

Prepared for:
Great Plains Telehealth Resource & Assistance Center

Telehealth Billing and Reimbursement Guide— Wisconsin

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Virtual Visit Types

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Payor Matrix

Payor Guidelines

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Definition:

There are two types of telehealth services:

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

CPT/HCPCS Codes:

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 Provided in Patient's Home

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

Modifiers

Synchronous Telehealth Modifiers:

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

Asynchronous Telehealth Modifier:

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

Reporting Criteria:

- Report the appropriate E/M code for the professional service provided.
- Communication must be performed via live two-way interaction with both video and audio.
- HIPAA compliant platform

Documentation Requirements:

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

Definition:

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

CPT/HCPCS Codes:

Reportable by Qualified Healthcare Professionals:

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

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

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

Reporting Criteria:

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

Documentation Requirements:

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

Definition:

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

CPT/HCPCS Codes:

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

Reporting Criteria:

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

Documentation Requirements:

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

Definition:

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

CPT/HCPCS Codes:

Reportable by Qualified Healthcare Professionals:

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

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

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

Reporting Criteria:

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

Documentation Requirements:

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

PAYOR MATRIX

PAYOR	E-VISIT	TELEHEALTH	VIRTUAL CHECK-IN	TELEPHONE
AETNA	CONDITIONAL Check Contracted Fee Schedule	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 <u>Modifier:</u> GT, 95, FR, 93 or FQ	CONDITIONAL Check Contracted Fee Schedule	CONDITIONAL Check Contracted Fee Schedule
ANTEHM BCBS	CONDITIONAL Check Contracted Fee Schedule	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 or 10 <u>Modifier:</u> 95, GT, 93, FQ, GQ	CONDITIONAL Check Contracted Fee Schedule	CONDITIONAL Check Contracted Fee Schedule
CIGNA	NOT ALLOWABLE	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 <u>Modifier:</u> 95, GT, 93, FQ	ALLOWABLE G2012	ALLOWABLE 99441-99443
MEDICA	ALLOWABLE 99421-99423 98970 -98972 G2061-G2063	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 or 10 <u>Modifier:</u> GT, 95, 93, or FQ	ALLOWABLE G2010 G2012	ALLOWABLE 99441-99443 98966-98968
MEDICARE	ALLOWABLE 99421-99423 G2061-G2063 RHC: G0071	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 or 10 <u>Modifier:</u> Hospital Based Provider-95 Audio Only-93 <u>Method II:</u> Modifier GT <u>RHC:</u> G2025	ALLOWABLE G2010 G2012 G2250-G2252 RHC: G0071	ALLOWABLE 99441-99443 98966-98968 Modifier 95 RHC: G2025
WI MEDICAID	ALLOWABLE 99421-99423 98970 -98972	ALLOWABLE <u>Allowable Codes:</u> Code on provider's fee schedule. <u>Pos:</u> 02 OR 10 <u>Modifier:</u> 93, FQ, GQ or GT	ALLOWABLE G2010, G2012, G2250-G2252	ALLOWABLE 99441-99443
UHC COMMERCIAL	ALLOWABLE 99421-99423 98970 -98972	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>Professional:</u> 02 or 10 <u>Modifier:</u> 95 or GT	ALLOWABLE G2010 G2012 G2250-G2252	ALLOWABLE 99441-99443

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits:** Not allowable
- **Telephone:** Not allowable
- **Virtual Check-Ins:** Not allowable

Remote Patient Monitoring:

Allowable Codes:

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

Telehealth:

Allowable Services:

See table below for allowable code set

Audio Only Services:

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

Modifiers/POS:

- **POS:** N/A
- **Modifier**
 - **Audio Visual:** GT, 95, FR
 - **Audio Only:** 93, FQ
 - **Asynchronous:** GQ

Direct Patient Contact:

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

Not Reimbursable:

- Care Plan Oversight
- Concierge Medicine (boutique medicine)
- Missed appointments

Transmission & Originating Site Fees:

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

Reference:

- Telemedicine and Direct Patient Contact Payment Policy available on [Avality](#)

AETNA ELIGIBLE TELEHEALTH CODES

Telehealth Allowable Codes

90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845	90846	90847
90849	90853	90863	90951	90952	90954	90955	90957	90958	90960	90961	90963	90964	90965
90966	90967	90968	90969	90970	92227	92228	92507	92508	92521	92522	92523	92524	92526
92601	92602	92603	92604	93228	93229	93268	93270	93271	93272	94664	96040	96105	96110
96112	96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138	96139
96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171	97110	97112	97116
97129	97130	97151	97153	97155	97156	97157	97161	97162	97163	97164	97165	97166	97167
97168	97530	97535	97750	97755	97760	97761	97802	97803	97804	98960	98961	98962	99202
99203	99204	99205	99211	99212	99213	99214	99215	99231	99232	99233	99252	99253	99254
99255	99307	99308	99309	99310	99406	99407	99408	99409	99417	99418	99446	99447	99448
99449	99451	99452	99483	99495	99496	99497	99498	C7900	C7901	C7902	G0108	G0109	G0270
G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0425	G0426	G0427	G0438
G0439	G0442	G0443	G0444	G0445	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087
G2088	G2212	G3002	G3003	H0015	H0035	H0038	H2012	H2036	S9443	S9480			

Cells Highlighted in Yellow do **NOT** Require a Modifier
 Codes in Blue are Allowable via an audio only connection

Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits:** Check fee schedule
- **Telephone:** Check fee schedule
- **Virtual Check-In:** Check fee schedule

Remote Patient Monitoring:

- Professional Virtual Visits rendered for Remote Patient Monitoring must be submitted with the place of service appropriate to the location of the billing provider
- Facility Virtual Visits rendered for Report Patient Monitoring must be submitted with the appropriate revenue code for the service rendered.

Telehealth:

Allowable Services:

Anthem states there is an administrative policy with a allowable virtual services, but it is not longer available on their website, therefore refer to contracted fee schedule for allowable codes

Audio Only Services: An audiovisual component is required.

Non-Reimbursable:

- Non-direct member services other than Remote Patient Monitoring
- Services that require equipment and/or direct physical hands-on care that cannot be provided remotely
- Services rendered virtually that are not eligible for reimbursement when rendered in-person
- Services rendered by facsimile, e-mail, instant messaging, electronic chart, or other electronic communication
- Services that do not represent real-time interaction between a member located at the originating site and a provider located at a distant site.
- PT/OT/ST services provided without live audio/visual communication
- In person services not rendered in an office or facility setting are not eligible for virtual reimbursement under this policy

Modifiers/POS:

- **POS 02 or 10**
- **Modifier 95, GT, 93, FQ, GQ**
- **Facility (UB) Claims:**

Rendered At Distant Site: Appropriate revenue code for the service rendered with modifier 95 or GT

Reimbursement:

Services reported by a professional provider with a POS 02 or 10 will be eligible for non-office place of service reimbursement.

Transmission & Originating Site Fees:

Originating site fee (Q3014) is allowable for originating site facilities. Transmission fees are not allowed

Reference:

- [Anthem Commercial Telehealth Reimbursement Policy](#)

Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

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

Remote Patient Monitoring:

Allowable Codes:

- 99091, 99453, 99454, 99457, 99458, 99473, 99474, G0322

Indications:

Remote Patient Monitoring is only covered for the following indications, no other indications are covered

- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes Mellitus
- Heart Failure

All of the following must be met:

- Medical device that is FDA approved, cleared or has received emergency use authorization (EUA) designation
- Prescribed and administered by a board-eligible or board-certified medical provider or subspecialist (e.g., cardiologist, pulmonologist, endocrinologist), nurse practitioner (NP) or physician assistant (PA)
- Physiologic data must be electronically collected and automatically uploaded for analysis and interpretation
- Must be intended for the purpose of displaying or analyzing the physiological parameter(s) measured
- Used for remote communication, counseling and monitoring of acute or chronic health conditions

Not Covered:

Remote Therapeutic Monitoring (RTM), CPT codes 98975, 98976, 98977, 98978, 98980, 98981, are not covered, regardless of indication

Telehealth

Allowable Services:

See below table for allowable medical telehealth codes.

All of the following must be met:

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

Excluded Services:

- The virtual care service occurs on the same day as a face to face visit, when performed by the same provider and for the same condition
- Virtual care services billed within the post-operative period of a previously completed surgical procedure will be considered part of the global payment for the procedure
- Services were performed via asynchronous communications systems (e.g., fax)
- Store and forward telecommunication, whether an appropriate virtual care modifier is appended to the procedure code or not

- Patient communications are incidental to E/M services, counseling, or medical services, including, but not limited to reporting of test results and provision of educational materials
- Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient
- No reimbursement will be made for any equipment used for virtual care communications

Store and Forward Telehealth:

Asynchronous communications occur when medical information is stored and forwarded to be reviewed later by a physician or other health care provider at a distant site. The medical information is reviewed without the patient being present. Asynchronous communications are also referred to as store-and-forward or non-interactive communications. Cigna does not reimburse asynchronous communications.

Modifiers/POS:

- **POS 02**
 - Do not bill POS 10 until further notice
- **Modifier 93, 95, FQ, GQ, or GT**

Audio Only Services:

Services rendered via audio only will be reimbursed when the appropriate telephone only code is billed

Transmission & Originating Site Fees:

Cigna will not reimburse transmission fees or an originating site of service fee or facility fee for telehealth visits (HCPCS G2025, Q3014, T1014)

References:

- [Reimbursement Policy- Virtual Care and Remote Patient Monitoring](#)

CIGNA MEDICAL ELIGIBLE VIRTUAL CODES												
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962	90963
90964	90965	90966	90967	90968	90969	90970	92507	92508	92521	92522	92523	92524
92601	92602	92603	92604	96040	96112	96113	96116	96156	96158	96159	96160	96161
96164	96165	96167	96168	97110	97112	97161	97162	97163	97164	97165	97166	97167
97168	97530	97755	97760	97761	97802	97803	97804	92202	92203	99204	99205	99211
99212	99213	99214	99215	99381	99382	99383	99384	99385	99386	99387	99391	99392
99393	99394	99395	99396	99397	99401	99402	99403	99404	99406	99407	99408	99409
99411	99412	99441	99442	99443	99446	99447	99448	99449	99451	99452	99495	99496
99497	99498	G0108	G0151	G0152	G0153	G0155	G0157	G0158	G0270	G0296	G0299	G0300
G0396	G0397	G0438	G0439	G0442	G0443	G0444	G0445	G0446	G0447	G0493	G0513	G0514
G2012	S9123	S9129	S9129	S9131	S9152							

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



CIGNA BEHAVIORAL HEALTH ELIGIBLE VIRTUAL CODES

90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845	90846
90847	90849	90853	90863	90875	90876	90880	96110	96127	96156	96158	96159	96164
96165	96167	96168	96170	96171	97151	97152	97153	97154	97155	97156	97157	97158
99058	99078	99202	99203	99204	99205	99211	99212	99213	99214	99215	99217	99218
99219	99220	99221	99222	99223	99224	99225	99226	99231	99232	99233	99234	99235
99236	99238	99239	99281	99282	99283	99284	99285	99304	99305	99306	99307	99308
99309	99310	99315	99316	99318	99324	99325	99326	99327	99328	99334	99335	99336
99337	99354	99355	99356	99357	99404	99409	99415	99416	99417	99441	99442	99443
99446	99447	99448	99449	99456	99484	99495	99496	0591T	0592T	G0410	H0015	H0035
H0038	H2011	S0201	S9480									



Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits:** 98970-98972, 99421-99423
- **Telephone:** 98966-98968, 99441-99443
- **Virtual Check-In:** G0071, G2010, G2012

Telehealth:

Synchronous Telehealth Allowable Codes:

See table below for specific codes.

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

Store and Forward Telehealth:

Medica will allow asynchronous (store and forward) telehealth

- Utilize modifier GQ
- Medical information may include: video clips, still images, X-rays, MRIs, EKGs, laboratory results, audio clips and text

Modifiers/POS:

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

Provider Type:

Audiologist, Certified Genetic Counselor, Certified Nurse Anesthetists, 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

Originating Sites:

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

Transmission & Originating Site Fees:

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

Coverage Limitations: The following services are not covered under telehealth: Provider initiated e-mails; 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, providing educational materials, brief follow-up of a medical procedure to confirm stability of the member'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 member's chronic condition without change in current treatment; when information is exchanged and the member 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 member that consists solely of an e-mail or facsimile.

Audio Only Services:

Designated codes, highlighted in yellow in the below "Telehealth Allowable Codes" matrix, can be performed via an audio only connection

References:

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

MEDICA ALLOWABLE TELEHEALTH CODES											
0362T	0373T	0591T	0592T	0593T	77427	87633	90785	90791	90792	90832	90833
90834	90836	90837	90838	90839	90840	90845	90846	90847	90853	90863	90875
90901	90951	90952	90953	90954	90955	90956	90957	90958	90959	90960	90961
90962	90963	90964	90965	90966	90967	90968	90969	90970	92002	92004	92012
92014	92227	92228	92507	92508	92521	92522	92523	92524	92526	92550	92552
92553	92555	92556	92557	92563	92565	92567	92568	92570	92587	92588	92601
92602	92603	92604	92607	92608	92609	92610	92625	92626	92627	93228	93229
93268	93270	93271	93272	93298	93750	93797	93798	94002	94003	94004	94005
94625	94626	94664	95970	95971	95972	95983	95984	96040	96105	96110	96112
96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138
96139	96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171
97110	97112	97116	97129	97130	97150	97151	97152	97153	97154	97155	97156
97157	97158	97161	97162	97163	97164	97165	97166	97167	97168	97530	97535
97537	97542	97750	97755	97760	97761	97763	97802	97803	97804	98960	98961
98962	98966	98967	98968	99202	99203	99204	99205	99211	99212	99213	99214
99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238	99239
99242	99243	99244	99245	99252	99253	99254	99255	99281	99282	99283	99284
99285	99291	99292	99304	99305	99306	99307	99308	99309	99310	99315	99316
99341	99342	99344	99345	99347	99348	99349	99350	99406	99407	99408	99409
99417	99418	99441	99442	99443	99468	99469	99471	99472	99473	99475	99476
99477	99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0136
G0270	G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0420
G0421	G0422	G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445
G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211
G2212	G3002	G3003	G9685	Q3014							

All codes in the table can be provided using interactive audio and video.
Codes in **Yellow** meet the interaction requirement when provided via audio only

MEDICA BEHAVIORAL HEALTH TELEHEALTH CODES

90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90480	90845
90846	90847	90853	99202	99203	99204	99205	99211	99212	99213	99214	99215

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

E-Visits: 99421-99423, G2061-G2063

Telephone: 99441-99443, 98966-98968

Allowed through December 31st, 2024

Virtual Check-In: G2010, G2012, G2250-G2252

Modifiers:

E-Visits & Virtual Check-Ins: None

Telephone: Modifier 95

Reimbursement:

Audio-only codes 99441-99443 will be paid at parity with 99212-99214 through December 31st, 2024

- Document why patient could not be seen for an audiovisual visit or attend an in-person encounter

Telehealth:

Consolidated Appropriations Act:

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

- Originating site restriction waiver
- Allows additional telehealth practitioners to include OTs, PTs, SLPs, mental health counselors, and marriage and family therapists
- Audio only telehealth services
- In person requirement for mental health services via telehealth waived
- Extension of FQHC/RHC to serve as originating site for non-behavioral/mental telehealth services

Allowable Codes:

See table below for codes allowable via telehealth

Audio Only:

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

- Telephone Codes only available for use through December 31st, 2024
- For behavioral or mental telehealth, 2-way, interactive, audio-only technology can be utilized

Consent:

Providers may get patient consent at the same time they initially provide the services. Direct supervision isn't required to get consent. In general, auxiliary personnel under general supervision of the billing practitioner can get patient consent for these services.

Hospital Based Providers:

Hospitals and other providers of PT, OT, SLP, diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services can continue to bill for telehealth services when provided remotely in the same way they've been during the PHE and the remainder of CY 2023, except that:

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

Modifiers/POS:

- **POS:**
 - 02 or 10
- **Modifier:**
 - Use modifier 95 when the clinician is in the hospital and the patient is in the home, as well as for outpatient therapy services provided via telehealth by qualified PTs, OTs, or SLPs through December 31, 2024
- **Mental Health Claims:** POS 02 or 10
 - **Modifier 93** if performed over audio only
 - **RHC/FQHC:** Modifier FQ
- **CAH Method II (UB) Claims:** Modifier GT

Patient Location:

Through December 31st, 2024, there is not an originating site or geographic restriction

Mental Health Place of Service:

CMS permanently added a patient's home as an originating site for patients receiving mental health services via telehealth. "Home" includes temporary lodging. Must meet the following requirements:

- The provider (or another provider in the same practice and subspecialty) has conducted an in-person (non-telehealth) visit within 6 months
- After the initial tele-mental health visit, the provider must conduct an in-person visit at least once every 12 months
 - However, this visit is not required if the patient and provider consider the risks of an in-person visit and agree that the risks outweigh the benefits
 - Provider should document decision in the patient's medical record
- Through December 31st, 2024, the initial 6 month visit and the in person visit every 12 month requirement is waived

Provider Type:

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

- Through December 31st, 2024, OTs, PTs, SLPs, mental health counselors, and marriage and family therapists may also provide and bill telehealth services

Reimbursement:

Through December 31st, 2024, when telehealth services are provided to people in their homes (POS 10), the service will be reimbursed at the non-facility rate. However, if the telehealth service is provided when the patient is not in their home, and POS 02 is utilized, then the service will be reimbursed at the facility rate.

Rural Health Clinics & Federally Qualified Health Centers:

See the RHC and FQHC section for specific billing regulations

Supervision:

Through December 31st, 2024, CMS will continue to define direct supervision to permit the presence and immediate availability of the supervising practitioner through real time audio and video interactive telecommunications

Teaching Physicians:

Through December 31st, 2024 teaching physicians can use telehealth when the resident provides services in all residency training locations

Transmission/ Originating Site Fees:

Medicare does not reimburse for transmission fees. If applicable, Medicare will reimburse an originating site fee (HCPCS Q3014)

Reference:

- [MLN Matters-Telehealth Services](#)
- [SE22001 Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers](#)
- [Consolidated Appropriations Act, 2024](#)

MEDICARE ELEGIBLE TELEHEALTH CODES

2024 Telehealth Codes

0362T	0373T	0591T	0592T	0593T	77427	90785	90791	90792	90832	90833	90834
90836	90837	90838	90839	90840	90845	90846	90847	90853	90875	90901	90951
90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962	90963
90964	90965	90966	90967	90968	90969	90970	92002	92004	92012	92014	92507
92508	92521	92522	92523	92524	92526	92550	92552	92553	92555	92556	92557
92563	92565	92567	92568	92570	92587	92588	92601	92602	92603	92604	92607
92608	92609	92610	92625	92626	92627	93750	93797	93798	94002	94003	94004
94005	94625	94626	94664	95970	95971	95972	95983	95984	96105	96110	96112
96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138
96139	96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171
97110	97112	97116	97129	97130	97150	97151	97152	97153	97154	97155	97156
97157	97158	97161	97162	97163	97164	97165	97166	97167	97168	97530	97535
97537	97542	97750	97755	97760	97761	97763	97802	97803	97804	98960	98961
98962	98966	98967	98968	99202	99203	99204	99205	99211	99212	99213	99214
99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238	99239
99281	99282	99283	99284	99285	99291	99292	99304	99305	99306	99307	99308
99309	99310	99315	99316	99341	99342	99344	99345	99347	99348	99349	99350
99406	99407	99441	99442	99443	99468	99469	99471	99472	99473	99475	99476
99477	99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0136
G0270	G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0420
G0421	G0422	G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445
G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211
G2212	G3002	G3003	G9685								

Codes Highlighted in Blue Can Be Performed via Audio only

Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits:** 99421-99423, 98970-98972
- **Telephone:** 99441-99443
- **Virtual Check-In:** G2010, G2012, G2250-G2252

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

Provider Requirements:

- The treating provider may be a physician, nurse practitioner, physician assistant, or podiatrist
- The consulting provider must be a physician
- Both the consulting and treating providers must be enrolled in WI Medicaid as eligible rendering providers.

Remote Physiologic Monitoring:

Allowable Codes: 99453, 99454, 99457, 99458

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, nurse practitioner, or physician assistant 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).
- Only physicians, nurse practitioners, and physician assistants enrolled in Medicaid are eligible to render and submit claims for remote physiologic services.

Documentation:

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

- The members consent
- The provider must document how remote physiologic monitoring is tied to the member-specific needs and will assist the member to achieve the goals of treatment.

Telehealth

Allowable Services:

Allowable telehealth services are those listed on the Max Fee Schedules with a POS code 02 and 10 listed within the allowable POS column on the fee schedule.

• **Group Treatment:**

- WI Medicaid has stated that group leaders should provide members with information on the risks, benefits, and limits to confidentiality related to group telehealth and document the member’s consent prior to the first session. Group leaders should adhere to and uphold the highest privacy standards possible for the group. Group members should be instructed to respect the privacy of others by not disclosing group members’ images, names, screenshots, identifying details, or circumstances. Group members should also be reminded to prevent non-group members from seeing or overhearing telehealth sessions. Providers may not compel members to participate in telehealth-based group treatment and should make alternative services available for members who elect not to participate in telehealth-based group treatment.

Services Not Appropriate Via Telehealth:

- Services that are not covered when provided in-person
- Services that do not meet applicable laws, regulations, licensure requirements, or procedure code definitions if delivered via telehealth
- Services where a provider is required to physically touch or examine the recipient and delegation is not appropriate
- Services the provider declines to deliver via telehealth
- Services the recipient declines to receive via telehealth
- Transportation services
- Services provided by personal care workers, home health aides, private duty nurses, or school-based service care attendants

Audio Only Services:

When possible, telehealth services should include both an audio and visual component. In circumstances where audio-visual telehealth is not possible due to member preference or technology limitations, telehealth may include real-time interactive audio-only communication if the provider feels the service is functionally equivalent to the in-person service and there are no face-to-face or in-person restrictions listed in the procedural definition of the service.

- Documentation should include that the service was provided via interactive synchronous audio-only telehealth.
- Modifier 93 should be used for any service performed via audio-only telehealth

Documentation:

Requirements for a telehealth service are the same as for an in-person visit and must accurately reflect the service rendered. Documentation must identify the delivery mode of the service when provided via telehealth and document the following:

- Whether the service was provided via audio-visual telehealth, audio-only telehealth, or via telehealth externally acquired images
- Whether the service was provided synchronously or asynchronously

Additional information for which documentation is recommended, but not required, includes:

- Provider location (for example, clinic [city/name], home, other)
- Member location (for example, clinic [city/name], home)
- All clinical participants, as well as their roles and actions during the encounter

As a reminder, documentation for originating sites must support the member's presence to submit a claim for the originating site facility fee.

Modifiers/POS:

- **POS** 02 or 10
- **Modifier** 93, FQ, GQ, or GT

Behavioral Treatment: FQ, FR, GQ, or GT

Claims for services delivered via telehealth must include all modifiers required by the existing benefit coverage policy in order to reimburse the claim correctly. Telehealth delivery is shown on the claim by indicating POS 02 or 10 and including either GQ, GT, FQ, or 93 modifier. Note: The GT, FQ or 93 modifiers may not be listed on the fee schedule, but it is still required on all claim submissions that use POS 02 or 10. The GQ modifier is required to indicate the telehealth service was performed asynchronously

Noncovered services:

Services that are not covered when delivered in person are not covered as telehealth services. In addition, services that are not functionally equivalent to the in-person service when provided via telehealth are not covered.

- The following cannot be billed to the member:
 - Telehealth equipment like tablets or smart devices
 - Charges for mailing or delivery of telehealth equipment
 - Charges for shipping and handling of:
 - Diagnostic tools
 - Equipment to allow the provider to assess, diagnose, repair, or set up medical supplies online such as hearing aids, cochlear implants, power wheelchairs or other equipment

Provider Type:

There is no restriction on the location of a distant site provider. In addition, there are no limitations on what provider types may be reimbursed for telehealth services.

Claims for services provided via telehealth by distant site ancillary providers should continue to 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.

Originating Site & Transmission Fees:

An eligible originating site can bill an originating site fee (HCPCS Q3014), modifiers GQ, GT, FQ or 93 should not be included. WI Medicaid does not provide guidance on transmission fees.

- The following locations are eligible for the originating site fee under permanent telehealth policy:
 - Office or clinic: Medical, Dental, Therapies (physical therapy, occupational therapy, speech and language pathology)
 - Behavioral and mental health agencies
 - Hospital
 - Skilled nursing facility
 - Community mental health center

- Intermediate care facility for individuals with intellectual disabilities
- Pharmacy
- Day treatment facility
- Residential substance use disorder treatment facility

Reimbursement:

Reimbursement will be at the same rate as when the service is provided face-to-face

Pediatric and Health Professional Shortage Area-Eligible Services

Claims for services provided via telehealth by distant site providers may additionally qualify for pediatric (services for members 18 years of age and under) or HPSA-enhanced reimbursement. Pediatric and HPSA-eligible providers are required to indicate POS code 02 or 10, along with modifier GQ, GT, FQ, or 93 and the applicable pediatric or HPSA modifier, when submitting claims that qualify for enhanced reimbursement.

Reference:

[Covered and Noncovered Telehealth Services-Topic 22737](#)

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits:** 98970-98972, 99421-99423
- **Telephone:** 99441-99443
- **Virtual Check-In:** G2010, G2012, G2250-G2252

POS/Modifier:

POS utilized if visit would have in person and no modifier

Remote Patient Monitoring Codes:

Allowable Codes:

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

POS/Modifier:

POS utilized if visit would have in person and no modifier

Interprofessional Assessment Codes:

Allowable Codes:

- 99446-99449, 99451-99454

POS/Modifier:

POS utilized if visit would have in person and no modifier

Telehealth:

Allowable Codes:

UHC will allow any services on the below lists:

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

Modifiers/POS:

- **POS** 02 or 10
- **Modifiers** 95, GT, GQ, and G0 are not required to identify telehealth services but are accepted as informational if reported on claims

Provider Type:

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

Patient Location:

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

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

Transmission & Originating Site Fees:

UHC will allow the originating site using HCPS Q3014, but will not allow transmission fees (T1014) to be reimbursed

- For POS where code Q3014 is required, report the valid POS code reflecting the location of the patient

Audio Only Services:

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

- UHC will align with the AMA and will consider for reimbursement the services included in Appendix T of the CPT code set, which are appropriate for reporting real-time, interactive audio-only telehealth, when appended with modifier 93, and reported with POS 02 or 10.
- All PT/OT/ST Telehealth visits must be performed using live, interactive video conferencing that 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.

Reference:

- [Reimbursement Policy-Telehealth/Virtual Health Policy, Professional](#)

UHC ELEGIBLE TELEHEALTH CODES											
0362T	0373T	77427	90785	90791	90792	90832	90833	90834	90836	90837	90838
90839	90840	90845	90846	90847	90853	90863	90875	90901	90951	90952	90953
90954	90955	90956	90957	90958	90959	90960	90961	90962	90963	90964	90965
90966	90967	90968	90969	90970	92002	92004	92012	92014	92227	92228	92507
92508	92521	92522	92523	92524	92526	92550	92552	92553	92555	92556	92557
92563	92565	92567	92568	92570	92587	92588	92601	92602	92603	92604	92607
92608	92609	92610	92625	92626	92627	93228	93229	93268	93270	93271	93272
93750	93797	93798	94002	94003	94004	94005	94625	94626	94664	95970	95971
95972	95983	95984	96040	96105	96110	96112	96113	96116	96121	96125	96127
96130	96131	96132	96133	96136	96137	96138	96139	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171	97110	97112	97116	97129	97130
97150	97151	97152	97153	97154	97155	97156	97157	97158	97161	97162	97163
97164	97165	97166	97167	97168	97530	97535	97537	97542	97750	97755	97760
97761	97763	97802	97803	97804	98960	98961	98962	98966	98967	98968	99202
99203	99204	99205	99211	99212	99213	99214	99215	99221	99222	99223	99231
99232	99233	99234	99235	99236	99238	99239	99281	99282	99283	99384	99285
99291	99292	99304	99305	99306	99307	99308	99309	99310	99315	99316	99341
99342	99344	99345	99347	99348	99349	99350	99406	99407	99408	99409	99417
99418	99441	99442	99443	99468	99469	99471	99472	99473	99475	99476	99477
99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0136	G0270
G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0420	G0421
G0422	G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445	G0446
G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211	G2212
G3002	G3003	G9481	G9482	G9483	G9484	G9485	G9486	G9487	G9488	G9489	G9685
G9978	G9979	G9980	G9981	G9982	G9983	G9984	G9985	G9986			



PT/OT/ST											
92507	92521	92522	92523	92524	97110	97112	97116	97161	97162	97163	97164
97165	97166	97167	97168	97535	97750	97755	97760	97761			

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

MEDICARE

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

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

Virtual Check Ins/E-Visits/Telephone:

Virtual Check-Ins & E-Visits:

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

- RHCs should bill HCPCS G0071 if E-Visit or Virtual Check-In services are performed.
- **Reimbursement:** is set at the average of the national non-facility PFS payment rates for the 5 E-visits and Virtual Check-In codes. For 2024 the rate is set at \$12.93
- **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

Telephone Services:

Until December 31st, 2024, RHC/FQHCs can perform audio only telephone services utilizing CPT codes 99441-99443

- 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.

RHC General Care Management:

General Care Management (HCPCS G0511) Services:

- Remote Physiologic Monitoring
- Remote Therapeutic Monitoring
- Community Health Integration
- Principal Illness Navigation
- Chronic Care Management
- Behavioral Health Integration

Reimbursement:

- Methodology to calculate the payment rate for the general care management HCPCS code G0511 takes account how frequently the various services are utilized along with payment averages
- 2024 Rate: \$72.98

Telehealth:

Consolidated Appropriations Act:

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

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

Allowable Codes:

RHCs/FQHCs can perform any service listed in the below telehealth allowable code set matrix, but must bill G2025

Billing:

- **HCPCS** G2025
- **POS** 02 or 10
- **Modifier:** 95 (Optional)
- **Mental Health Claims:** POS 02 or 10 and modifier FQ if performed via audio only

Mental Health Services:

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

Provider Type:

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

- Through December 31st, 2024, OTs, PTs, SLPs, mental health counselors, and marriage and family therapists may also provide and bill telehealth services

Reimbursement:

The RHC/FQHC telehealth payment rate is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS. For 2024 the rate is \$95.37

Transmission/ Originating Site Fees:

Medicare does not reimburse transmission fees. If applicable, Medicare will reimburse an originating site fee (HCPCS Q3014)

Audio Only:

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

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

Reference:

[MLN Matters-Telehealth Services](#)

[SE22001 Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers](#)

[SE 20016 New & Expanded Flexibilities for Rural Health Clinics & Federally Qualified Health Centers](#)

[Consolidated Appropriations Act, 2024](#)

MEDICARE ELEGIBLE TELEHEALTH CODES

2024 Telehealth Codes

0362T	0373T	0591T	0592T	0593T	77427	90785	90791	90792	90832	90833	90834
90836	90837	90838	90839	90840	90845	90846	90847	90853	90875	90901	90951
90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962	90963
90964	90965	90966	90967	90968	90969	90970	92002	92004	92012	92014	92507
92508	92521	92522	92523	92524	92526	92550	92552	92553	92555	92556	92557
92563	92565	92567	92568	92570	92587	92588	92601	92602	92603	92604	92607
92608	92609	92610	92625	92626	92627	93750	93797	93798	94002	94003	94004
94005	94625	94626	94664	95970	95971	95972	95983	95984	96105	96110	96112
96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138
96139	96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171
97110	97112	97116	97129	97130	97150	97151	97152	97153	97154	97155	97156
97157	97158	97161	97162	97163	97164	97165	97166	97167	97168	97530	97535
97537	97542	97750	97755	97760	97761	97763	97802	97803	97804	98960	98961
98962	98966	98967	98968	99202	99203	99204	99205	99211	99212	99213	99214
99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238	99239
99281	99282	99283	99284	99285	99291	99292	99304	99305	99306	99307	99308
99309	99310	99315	99316	99341	99342	99344	99345	99347	99348	99349	99350
99406	99407	99441	99442	99443	99468	99469	99471	99472	99473	99475	99476
99477	99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0136
G0270	G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0420
G0421	G0422	G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445
G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211
G2212	G3002	G3003	G9685								

Codes Highlighted in Blue Can Be Performed via Audio only

MEDICAID

Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits:** 99421-99423, 98970-98972
- **Telephone:** 99441-99443
- **Virtual Check-In:** G2010, G2012, G2250-G2252

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

Provider Requirements:

- The treating provider may be a physician, nurse practitioner, physician assistant, or podiatrist
- The consulting provider must be a physician
- Both the consulting and treating providers must be enrolled in WI Medicaid as eligible rendering providers.

Remote Physiologic Monitoring:

Allowable Codes: 99453, 99454, 99457, 99458

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, nurse practitioner, or physician assistant 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).
- Only physicians, nurse practitioners, and physician assistants enrolled in Medicaid are eligible to render and submit claims for remote physiologic services.

Documentation:

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

- The members consent
- The provider must document how remote physiologic monitoring is tied to the member-specific needs and will assist the member to achieve the goals of treatment.

Telehealth

Allowable Services:

Allowable telehealth services are those listed on the Max Fee Schedules with a POS code 02 and 10 listed within the allowable POS column on the fee schedule.

• **Group Treatment:**

- WI Medicaid has stated that group leaders should provide members with information on the risks, benefits, and limits to confidentiality related to group telehealth and document the member’s consent prior to the first session. Group leaders should adhere to and uphold the highest privacy standards possible for the group.



Group members should be instructed to respect the privacy of others by not disclosing group members' images, names, screenshots, identifying details, or circumstances. Group members should also be reminded to prevent non-group members from seeing or overhearing telehealth sessions. Providers may not compel members to participate in telehealth-based group treatment and should make alternative services available for members who elect not to participate in telehealth-based group treatment.

Services Not Appropriate Via Telehealth:

- Services that are not covered when provided in-person
- Services that do not meet applicable laws, regulations, licensure requirements, or procedure code definitions if delivered via telehealth
- Services where a provider is required to physically touch or examine the recipient and delegation is not appropriate
- Services the provider declines to deliver via telehealth
- Services the recipient declines to receive via telehealth
- Transportation services
- Services provided by personal care workers, home health aides, private duty nurses, or school-based service care attendants

Audio Only Services:

When possible, telehealth services should include both an audio and visual component. In circumstances where audio-visual telehealth is not possible due to member preference or technology limitations, telehealth may include real-time interactive audio-only communication if the provider feels the service is functionally equivalent to the in-person service and there are no face-to-face or in-person restrictions listed in the procedural definition of the service.

- Documentation should include that the service was provided via interactive synchronous audio-only telehealth.
- Modifier 93 should be used for any service performed via audio-only telehealth

Documentation:

Requirements for a telehealth service are the same as for an in-person visit and must accurately reflect the service rendered. Documentation must identify the delivery mode of the service when provided via telehealth and document the following:

- Whether the service was provided via audio-visual telehealth, audio-only telehealth, or via telehealth externally acquired images
- Whether the service was provided synchronously or asynchronously

Additional information for which documentation is recommended, but not required, includes:

- Provider location (for example, clinic [city/name], home, other)
- Member location (for example, clinic [city/name], home)
- All clinical participants, as well as their roles and actions during the encounter

As a reminder, documentation for originating sites must support the member's presence to submit a claim for the originating site facility fee.

Modifiers/POS:

- **POS 02 or 10**
- **Modifier 93, FQ, GQ, or GT**

Behavioral Treatment: FQ, FR, GQ, or GT

Claims for services delivered via telehealth must include all modifiers required by the existing benefit coverage policy in order to reimburse the claim correctly. Telehealth delivery is shown on the claim by indicating POS 02 or 10 and including either GQ, GT, FQ, or 93 modifier. Note: The GT, FQ or 93 modifiers may not be listed on the fee schedule, but it is still

required on all claim submissions that use POS 02 or 10. The GQ modifier is required to indicate the telehealth service was performed asynchronously

Noncovered services:

Services that are not covered when delivered in person are not covered as telehealth services. In addition, services that are not functionally equivalent to the in-person service when provided via telehealth are not covered.

- The following cannot be billed to the member:
 - Telehealth equipment like tablets or smart devices
 - Charges for mailing or delivery of telehealth equipment
 - Charges for shipping and handling of:
 - Diagnostic tools
 - Equipment to allow the provider to assess, diagnose, repair, or set up medical supplies online such as hearing aids, cochlear implants, power wheelchairs or other equipment

Provider Type:

There is no restriction on the location of a distant site provider. In addition, there are no limitations on what provider types may be reimbursed for telehealth services.

Claims for services provided via telehealth by distant site ancillary providers should continue to 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.

Originating Site & Transmission Fees:

An eligible originating site can bill an originating site fee (HCPCS Q3014), modifiers GQ, GT, FQ or 93 should not be included. WI Medicaid does not provide guidance on transmission fees.

- The following locations are eligible for the originating site fee under permanent telehealth policy:
 - Office or clinic: Medical, Dental, Therapies (physical therapy, occupational therapy, speech and language pathology)
 - Behavioral and mental health agencies
 - Hospital
 - Skilled nursing facility
 - Community mental health center
 - Intermediate care facility for individuals with intellectual disabilities
 - Pharmacy
 - Day treatment facility
 - Residential substance use disorder treatment facility

Reimbursement:

Reimbursement will be at the same rate as when the service is provided face-to-face

Pediatric and Health Professional Shortage Area-Eligible Services

Claims for services provided via telehealth by distant site providers may additionally qualify for pediatric (services for members 18 years of age and under) or HPSA-enhanced reimbursement. Pediatric and HPSA-eligible providers are required to indicate POS code 02 or 10, along with modifier GQ, GT, FQ, or 93 and the applicable pediatric or HPSA modifier, when submitting claims that qualify for enhanced reimbursement.

Reference:

[Covered and Noncovered Telehealth Services-Topic 22737](#)

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