Provider Manual are provided as audio only (phone) services, providers have three billing options:
      - Report the service as instructed for temporary services with informational modifier 95 and the POS of where the distant site provider is located. Distant site providers working remotely should use the POS that they are connecting to. For example, a provider working remotely from their clinic should use POS code 11 (Office).
      - Follow the billing policies in the Telehealth topic (#510), with modifier GT included and POS 02 (Telehealth), adding the informational modifier 95 after modifier GT.
      - Follow the billing policies in the Telehealth topic (#510), with modifier GT included and POS 02. In the documentation of the visit, note that the service was performed with audio only as allowed by Executive Order 72.

*Seeking clarification if the above three options apply to RHC providers.
Cost Share Waiver:

- Effective March 18th, 2020-December 31st, 2020, WI Medicaid has waived cost sharing for medical visits that result in an order for, or administration of, a COVID-19 test, are related to furnishing or administering a test, or related to the evaluation of an individual for purposes of determining the need for a test.
- Effective July 1st, 2020-December 31st, 2020, WI Medicaid has waived cost sharing for any treatment services related to COVID-19 care.
- Effective January 1st, 2021-End of PHE, WI Medicaid will waive cost sharing for COVID related testing and related services.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) MEDICARE

On March 27th, 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law. As part of the CARES Act, Congress has authorized FQHCs to act as a "distant site" for telehealth visits, therefore allowing FQHC practitioners to provide telehealth services.

- **Allowable Telehealth Codes**: During the COVID-19 PHE, FQHCs can furnish any telehealth service that is approved as a Medicare telehealth service under the PFS (see the Medicare Allowable Telehealth Code Table in the Medicare section).

- **Billing**:
  - Telehealth Services Furnished January 27, 2020- June 30, 2020: FQHCs should report 3 HCPCS/CPT codes: the FQHC Prospective Payment System (PPS) specific payment code (G0466, G0467, G0468, G0469, or G0470); the HCPCS/CPT code that describes the services furnished via telehealth with modifier 95; and G2025 with modifier 95.
    - Must be an FQHC qualifying visit.
    - These claims will be paid at the FQHC PPS rate until June 30th, 2020.
    - Claims will be automatically reprocessed beginning July 1st, 2020 at the $92.03 rate.
    - FQHCs do not need to resubmit these claims for payment adjustment.
    - Telehealth Services Furnished for Non-Qualifying FQHC Visits: FQHCs would need to hold these visits until July 1st, 2020 and then bill with HCPCS code G2025.
  - Telehealth Services Furnished July 1, 2020 and Forward: FQHCs will only need to submit HCPCS code G2025. Modifier "95" may be appended but is not required.
  - COIVD-19 Related Care: Append modifier CS

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>052X</td>
<td>FQHC Specific Payment Code- G0466, G0467, G0468, G0469, G0470</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>052X</td>
<td>FQHC PPS Qualifying Payment Code</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>052X</td>
<td>G2025</td>
<td>95</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FQHC Claims for Telehealth Services Starting July 1, 2020</th>
<th>Revenue Code</th>
<th>HCPCS Code</th>
<th>Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>G2025</td>
<td>95 (optional)</td>
<td></td>
</tr>
</tbody>
</table>

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

- **Cost Share Insurance Waiver**: Effective March 18th-the end of the COVID-19 PHE, Medicare is waiving cost sharing for specified categories of E/M services if the service results in an order for or an administration of a
COVID-19 test and relate to the furnishing or administration of such test or to the evaluation of an individual for purposes of determining the need for such test.
- FQHCs must waive collection of co-insurance from beneficiaries.
- Apply CS modifier to the service item.
- Claims with CS modifier will automatically reprocess July 1st, 2020.

- **Preventative Services**: If an FQHC performs a preventive service via telehealth that is traditionally subject to a cost share waiver, then the FQHC should apply a CS modifier to HCPCS G2025, even though the service is unrelated to COVID-19.
- **Reimbursement**: The FQHC telehealth payment rate is set at $92.03 per visit, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS.
- **Mental Health Services**:
  - As of January 1st, 2022, CMS will continue to allow mental health telehealth services, performed by an RHC/FQHC even after the PHE ends
    - The service must be either audio visual OR
    - Audio-only, IF the following are present:
      - The patient is incapable of, or fails to consent to, the use of video technology for the service
      - The provider has conducted an in-person visit within the last 6 months of the initial tele-mental service
      - The services are medical necessary
      - After the initial telehealth visit, the provider conducts an in-person visit at least once every 12 months of each tele-mental visit.
        - However, if the patient and provider consider the risks of an in person service and agree that these risks outweigh the benefits, then the annual visit may be skipped.
        - Providers must document the decision

- **Telephone Services**: Effective March 1st, 2020 FQHCs can perform audio only telephone E/M services utilizing CPT codes 99441, 99442, and 99443.
  - FQHCs can furnish and bill for these services using HCPCS code G2025.
  - At least 5 minutes of telephone E/M by physician or other qualified health care professional who may report E/M services must be provided to an established patient, parent, or guardian.
  - Cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

- **Virtual Check-Ins & E-Visits**: Medicare will allow FQHCs to perform E-Visits (CPT codes 99421-99423), which are online digital E/M services that utilize a secure patient portal. Medicare will also allow FQHCs to perform Virtual Check Ins (HCPCS G2012 and G2010).
  - FQHCs should bill HCPCS G0071 if E-Visit or Virtual Check-In services are performed.
  - For claims submitted with G0071 on or after March 1, 2020, and for the duration of the COVID-19 PHE, payment for G0071 is set at the average of the national non-facility PFS payment rates for the 5 E-visits and Virtual Check-In codes, which is $24.76.
  - MACs will automatically reprocess any claims with G0071 for services furnished on or after March 1 that were paid at the CY 2020 rate of $13.53 before the claims processing system was updated.
  - G0071 Definition: Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an RHC or FQHC practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC.

**WISCONSIN MEDICAID**

**Payor Specific Key Points**

**E-Visits/Telephone/Virtual Check Ins:**
• **Allowable Codes:**
  o **E-Visits:** 99421-99423, 98970-98972
  o **Telephone:** 99441-99443, 98966-98968
  o **Virtual Check-In:** Not Allowed

• **Effective Date:** WI Medicaid made e-visit and telephone E/M codes permanently allowable on March 1\textsuperscript{st}, 2020, except for CPT 98966-98968, which are considered temporary codes only available during the PHE.

• **Modifier:** None

• **Patient Type:** Not specified

**Interprofessional Consultations:**

• **Allowable Codes:** 99446-99449, 99451, 99452. Providers are expected to follow CPT guidelines including, but not limited to, the following:
  o CPT 99446–99449 and 99451 may be billed by the consulting provider.
  o CPT 99452 may be billed by the treating provider.
  o CPT 99446–99449, 99451, and 99452 are not covered if the consultation leads to a transfer of care or other face-to-face service within the next 14 days or next available date of the consultant.
  o If the only purpose of the consultation is to arrange a transfer of care or other face-to-face service, then an interprofessional consultation code cannot be billed.
  o The CPT procedure codes should not be submitted if the consulting provider saw the member in a face-to-face encounter within the previous 14 days.
  o CPT 99446–99449 and 99451 are covered once in a seven-day period.
  o CPT 99452 is covered once in a 14-day period.

• **Documentation:** The following is required to be documented in the patient’s medical record:
  o The consulting provider’s opinion.
  o The written or verbal request for a consultation by the treating provider.
  o Verbal consent for each consultation, including assurance that the member is aware of any applicable cost-sharing

• **Effective Date:** September 1\textsuperscript{st}, 2020—Further Notice

• **Modifier:** None Required

• **Provider Requirements:**
  o The treating provider must be a physician, nurse practitioner, physician assistant, or podiatrist
  o The consulting provider must be a physician, nurse practitioner, or physician assistant.
  o Both the consulting and treating providers must be enrolled in WI Medicaid as eligible rendering providers.

**Remote Physiologic Monitoring:**

• **Allowable Codes:** 99091, 99453, 99454, 99457, 99458, 99473, 99474. Providers must follow the CPT guidelines, including, but not limited to:
  o CPT 99453–99458: the members’ physiologic data must be wirelessly synced so it can be evaluated by the physician, nurse practitioner, or physician assistant. Transmission can be synchronous or asynchronous (data does not have to be transmitted in real time if it is automatically updated on an ongoing basis for the provider to review).
  o CPT 99453 and 99454: can be used for blood pressure remote physiologic monitoring if the device used to measure blood pressure meets remote monitoring requirements. If the member self-reports blood pressure readings, the provider must instead submit self-measured blood pressure monitoring CPT procedure codes 99473–99474.
  o CPT 99457 should be used when the physician, APRN, or PA uses medical decision making based on interpreted data received from a remote monitoring device to assess the member’s clinical stability, communicate the results to the member, and oversee the management and/or coordination of services as needed.
  o Remote monitoring services are not separately reimbursable if bundled or covered by other procedure codes (for example, continuous glucose monitoring is covered under CPT procedure code 95250 and should not be submitted under CPT procedure codes 99453–99454).
• Providers must also follow the additional CPT specific guidelines, including but not limited to, the guidelines found in the table at the following link: https://www.forwardhealth.wi.gov/kw/pdf/2020-36.pdf

• Documentation: The following must be documented in the patient’s medical record:
  o The consulting provider’s opinion.
  o The written or verbal request for a consultation by the treating provider.
  o Verbal consent for each consultation, including assurance that the patient is aware of any applicable cost-sharing.

• Effective Date: September 1st, 2020-Further Notice
• Modifier: None Required
• Provider Type: Physicians, nurse practitioners, and physician assistants enrolled in with WI Medicaid.

Telehealth:

• Allowable Codes:
  o Temporary Telehealth Services: WI Medicaid will temporarily allow any currently covered Medicaid service that can be delivered with functional equivalency to the face-to-face service to be performed over interactive synchronous (real-time) telehealth technology or audio-only phone communication.

  • Group Services: Telehealth-based group services will be temporarily allowed, which includes benefit areas listed as “for individual services only” in the Telehealth topic (topic #510) of the Online Handbook. These services can be provided via an audiovisual or audio only connection.
    ▪ WI Medicaid has stated that group leaders are obligated to provide information about issues of privacy and confidentiality to their members at the beginning of telehealth-based meetings. Members should confirm their understanding of the risks and acceptance of telehealth-based group services in writing or verbally. Group leaders should direct group members to participate in telehealth group sessions in ways that prevent violating one another’s privacy, without disclosing group members’ faces, names, identifying details, or circumstances. Providers should make individual services available to the greatest extent possible for members who elect not to participate in telehealth-based group treatment due to privacy concerns.

  • Face to Face Mental Health Requirement: WI Medicaid will allow mental health screenings to be conducted via telehealth. When possible, face-to-face technology is preferred for screening and initial assessment.

  • Community Health Services: The following HCPS may be billed for Community Health Services provided via telehealth: H0038, H0043, U8, H2023.

  • Behavioral Treatment: The services and provider types noted below may be reimbursed for services delivered via telehealth.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>PROCEDURE CODE</th>
<th>REQUIRED MODIFIERS</th>
<th>RENDERER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>97151</td>
<td>TG or TF</td>
<td>Licensed supervisor</td>
</tr>
<tr>
<td>Treatment</td>
<td>97153</td>
<td>TG or TF</td>
<td>Licensed supervisor or treatment therapist</td>
</tr>
<tr>
<td>Treatment with protocol modification</td>
<td>97155</td>
<td>TG or TF</td>
<td>Licensed supervisor or treatment therapist</td>
</tr>
<tr>
<td>Family treatment guidance</td>
<td>97156</td>
<td>TG or TF</td>
<td>Licensed supervisor</td>
</tr>
<tr>
<td>Team meeting</td>
<td>97156</td>
<td>TG or TF with AM</td>
<td>Licensed supervisor or treatment therapist</td>
</tr>
</tbody>
</table>

  • Targeted Case Management Services: The services noted below may be reimbursed for services delivered via telehealth. WI Medicaid has stated that face-to-face technology is preferred for the initial assessment, when possible.
### Narcotic Treatment Services
WI Medicaid will allow real-time audio only communication in place of face-to-face daily dosing contact by registered nurses or licensed practical nurses working in an opioid treatment program clinic. Utilize CPT 98966-98968.

### Therapy Provided as Part of the Birth to 3 Program
WI Medicaid will reimburse therapy providers supplying services as part of the Birth to 3 Program at an enhanced rate when occupational therapy, physical therapy, and/or speech therapy is performed using telehealth and the member is located in their natural environment as defined in both 34 C.F.R. Part 303 and Wis. Admin. Code § DHS 90.03(25). To receive this reimbursement, therapy providers must meet all other requirements and indicate modifier TL (Early intervention/individualized family service plan [IFSP]) when submitting claims.

### Permanent Telehealth Services:
- **WI Medicaid is NOT** expanding their coverage policy for services allowable under their permanent telehealth coverage policy as outlined in the Telehealth topic (#510) of the Online Handbook
- Under their permanent telehealth services policy, group services are not covered, however they are covered within the temporary policy.
- Below are the allowable permanent telehealth services.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health Day Treatment Services</td>
<td>H2012 (for individual services only)</td>
</tr>
<tr>
<td>Audiology Services</td>
<td>92550, 92585, 92586, 92587, 92588</td>
</tr>
<tr>
<td>Child/Adolescent Day Treatment Services (HealthCheck <em>Other Services</em>)</td>
<td>H2012 (for individual services only)</td>
</tr>
<tr>
<td>Community Support Program Services</td>
<td>M0039 (for individual services only)</td>
</tr>
<tr>
<td>Comprehensive Community Services</td>
<td>H2017 (for individual services only)</td>
</tr>
<tr>
<td>Crisis Intervention Services</td>
<td>59484</td>
</tr>
<tr>
<td>End-Stage Renal Disease-Related Services</td>
<td>90951-90952, 90954-90958, 90960-90961, 90967-90970</td>
</tr>
<tr>
<td>E-Visits</td>
<td>98970-98972, 99421-99423</td>
</tr>
<tr>
<td>Health and Behavior Assessment/Intervention</td>
<td>96156, 96158-96159, 96167, 96170-96171</td>
</tr>
<tr>
<td>Initial Inpatient Consultations</td>
<td>99251-99255</td>
</tr>
<tr>
<td>Inpatient Consultations</td>
<td>99231-99233, 99356-99357</td>
</tr>
<tr>
<td>Nursing Facility Service Assessments</td>
<td>99307-99310</td>
</tr>
<tr>
<td>Office or Other Outpatient Services</td>
<td>99201-99205, 99211-99215*</td>
</tr>
<tr>
<td>Office or Other Outpatient Consultations</td>
<td>99241-99245*</td>
</tr>
<tr>
<td>Outpatient Mental Health Services (Evaluation, Psychotherapy)</td>
<td>90785, 90791-90792, 90832-90834, 90836-90840, 90845-90847, 90849, 90875, 90876, 90887</td>
</tr>
<tr>
<td>Outpatient Substance Abuse Services</td>
<td>H0022, H0047, T1006</td>
</tr>
<tr>
<td>Phone Services, Qualified Health Professional</td>
<td>99441-99443</td>
</tr>
<tr>
<td>Substance Abuse Day Treatment</td>
<td>H2012 (for individual services only)</td>
</tr>
</tbody>
</table>

* Telehealth services that are medical in nature and would otherwise be coded as an office visit or consultation evaluation and management visit are covered for members residing in a skilled nursing facility. Some Nursing Facility Service Assessments are not covered as telehealth services (e.g. 99304-99318). Domiciliary, Rest Home, or Custodial Care Services and Oversight Services (codes 99324-99340) are not allowable as telehealth services.

### Documentation
All services provided via telehealth must be thoroughly documented in the member’s medical record in the same manner as services provided face-to-face. As a reminder, documentation for originating sites must support the member’s presence to submit a claim for the originating site facility fee.

### Effective Date
March 1st, 2020-Further notice.
- **HIPAA Compliant Platform:** Telehealth visits can be performed via non-public facing, non-compliant HIPAA platforms, such as FaceTime, Facebook Messenger, and Skype. WI Medicaid encourages providers to let patients know that these third-party applications can introduce privacy risks. Providers should also enable all available encryption and privacy functions when using such applications.

- **Modifiers/POS:**
  - For dates of service on and after March 1, 2020, WI Medicaid will allow services billed with modifier GT to be considered under the Prospective Payment System reimbursement method for FQHCs.
    - Services billed with modifier GT will be considered under the PPS reimbursement method for FQHCs.
    - Billing HCPCS procedure code T1015 (Clinic visit/encounter, all-inclusive) with a telehealth procedure code will result in a PPS rate for fee-for-service encounters.
  - **COVID-19 Related:** Apply a CS modifier to COVID-19 testing related services, which are medical visits that result in an order for, or administration of, a COVID-19 test, are related to furnishing or administering such a test, or to the evaluation of an individual for purposes of determining the need for such a test.
  - **Audio Only Permanent Telehealth Services:** When audiovisual services listed as allowable in the telehealth topic (#510) in the Online Provider Manual are provided as audio only (phone) services, providers have three billing options:*
    - Report the service as instructed for temporary services with informational modifier 95 and the POS of where the distant site provider is located. Distant site providers working remotely should use the POS that they are connecting to. For example, a provider working remotely from their clinic should use POS code 11 (Office).
    - Follow the billing policies in the Telehealth topic (#510), with modifier GT included and POS 02 (Telehealth), adding the informational modifier 95 after modifier GT.
    - Follow the billing policies in the Telehealth topic (#510), with modifier GT included and POS 02. In the documentation of the visit, note that the service was performed with audio only as allowed by Executive Order 72.
    - *Seeking clarification if the three options apply to FQHC providers.
  - **Medicaid Managed Care:** The managed care organizations are required to provide at least the same benefits as those provided under fee for-service arrangements. BadgerCare Plus and Medicaid SSI HMOs, as well as special managed care programs including Children Come First, Wraparound Milwaukee, and Care4Kids are expected to extend the same considerations to allowable telehealth services.
• **Non-Covered Services:** The following are not covered as telehealth services:
  o Store and forward services (defined as the asynchronous transmission of medical information to be reviewed later by a provider at a distant site).
  o Services that are not covered when delivered face-to-face.
  o Services or activities that require physical interaction or for goals that require hands-on support or physical prompting.

• **Patient Location:** Effective March 1st, 2020 the patient may be located at their home, an originating site, or any other location.

• **Patient Type:** New and established patients.

• **Provider Type:**
  o **Permanent Telehealth Services:**
    • Audiologists, Individual mental health and substance abuse practitioners not in a facility certified by the DQA, Nurse midwives, Nurse practitioners, Ph.D. psychologists, Physician assistants, Physicians, Psychiatrists, Professionals providing services in mental health or substance abuse programs certified by the DQA.
  o **Ancillary Providers:** Telehealth provided by ancillary providers should be submitted under the supervising physician’s NPI using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT code for the service performed. These services must be provided under the direct on-site supervision of a physician who is located at the same physical site as the ancillary provider and must be documented in the same manner as services that are provided face to face.
  o **Pediatric and Health Professional Shortage Area-Eligible Services:** Telehealth services provided by distant site providers may qualify for pediatric (services for members 18 years of age and under) or HPSA-enhanced reimbursement. Pediatric and HPSA-eligible providers should report the applicable pediatric or HPSA modifier, with a POS 02 and GT modifier, when submitting claims that qualify for enhanced reimbursement.
  o **Temporary Telehealth Services:**
    • All enrolled professionals and paraprofessional providers can provide services via telehealth.
      ▪ Paraprofessional providers are providers who do not hold a license to practice independently but are providing services under the direction of a licensed provider. Paraprofessional providers are subject to supervision requirements, which may include face-to-face supervision. Supervision requirements can be met via telehealth, but this flexibility does not change or replace licensure or certification requirements of the provider’s supervising body or other regulatory authorities. When possible, face-to-face supervision requirements should be met via audio-visual technologies. Supervision must be documented according to existing benefit policy
      • All providers are required to act within their scope of practice. Providers must make a good faith effort to provide direct oversight of treatment, but the required minimum hours of supervision will be relaxed during the Wisconsin public health emergency.
  
• **Reimbursement:** Services billed with modifier GT will be considered under the PPS reimbursement method for non-tribal FQHCs.

• **Transmission & Originating Site Fees:** An eligible originating site can bill an originating site fee (HCPCS Q3014). WI Medicaid does not provide guidance on transmission fees.
  o Originating sites eligible for a facility fee reimbursement:
    • Hospitals, including emergency departments
    • Office/clinic
    • Skilled nursing facility
  o For FQHCs, originating site services should be billed, but no reimbursement will be issued as all costs for providing originating site services have already been incorporated into the PPS rates. Claims billed by FQHCs for originating site services may be used for future rate setting purposes.

• **Video Component:** WI Medicaid will allow remote services utilizing interactive synchronous (real-time) technology, including audio-only phone communication, for services that can be delivered with functional
equivacency to the face-to-face service. This applies to both permanent telehealth services listed in the Telehealth topic (#510) of the Online Handbook and temporarily allowed telehealth services.

- **Temporarily Covered Telehealth Services:** Any services that is currently covered by WI Medicaid and delivered through audio-only methods (phone) should be billed the same way as interactive video services, which is with the POS code for an in-person visit and modifier 95.

- **Permanent Covered Telehealth Services:** When audiovisual services listed as allowable in the telehealth topic (#510) in the Online Provider Manual are provided as audio only (phone) services, providers have three billing options:*
  - Report the service as instructed for temporary services with informational modifier 95 and the POS of where the distant site provider is located. Distant site providers working remotely should use the POS that they are connecting to. For example, a provider working remotely from their clinic should use POS code 11 (Office).
  - Follow the billing policies in the Telehealth topic (#510), with modifier GT included and POS 02 (Telehealth), adding the informational modifier 95 after modifier GT.
  - Follow the billing policies in the Telehealth topic (#510), with modifier GT included and POS 02. In the documentation of the visit, note that the service was performed with audio only as allowed by Executive Order 72.

*Seeking clarification if the three options apply to FQHC providers.

**Cost Share Waiver:**

- Effective March 18th, 2020-December 31st, 2020, WI Medicaid has waived cost sharing for medical visits that result in an order for, or administration of, a COVID-19 test, are related to furnishing or administering a test, or related to the evaluation of an individual for purposes of determining the need for a test.
- Effective July 1st, 2020-December 31st, 2020, WI Medicaid has waived cost sharing for any treatment services related to COVID-19 care.
- Effective January 1st, 2021-End of PHE, WI Medicaid will waive cost sharing for COVID related testing and related services.

**HOSPITAL OUTPATIENT**

The following list is a summary of telehealth services that some payors are allowing – see payor’s allowable telehealth code list in the payor’s section.

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

**Commercial Billing:**

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

**Medicare Billing:**

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

Facility (UB Form): CMS-5531-IFC specifically outlines appropriate billing for hospitals during the COVID-19 pandemic.

- CAHs: The extraordinary circumstances policy in CMS-5531-IFC only applies to PPS hospitals and to services paid on OPPS. **It does not apply to CAHs.**
  - CAH PT/OT/ST: Append modifier 95 if therapy services are provided via telehealth.

- PPS Hospitals:
  - Hospital OP services reimbursed at the OPPS rate (i.e. diabetic management services, behavioral health, etc.), have the following choices:
    - Utilize the extraordinary circumstances policy, appending a PO modifier reimbursed at the OPPS rate.
    - Not utilize the extraordinary circumstances policy appending a PN modifier and DR condition code which is reimbursed a using the Physician Fee Schedule (PFS).

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

Medicare FAQ:
Question: When hospital clinical staff furnish a service using telecommunication technology to the patient who is a registered outpatient of the hospital and the hospital makes the patient’s home provider-based to the hospital as a temporary expansion site, should the hospital bill using the telehealth modifier (modifier 95)?
Answer: No. In this situation the hospital is furnishing an outpatient hospital service, not a telehealth service, to a patient in a temporarily relocated department of the hospital as discussed at 85 FR 27560. Accordingly, the hospital would bill as it ordinarily would bill and would include the DR condition code or CR condition code (as applicable) on the claim. If the situation involves a relocation of an on-campus or excepted off-campus provider-based department to an off-campus hospital location, the hospital would bill using the PO modifier (service provided at an excepted off-campus provider-based department) only if the hospital requests an extraordinary circumstances relocation request within 120 days of the date the temporary expansion site is made provider-based to the hospital; otherwise, the hospital would append the PN modifier (service provided at a non-excepted off-campus [https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf](https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf)

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

Medicare FAQ:
Question: How do hospitals bill for outpatient therapy services furnished by employed or contracted therapists using telecommunications technology on the UB-04 claim form during the COVID-19 PHE?
Answer: There are two options available to hospitals and their therapists.

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

2.) A hospital could, instead, use the flexibilities available under the Hospital Without Walls initiative. The hospital would register the patient as a hospital outpatient, where the patient’s home acts as a provider-based department of the hospital. The hospital’s
employed/contracted PT, OT, SLP would furnish the therapy care that the hospital believed could be furnished safely and effectively through telecommunications technology. The hospital is not limited to services included on the telehealth list (since these would not be considered telehealth services), but must ensure the care can be fully furnished remotely using telecommunications technology. The hospital would bill as if the therapy had been furnished in the hospital and the applicable PO/PN modifier would apply for the patient’s home since it would be serving as an off-campus department of the hospital. The option to bill for telehealth services, along with the -95 modifier, furnished by employed/contracted PTs, OTs, and SLPs using applicable audio-visual telecommunications technology applies to the following types of hospitals and institutions: Hospital – 12X or 13X (for hospital outpatient therapy services); Skilled Nursing Facility (SNF) – 22X or 23X (SNFs may, in some circumstances, furnish Part B PT/OT/SLP services to their own long-term residents); Critical Access Hospital (CAH) – 85X (CAHs may separately provide and bill for PT, OT, and SLP services on 85X bill type); Comprehensive Outpatient Rehabilitation Facility (CORF) – 75X (CORFs provide ambulatory outpatient PT, OT, SLP services); Outpatient Rehabilitation Facility (ORF) – 74X (ORFs, also known as rehabilitation agencies, provide ambulatory outpatient PT and SLP, as well as OT services); and Home Health Agency (HHA) – 34X (agencies may separately provide and bill for outpatient PT/OT/SLP services to persons in their homes only if such patients are not under a home health plan of care) https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

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

**PT/OT/ST**

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

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

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

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

<table>
<thead>
<tr>
<th>Payor</th>
<th>Telehealth Codes</th>
<th>E-Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aetna</strong></td>
<td>ALLOWABLE</td>
<td>1500 FORM-ALLOWABLE</td>
</tr>
<tr>
<td></td>
<td>- Allowable PT/OT/ST code set is available in the “Aetna” section of this guide.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- PT/OT/STs are considered providers eligible to bill for telehealth services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- 1500 Form: Utilize modifier GT or 95 and 02 POS. UB Form: Utilize GT or 95 modifier.</td>
<td></td>
</tr>
<tr>
<td><strong>Anthem BCBS</strong></td>
<td>ALLOWABLE</td>
<td>CONDITIONAL</td>
</tr>
<tr>
<td></td>
<td>- Allowable PT/OT/ST code set is available in the “Anthem BCBS” section of this guide.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- PT/OT/STs are considered providers eligible to bill for telehealth services.</td>
<td></td>
</tr>
</tbody>
</table>

Disclaimer: Although the data found here has been produced and processed from payor sources believed to be reliable, no warranty expressed or implied is made regarding accuracy, adequacy, completeness, legality, reliability, or usefulness of any information.
The Office of Civil Rights (OCR) has issued the below statement, and therefore Medicare and most other payors are allowing non-HIPAA compliant software to be used for virtual visits. However, some payors have still not waived this as requirement for payment. Refer to the HIPAA compliant statement within each payor section, or if the payor is not listed within this guide, reach out to the payor to verify their telehealth platform requirements.

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

**HIPAA COMPLIANT SOFTWARE**

The Office of Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by

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**Cigna**
- 1500 Form: Utilize POS 02 with modifier 95 or GT UB Claims: Applicable in-person revenue code with modifier 95 or GT
- PT/OT/STs can provide therapy services on their fee schedule, if appropriate to be provided via telehealth
  - PT/OT/STs are considered providers eligible to bill for telehealth services.
  - 1500 Form: Utilize modifier GT or 95 and in person POS. UB Form: Not allowable as of January 1st, 2021

**Medica**
- Allowable PT/OT/ST code set is available in the “Medica” section of this guide.
- PT/OT/STs are considered providers eligible to bill for telehealth services.
- 1500 Form: Utilize modifier GT or 95 and POS 02. UB Form: Utilize GT or 95 modifier.

**Medicare**
- Allowable PT/OT/ST code set is available in the “Medicare” section of this guide.
- PT/OT/STs are considered providers eligible to bill for telehealth services.
- PT/OT/ST services can be furnished to a beneficiary in their home by a hospital-based therapist when the beneficiary is registered as an outpatient of the hospital and the hospital considers the beneficiary’s home to be a provider-based department of the hospital.
- 1500 Form: Utilize POS for in person visit and 95 modifier. UB Form: Utilize 95 modifier.

**WI Medicaid & MCOs**
- PT/OT/STs can provide currently covered Medicaid services that can be delivered with functional equivalency to the face-to-face service.
- PT/OT/STs are considered eligible telehealth providers.
- Permanent Telehealth Services:
  - 1500 Claims: Utilize POS 02 and GT modifier. UB Claims: Modifier GT
  - Temporary Telehealth Services:
  - 1500 claims: POS utilized for in person visit with modifier 95. UB Claims: Modifier 95

**Wellmark BCBS**
- Allowable PT/OT/ST code set is available in the “Wellmark BCBS” section of this guide.
- PT/OT/STs are considered providers eligible to bill for telehealth services.
- 1500 Form: POS 02. UB Form: Modifier GT and telehealth comment.

**UHC**
- Allowable PT/OT/ST code set is available in the “UHC” section of this guide.
- 1500 Form: POS 02. UB Form: Modifier 95 and revenue code 780.

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the Health Information Technology for Economic and Clinical Health (HITECH) Act, to protect the privacy and security of protected health information, namely the HIPAA Privacy, Security and Breach Notification Rules (the HIPAA Rules).

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


REFERENCES & RESOURCES

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

Anthem BCBS:

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

Cigna:

CMS:
https://www.cms.gov/index.php/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
1#:~:text=In%20the%20CY%202021%20PFS%20proposed%20rule%2C%20CMS%20proposed%20to%20ends%20ora%20December%2031%2C%202021.

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