portland ipa
doctors making a difference

TEMPORARY VIRTUAL CARE GUIDELINES IN RESPONSE TO COVID-19

(As of 04/28/2020 - Updates made to this version are highlighted in red)

Payer	Virtual Care Policy Title(s)	Policy and Additional Information (Attachment and/or Link to Website)	Types of Visits Covered (Codes for Most Common Visit Types - See Policy for All Inclusive List of Codes)	Virtual E&M Reimbursement RVUs
Traditional Medicare	COVID-19 - Physicians and Practitioners - 508c Final (Updated 3/30/2020)	See Attached	**Medicare:** 99201-99205 -- POS 11, Modifier 95 99211-99215 -- POS 11, Modifier 95 99421-99423 -- POS 11, Modifier 95 99441-99443 -- POS 11, Modifier 95 99495-99496 -- POS 11, Modifier 95 G0438 & G0439 -- POS 11, Modifier 95 G2010 & G2012 -- POS 11, Modifier 95	**Medicare:** Non-Facility RVUs
	Medicare Telemedicine Health Care Provider Fact Sheet (Updated 3/17/2020)	https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet		
	Notification of Enforcement Discretion for Telehealth Remote Communications During COVID-19	https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html		
Aetna	Telemedicine and Direct Patient Contact *in effect until June 4, 2020* (Updated 4/21/2020)	See Attached	**Commercial:** 99201-99205 -- POS 02, Modifier GT or 95 99211-99215 -- POS 02, Modifier GT or 95 99421-99423 -- POS 02 99441-99443 -- POS 02 99495-99496 -- POS 02, Modifier GT or 95 G0438 & G0439 -- POS 02, Modifier GT or 95 G2010 & G2012 -- POS 02	**Commercial:** Non-Facility RVUs
	COVID-19 Provider FAQs-Telemedicine (Effective 3/6/2020)	See Attached	**Medicare:** 99201-99205 -- POS 11, Modifier 95 99211-99215 -- POS 11, Modifier 95 99421-99423 -- POS 11, Modifier 95 99441-99443 -- POS 11, Modifier 95 99495-99496 -- POS 11, Modifier 95 G0438 & G0439 -- POS 11, Modifier 95 G2010 & G2012 -- POS 11, Modifier 95	**Medicare:** Non-Facility RVUs
	COVID-19 Aetna Website-Supporting our Providers (Updated 4/24/2020)	https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html#acc_link_content_section_responsivegrid_copy__responsivegrid_accordion_11		

Insurance company Telehealth payment policies are frequently updated. The information contained in this document reflects information available on (as of date) located in the document header.

4/29/2020

portland ipa
doctors making a difference

TEMPORARY VIRTUAL CARE GUIDELINES IN RESPONSE TO COVID-19

(As of 04/28/2020 - Updates made to this version are highlighted in red)

Payer	Virtual Care Policy Title(s)	Policy and Additional Information (Attachment and/or Link to Website)	Types of Visits Covered (Codes for Most Common Visit Types - See Policy for All Inclusive List of Codes)	Virtual E&M Reimbursement RVUs
CareOregon	Physical Health Codes for Telemedicine Services in Response to COVID-19 (Updated 4/16/2020) CMS Medicare Rule (Updated 3/31/2020)	See Attached See Attached	**Medicaid:** 99201-99205* -- POS 11, Modifier 95 99211-99215* -- POS 11, Modifier 95 99381-99387* -- POS 11, Modifier 95 99391-99395* -- POS 11, Modifier 95 99421-99423 -- POS 02 99441-99443 -- POS 02 99495-99496* -- POS 11, Modifier 95 G0438* & G0439* -- POS 11, Modifier 95 G2012 -- POS 02 **Medicare:** 99201-99205* -- POS 11, Modifier 95 99211-99215* -- POS 11, Modifier 95 99421-99423 -- POS 11, Modifier 95 99441-99443 -- POS 11, Modifier 95 99495-99496* -- POS 11, Modifier 95 G0438* & G0439* -- POS 11, Modifier 95 G2010 & G2012 -- POS 11, Modifier 95 *Services can be provided by telephone, when appropriate, during the COVID-19 crisis	**Medicaid:** Non-Facility RVUs **Medicare:** Non-Facility RVUs
Cigna	Cigna's Response to COVID-19 *in effect until May 31, 2020* (Updated 4/23/2020)	https://static.cigna.com/assets/chcp/resourceLibrary/medicalResourcesList/medicalDoingBusinessWithCigna/medicalDbwcCOVID-19.html	**Commercial:** 99201-99205* -- POS 11, Modifier GQ, GT, or 95 99211-99215* -- POS 11, Modifier GQ, GT, or 95 99495-99496* -- POS 11, Modifier GQ, GT, or 95 G2012 -- POS 11, Modifier GQ, GT, or 95 *Services can be provided by telephone, when appropriate, during COVID-19 crisis	**Commercial:** Non-Facility RVUs

portland ipa
doctors making a difference

TEMPORARY VIRTUAL CARE GUIDELINES IN RESPONSE TO COVID-19

(As of 04/28/2020 - Updates made to this version are highlighted in red)

Payer	Virtual Care Policy Title(s)	Policy and Additional Information (Attachment and/or Link to Website)	Types of Visits Covered (Codes for Most Common Visit Types - See Policy for All Inclusive List of Codes)	Virtual E&M Reimbursement RVUs
Health Net	Telehealth Guidance (Updated 3/23/2020) Oregon Health Authority Guidelines (Updated 3/20/2020) Telemedicine Services During the COVID-19 Crisis *in effect until June 30, 2020*	See Attached See Attached https://www.healthnetoregon.com/for-providers/resources/Coronavirus/telemedicine.html	**Commercial:** 99201-99205 -- **POS 11, Modifier 95** 99211-99215 -- **POS 11, Modifier 95** **99421-99423 -- POS 11, Modifier 95** 99441-99443 -- **POS 11, Modifier 95** 99495-99496 -- **POS 11, Modifier 95** **G0438 & G0439 -- POS 11, Modifier 95** **G2010 & G2012 -- POS 11, Modifier 95** **Medicare:** 99201-99205 -- **POS 11, Modifier 95** 99211-99215 -- **POS 11, Modifier 95** 99421-99423 - **POS 11, Modifier 95** 99441-99443 -- **POS 11, Modifier 95** 99495-99496 -- **POS 11, Modifier 95** G0438 & G0439 -- **POS 11, Modifier 95** G2010 & G2012 -- **POS 11, Modifier 95**	**Commercial:** Non-Facility RVUs **Medicare:** Non-Facility RVUs
Humana	COVID-19 Telehealth (Updated 4/9/2020) Telehealth Services (Updated 12/2019)	See Attached See Attached	**Commercial & Medicare:** 99201-99205* -- POS 11, Modifier 95 99211-99215* -- POS 11, Modifier 95 99387* & 99397* -- POS 11, Modifier 95 99421-99423 -- POS 11, Modifier 95 99441-99443 -- POS 11, Modifier 95 99495-99496* -- POS 11, Modifier 95 G0438* & G0439* -- POS 11, Modifier 95 G2010 & G2012 -- POS 11, Modifier 95 *Services can be provided by telephone, when appropriate, during the COVID-19 crisis	**Commercial:** Non-Facility RVUs **Medicare:** Non-Facility RVUs

Insurance company Telehealth payment policies are frequently updated. The information contained in this document reflects information available on (as of date) located in the document header.

4/29/2020

portland ipa
doctors making a difference

TEMPORARY VIRTUAL CARE GUIDELINES IN RESPONSE TO COVID-19

(As of 04/28/2020 - Updates made to this version are highlighted in red)

Payer	Virtual Care Policy Title(s)	Policy and Additional Information (Attachment and/or Link to Website)	Types of Visits Covered (Codes for Most Common Visit Types - See Policy for All Inclusive List of Codes)	Virtual E&M Reimbursement RVUs
Moda	Telehealth and Telemedicine Expanded Services for COVID-19 *in effect until June 13, 2020* (Updated 4/27/2020) Medicaid Telemedicine and Telehealth Overview and Guidelines (Updated 3/26/2020)	See Attached See Attached	**Commercial:** 99201-99205 -- POS 02, Modifier 95 optional 99211-99215 -- POS 02, Modifier 95 optional 99381-99397 -- POS 02, Modifier 95 optional 99421-99423 -- POS 02, Modifier 95 optional 99441-99443 -- POS 02, Modifier 95 optional 99495-99496 -- POS 02, Modifier 95 optional G0438 & G0439 -- POS 02, Modifier 95 optional G2010 & G2012 -- POS 02, Modifier 95 optional **Medicaid:** 99201-99205* -- POS 02, Modifier GT or GQ 99211-99215* -- POS 02, Modifier GT or GQ 99421-99423 -- POS 02, Modifier GT or GQ 99441-99443 -- POS 02, Modifier GT or GQ 99495-99496* -- POS 02, Modifier GT or GQ G0438* & G0439* -- POS 02, Modifier GT or GQ G2012 -- POS 02, Modifier GT or GQ **Medicare:** 99201-99205 -- POS 02 99211-99215 -- POS 02 99421-99423 -- POS 02 99441-99443 -- POS 11, Modifier 95 99495-99496 -- POS 02 99295-99496 -- POS 02 G0438 & G0439 -- POS 11, Modifier 95 G2010 & G2012 -- POS 02 *Services can be provided by telephone, when appropriate, during COVID-19 crisis	**Commercial:** Non-Facility RVUs **Medicaid:** Non-Facility RVUs **Medicare:** Non-Facility RVUs
PacificSource	Telehealth Policy (Updated 3/2020) Medicare AWV Telehealth Component Guide PacificSource COVID-19 Provider FAQ (Updated 3/25/2020)	See Attached See Attached See Attached	**Commercial, Medicaid & Medicare:** 99201-99205* -- POS 02, Modifier GT 99211-99215* -- POS 02, Modifier GT 99421-99423 -- POS 02, Modifier GT 99441-99443 -- POS 02, Modifier GT 99495-99496* -- POS 02, Modifier GT G0438* & G0439* -- POS 02, Modifier GT G2010 & G2012 -- POS 02, Modifier GT *Services can be provided by telephone, when appropriate, during COVID-19 crisis	**Commercial:** Non-Facility RVUs **Medicaid:** Non-Facility RVUs **Medicare:** Non-Facility RVUs

Insurance company Telehealth payment policies are frequently updated. The information contained in this document reflects information available on (as of date) located in the document header.

4/29/2020

portland ipa
doctors making a difference

TEMPORARY VIRTUAL CARE GUIDELINES IN RESPONSE TO COVID-19

(As of 04/28/2020 - Updates made to this version are highlighted in red)

Payer	Virtual Care Policy Title(s)	Policy and Additional Information (Attachment and/or Link to Website)	Types of Visits Covered (Codes for Most Common Visit Types - See Policy for All Inclusive List of Codes)	Virtual E&M Reimbursement RVUs
Providence	Commercial Telehealth Services During COVID-19 Crisis Policy 67.0.B *in effect until June 30, 2020* (Updated 4/6/2020)	See Attached	**Commercial - DOS 3/6/2020 to 3/30/2020:** 99201-99205 -- POS 02 99211-99215 -- POS 02 99421-99423 -- POS 99 99441-99443 -- POS 99 99495-99496 -- POS 02 99381-99387 -- POS 11, Modifier 52 and 95 99391-99397 -- POS 11, Modifier 52 and 95 G0438 & G0439 -- POS 02 G2012 -- POS 02	**Commercial: (DOS 3/6/2020 - 3/30/2020)** Facility RVUs
	Medicare Telehealth Services During COVID-19 Crisis Policy 67.0.A *in effect until June 30, 2020* (Updated 4/6/2020)	See Attached	**Commercial - DOS 3/30/2020 to 5/31/2020:** 99201-99205 -- POS 11, Modifier GT or 95 99211-99215 -- POS 11, Modifier GT or 95 99421-99423 -- POS 99 99441-99443 -- POS 99 99381-99387 -- POS 11, Modifier 52 and 95 99391-99397 -- POS 11, Modifier 52 and 95 99495-99496 -- POS 11, Modifier GT or 95 G0438 & G0439 -- POS 11, Modifier 95 G2012 -- POS 11, Modifier 95 or POS 02	**Commercial: (DOS 3/30/2020 - 5/31/2020)** Non-Facility RVUs
	OHP Telehealth Services During COVID-19 Crisis Policy 67.0.C *in effect until June 30, 2020* (Updated 4/27/2020)	See Attached	**Medicaid & Medicare - DOS 3/1/2020 to 6/30/2020:** 99201-99205* -- POS 11, Modifier 95 99211-99215* -- POS 11, Modifier 95 99421-99423 - POS 99 99441-99443 -- POS 99 99381-99387* -- POS 11, Modifier 52 and 95 99391-99397* -- POS 11, Modifier 52 and 95 99495-99496* -- POS 11, Modifier 95 G0438 & G0439* -- POS 11, Modifier 95 G2012 -- POS 11, Modifier 95 *MEDICAID ONLY- On or after DOS 4/17/2020- Services can be provided by telephone, when appropriate, during the COVID-19 crisis	**Medicaid (DOS 3/1/2020 - 6/30/2020)** Non-Facility RVUs **Medicare: (DOS 3/1/2020 - 6/30/2020)** Non-Facility RVUs
	Online Digital E&M Services Policy 53.0 (Updated 3/20/2020)	See Attached		
	Telephone Services Policy 92.0 *in effect until June 30, 2020* (Updated 3/6/2020)	See Attached		

Insurance company Telehealth payment policies are frequently updated. The information contained in this document reflects information available on (as of date) located in the document header.

4/29/2020

portland ipa
doctors making a difference

TEMPORARY VIRTUAL CARE GUIDELINES IN RESPONSE TO COVID-19

(As of 04/28/2020 - Updates made to this version are highlighted in red)

Payer	Virtual Care Policy Title(s)	Policy and Additional Information (Attachment and/or Link to Website)	Types of Visits Covered (Codes for Most Common Visit Types - See Policy for All Inclusive List of Codes)	Virtual E&M Reimbursement RVUs
Regence	Coronavirus (COVID-19) (Updated 4/24/2020)	https://www.regence.com/provider/library/whats-new/covid-19#temporary-updates-to-telehealth	**Commercial & Medicare:** 99201-99203 -- POS 11, Modifier 95 99212-99214 -- POS 11, Modifier 95 99421-99423 -- POS 11, Modifier 95 99441-99443 -- POS 11, Modifier 95 99495-99496 -- POS 11, Modifier 95 G2010 -- POS 11, Modifier GQ and 95 G2012 -- POS 11, Modifier GT and 95 G0438 & G0439 -- POS 11, Modifier 95	**Commercial:** Non-Facility RVUs **Medicare:** Non-Facility RVUs
United Healthcare	United Telehealth and Telemedicine Policy (Updated 3/6/2020) COVID-19 Telehealth Services *in effect until June 18, 2020* (Updated 4/3/2020) COVID-19 United Telehealth Services Website (Updated 4/14/2020)	See Attached See Attached https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19/covid19-telehealth-services.html	**Commercial, Medicaid & Medicare:** 99201-99205* -- POS 11, Modifier 95 99211-99215* -- POS 11, Modifier 95 99421-99423 -- POS 11 99495-99496* -- POS 11, Modifier 95, GT or GQ G2010 & G2012 -- POS 11 G0438 & G0439 -- POS 11, Modifier GT or GQ *Services can be provided by telephone, when appropriate, during the COVID-19 crisis	**Commercial:** Non-Facility RVUs **Medicaid:** Non-Facility RVUs **Medicare:** Non-Facility RVUs

Insurance company Telehealth payment policies are frequently updated. The information contained in this document reflects information available on (as of date) located in the document header.

4/29/2020

Table of Contents

Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19

The Trump Administration is issuing an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. Made possible by President Trump's recent emergency declaration and emergency rule making, these temporary changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration. The goals of these actions are to 1) to ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients through temporary expansion sites (also known as CMS Hospital Without Walls); 2) remove barriers for physicians, nurses, and other clinicians to be readily hired from the community or from other states so the healthcare system can rapidly expands its workforce; 3) increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home; 4) expand in-place testing to allow for more testing at home or in community based settings; and 5) put Patients Over Paperwork to give temporary relief from many paperwork, reporting and audit requirements so providers, health care facilities, Medicare Advantage and Part D plans, and States can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

Medicare Telehealth

Clinicians can now provide more services to beneficiaries via telehealth so that clinicians can take care of their patients while mitigating the risk of the spread of the virus. Under the public health emergency, all beneficiaries across the country can receive Medicare telehealth and other communications technology-based services wherever they are located. Clinicians can provide these services to new or established patients. In addition, providers can waive Medicare copayments for these telehealth services for beneficiaries in Original Medicare.

To enable services to continue while lowering exposure risk, clinicians can now provide the following additional services by telehealth:

- Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
- Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217- 99220; CPT codes 99224- 99226; CPT codes 99234- 99236)
- Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238- 99239)
- Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316)
- Critical Care Services (CPT codes 99291-99292)
- Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327- 99328; CPT codes 99334-99337)
- Home Visits, New and Established Patient, All levels (CPT codes 99341- 99345; CPT codes 99347- 99350)
- Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT codes 99468- 99473; CPT codes 99475- 99476)

- Initial and Continuing Intensive Care Services (CPT code 99477- 994780)
- Care Planning for Patients with Cognitive Impairment (CPT code 99483)
- Psychological and Neuropsychological Testing (CPT codes 96130- 96133; CPT codes 96136- 96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161- 97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)
- Radiation Treatment Management Services (CPT codes 77427)
- Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services can be paid for as Medicare telehealth services.

A complete list of all Medicare telehealth services can be found here:
https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Virtual Check-Ins & E-Visits

- Additionally, clinicians can provide virtual check-in services (HCPCS codes G2010, G2012) to both new and established patients. Virtual check-in services were previously limited to established patients.
- Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits. (HCPCS codes G2061-G2063).
- A broad range of clinicians, including physicians, can now provide certain services by telephone to their patients (CPT codes 98966 -98968; 99441-99443)

Remote Patient Monitoring

- Clinicians can provide remote patient monitoring services to both new and established patients. These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry. (CPT codes 99091, 99457-99458, 99473-99474, 99493-99494)

Removal of Frequency Limitations on Medicare Telehealth

To better serve the patient population that would otherwise not have access to clinically appropriate in-person treatment, the following services no longer have limitations on the number of times they can be provided by Medicare telehealth:

- A subsequent inpatient visit can be furnished via Medicare 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 Medicare telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310)
- Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation (CPT codes G0508-G0509).

Other Medicare Telehealth and Remote Patient Care

- For Medicare patients with End Stage Renal Disease (ESRD), clinicians no longer must have one "hands on" visit per month for the current required clinical examination of the vascular access site.
- For Medicare patients with ESRD, we are exercising enforcement discretion on the following requirement so that clinicians can provide this service via telehealth: individuals must receive a face-to-face visit, without the use of telehealth, at least monthly in the case of the initial 3 months of home dialysis and at least once every 3 consecutive months after the initial 3 months.
- To the extent that a National Coverage Determination (NCD) or Local Coverage Determination (LCD) would otherwise require a face-to-face visit for evaluations and assessments, clinicians would not have to meet those requirements during the public health emergency.
- Beneficiary consent should not interfere with the provision of telehealth services. Annual consent may be obtained at the same time, and not necessarily before, the time that services are furnished.
- Physician visits: CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.

Workforce

- *Medicare Physician Supervision requirements:* For services requiring direct supervision by the physician or other practitioner, that physician supervision can be provided virtually using real-time audio/video technology.
- *Medicare Physician Supervision and Auxiliary Personnel:* The physician can enter into a contractual arrangement that meets the definition of auxiliary personnel at 42 CFR 410.26, including with staff of another provider/supplier type, such as a home health agency (defined under § 1861(o) of the Act) or a qualified home infusion therapy supplier (defined under § 1861(iii)(3)(D)), or entities that furnish ambulance services, that can provide the staff and technology necessary to provide care that would ordinarily be provided incident to a physicians' service (including services that are allowed to be performed via telehealth). In such instances, the provider/supplier would seek payment for any services provided by auxiliary personnel from the billing practitioner and would not submit claims to Medicare for such services.
- *Medicare Physician Supervision requirements:* Direct physician supervision is no longer required for non-surgical extended duration therapeutic services provided in hospital outpatient departments and critical access hospitals. Instead, a physician can provide a general level of supervision for these services so that a physician is no longer required to be immediately available in the office suite.
- *Physician Services:* CMS is waiving 482.12(c)(1-2) and (4), which requires that Medicare patients in the hospital be under the care of a physician. This allows hospitals to use other practitioners, such as physician's assistant and nurse practitioners, to the fullest extent possible. This waiver should be implemented in accordance with a state's emergency preparedness or pandemic plan.
- *National coverage determinations (NCDs) and Local Coverage Determinations (LCDs):* To the extent NCDs and LCDs require a specific practitioner type or physician specialty to furnish or supervise a service, during this public health emergency, the Chief Medical Officer or equivalent of a hospital or facility will have the authority to make those staffing decisions.

- *Practitioner Locations:* Temporarily waive Medicare and Medicaid's requirements that physicians and non-physician practitioners be licensed in the state where they are providing services. State requirements will still apply. CMS waives the Medicare requirement that a physician or non-physician practitioner must be licensed in the State in which s/he is practicing for individuals for whom the following four conditions are met: 1) must be enrolled as such in the Medicare program, 2) must possess a valid license to practice in the State which relates to his or her Medicare enrollment, 3) is furnishing services – whether in person or via telehealth – in a State in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity, and 4) is not affirmatively excluded from practice in the State or any other State that is part of the 1135 emergency area. A physician or non-physician practitioner may seek an 1135-based licensure waiver from CMS by contacting the provider enrollment hotline for the Medicare Administrative Contractor that services their geographic area. This waiver does not have the effect of waiving State or local licensure requirements or any requirement specified by the State or a local government as a condition for waiving its licensure requirements
- *Provider Enrollment:* CMS has established toll-free hotlines for physicians, non-physician practitioners and Part A certified providers and suppliers establishing isolation facilities to enroll and receive temporary Medicare billing privileges. CMS is providing the following flexibilities for provider enrollment:
  - Waive certain screening requirements.
  - Postpone all revalidation actions.
  - Allow licensed physicians and other practitioners to bill Medicare for services provided outside of their state of enrollment.
  - Expedite any pending or new applications from providers.
  - Allow practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from your currently enrolled location.
  - Allow opted-out practitioners to terminate their opt-out status early and enroll in Medicare to provide care to more patients.

Patients Over Paperwork

- *"Stark Law" Waivers:* The physician self-referral law (also known as the "Stark Law") prohibits a physician from making referrals for certain healthcare services payable by Medicare if the physician (or an immediate family member) has a financial relationship with the entity performing the service. There are statutory and regulatory exceptions, but in short, a physician cannot refer a patient to any entity with which he or she has a financial relationship. CMS will permit certain referrals and the submission of related claims that would otherwise violate the Stark Law. They include:
  - Hospitals and other health care providers can pay above or below fair market value to rent equipment or receive services from physicians (or vice versa). For example, a physician practice may be willing to rent or sell needed equipment to a hospital at a price that is below what the practice could charge another party. Or, a hospital may provide space on hospital grounds at no charge to a physician who is willing to treat patients who seek care at the hospital but are not appropriate for emergency department or inpatient care.
  - Health care providers can support each other financially to ensure continuity of health care operations. For example, a physician owner of a hospital may make a personal loan to the hospital without charging interest at a fair market rate so that the hospital can make payroll or pay its vendors.

- Hospitals can provide benefits to their medical staffs, such as multiple daily meals, laundry service to launder soiled personal clothing, or child care services while the physicians are at the hospital and engaging in activities that benefit the hospital and its patients.
- Allowing the provision of certain items and services that are solely related to COVID-19 Purposes (as defined in the waivers), even when the provision of the items or services would exceed the annual non-monetary compensation cap. For example, a home health agency may provide continuing medical education to physicians in the community on the latest care protocols for homebound patients with COVID-19, or a hospital may provide isolation shelter or meals to the family of a physician who was exposed to the novel coronavirus while working in the hospital's emergency department.
- Physician-owned hospitals can temporarily increase the number of their licensed beds, operating rooms, and procedure rooms, even though such expansion would otherwise be prohibited under the Stark Law. For example, a physician-owned hospital may temporarily convert observation beds to inpatient beds to accommodate patient surge during the COVID-19 pandemic in the United States.
- Loosen some of the restrictions when a group practice can furnish medically necessary designated health services (DHS) in a patient's home. For example, any physician in the group may order medically necessary DHS that is furnished to a patient by a technician or nurse in the patient's home contemporaneously with a physician service that is furnished via telehealth by the physician who ordered the DHS.
- Group practices can furnish medically necessary MRIs, CT scans or clinical laboratory services from locations like mobile vans in parking lots that the group practice rents on a part-time basis.

- *National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) on Respiratory Related Devices, Oxygen and Oxygen Equipment, Home Infusion Pumps and Home Anticoagulation Therapy:* Clinicians now have maximum flexibility in determining patient needs for respiratory related devices and equipment and the flexibility for more patients to manage their treatments at the home. The current NCDs and LCDs that restrict coverage of these devices and services to patients with certain clinical characteristics do not apply during the public health emergency. For example, Medicare will cover non-invasive ventilators, respiratory assist devices and continuous positive airway pressure devices based on the clinician's assessment of the patient.
- *Signature Requirements:* CMS is waiving signature and proof of delivery requirements for Part B drugs and Durable Medical Equipment when a signature cannot be obtained because of the inability to collect signatures. Suppliers should document in the medical record the appropriate date of delivery and that a signature was not able to be obtained because of COVID-19.
- *Changes to MIPS:* We are making two updates to the Merit-based Incentive Payment System (MIPS) in the Quality Payment Program. We are modifying the MIPS Extreme and Uncontrollable Circumstances policy to allow clinicians who have been adversely affected by the COVID-19 public health emergency to submit an application and request reweighting of the MIPS performance categories for the 2019 performance year. This is an important change that allows clinicians who have been impacted by the COVID-19 outbreak and may be unable to submit their MIPS data during the current submission period, to request reweighting and potentially receive a neutral MIPS payment adjustment for the 2021 payment year. Additionally, we are adding one new Improvement Activity for the CY 2020 performance year that, if selected, would provide high-weighted credit for clinicians within the MIPS Improvement Activities performance category. Clinicians will receive credit for this Improvement Activity by participating in a clinical trial utilizing a drug or biological product to treat a patient with COVID-19 and then reporting their findings to a clinical data repository or clinical data registry. This would help contribute to a clinicians overall MIPS final score, while providing important data to help treat patients and address the current COVID-19 pandemic.

- *Accelerated/Advance Payments:* In order to increase cash flow to providers impacted by COVID-19, CMS has expanded our current Accelerated and Advance Payment Program. An accelerated/advance payment is a payment intended to provide necessary funds when there is a disruption in claims submission and/or claims processing. CMS is authorized to provide accelerated or advance payments during the period of the public health emergency to any Medicare provider/supplier who submits a request to the appropriate Medicare Administrative Contractor (MAC) and meets the required qualifications. Each MAC will work to review requests and issue payments within seven calendar days of receiving the request. Traditionally repayment of these advance/accelerated payments begins at 90 days, however for the purposes of the COVID-19 pandemic, CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment. Providers can get more information on this process here: www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf.

Medicare appeals in Fee for Service, Medicare Advantage (MA) and Part D

- CMS is allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractor (QICs) in the FFS program 42 CFR 405.942 and 42 CFR 405.962 and MA and Part D plans, as well as the Part C and Part D Independent Review Entity (IREs), 42 CFR 562, 42 CFR 423.562, 42 CFR 422.582 and 42 CFR 423.582 to allow extensions to file an appeal;
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405. 950 and 42 CFR 405.966 and the Part C and Part D IREs to waive requirements for timeliness for requests for additional information to adjudicate appeals; MA plans may extend the timeframe to adjudicate organization determinations and reconsiderations for medical items and services (but not Part B drugs) by up to 14 calendar days if: the enrollee requests the extension; the extension is justified and in the enrollee's interest due to the need for additional medical evidence from a noncontract provider that may change an MA organization's decision to deny an item or service; or, the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest 42 CFR § 422.568(b)(1)(i), § 422.572(b)(1) and § 422.590(f)(1);
- CMS is allowing MACs and QICs in the FFS program 42 C.F.R 405.910 and MA and Part D plans, as well as the Part C and Part D IREs to process an appeal even with incomplete Appointment of Representation forms 42 CFR § 422.561, 42 CFR § 423.560. However, any communications will only be sent to the beneficiary;
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405. 950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs to process requests for appeal that don't meet the required elements using information that is available 42 CFR § 422.562, 42 CFR § 423.562.
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405. 950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs, 42 CFR 422.562, 42 CFR 423.562 to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.

Additional Guidance

- The Interim Final Rule and waivers can be found at: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers.
- CMS has released guidance to providers related to relaxed reporting requirements for quality reporting programs at https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting.

Telemedicine and Direct Patient Contact

Policy Type:	Revised
Applies to:	• All Medical Products (including Commercial & Medicare) • All participating and nonparticipating physicians, facilities, and other qualified health care professionals
Policy Implementation:	Date of Service
Policy Revision Date:	Click Here
Last Review:	December, 2019
Next Review	December, 2020

Our payment policies ensure that we pay providers based on the code that most accurately describes the procedure performed. We include CPT/HCPCS, CMS or other coding methodologies in our payment policies when appropriate. Unless noted otherwise, payment policies apply to all professionals who deliver health care services. When developing payment policies, we consider coding methodology, industry-standard payment logic, regulatory requirements, benefits design and other factors.

Table of Contents

Overview

This policy addresses our guidelines regarding payment for telehealth, telemedicine, direct patient contact, care plan oversight, concierge medicine, and missed appointments.

Refer to Expanded Claim Edits for additional coding and reimbursement policies that may apply separately from the policy detailed below.

Definitions/Glossary

Term	Definition
Asynchronous Telecommunication	Telecommunication systems that store medical information such as diagnostic images or video and forward it from one site to another for the physician or health care practitioner to view in the future at a site different from the patient. This is a non-interactive telecommunication because the physician or health care practitioner views the medical information without the patient being present.
Synchronous Interactive Audio and Video Telecommunication, Interactive Audio and Visual Transmissions and Audio-Visual Communication Technology	Real-time interactive video teleconferencing that involves communication between the patient and a distant physician or health care practitioner who is performing the medical service. The physician or health care practitioner sees the patient throughout the communication, so that two-way communication (sight and sound) can take place.

Telehealth	Telehealth is broader than telemedicine and takes in all health care services that are provided via live, interactive audio and visual transmissions of a physician-patient encounter. These health care services include non-clinical services, such as provider training, administrative meetings and continuing medical education; in addition to clinical services. Telehealth may be provided via real-time telecommunications or transmitted by store-and-forward technology.
Telemedicine	Telemedicine services involve the delivery of clinical medicine via real-time telecommunications such as telephone, the internet, or other communications networks or devices that do not involve in person direct patient contact.

Payment Guidelines

Telemedicine for Commercial Plans	
Two-way, Synchronous (i.e. real-time) Audiovisual Interactive Medical Service **Modifiers GT, 95**	We pay for two-way, synchronous (i.e. real-time) audiovisual interactive medical services between the patient and the provider. We consider services recognized by The Centers for Medicare and Medicaid Services (CMS) and appended with modifier GT, as well as services recognized by the AMA included in Appendix P of the CPT® Codebook and appended with modifier 95. A list of eligible CPT/HCPCS codes is available here. When a provider reports modifier GT or 95, it certifies the patient received services via an audiovisual telecommunications system. • GT: Telehealth service rendered via interactive audio and video telecommunications system • 95: Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system Click here for more information about our telemedicine visit co-pay liberalization in response to the Coronavirus COVID-19 outbreak.

Asynchronous Telecommunication **Modifier GQ**	We don't pay for asynchronous telemedicine services. • These services are considered incidental to the overall episode of care for the member. • When providers report modifier GQ it certifies the patient received services via an asynchronous method. Click here for more information about our telemedicine visit co-pay liberalization in response to the Coronavirus COVID-19 outbreak.
Tele-Stroke Services **Modifier G0**	We pay for tele-stroke services when appended with modifier G0. • G0: Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke

Telemedicine for Medicare Advantage Plans	
Telemedicine for Medicare Members/Plans	Medicare Advantage members may be eligible for telemedicine services in accordance with CMS regulations. We follow CMS policy. www.cms.gov

Direct Patient Contact	
Direct Patient Contact	Other than two-way synchronous (i.e. real time) audio visual interactive medical services, and tele-stroke services, as above, we don't pay for medical services that don't include direct in-person patient contact. Payment for these services is considered incidental to the overall episode of care for the member. One example of time spent without direct patient contact is physician standby services. We consider services payable only when provided in-person face-to-face.

Telehealth Transmission Fees	
Telehealth Transmission Fees **HCPCs codes Q3014 and T1014**	Charges for telehealth services or transmission fees aren't eligible for payment. These services are incidental to the charges associated with the evaluation and management of the patient.

Care Plan Oversight	
Care Plan Oversight	Care plan oversight is not eligible for payment. Care plan oversight is billed for physician supervision of patients under the care of home health agencies, hospice or nursing facilities. It includes the time spent

	reviewing reports on patient status and care conferences. We do not pay for time without direct patient contact. *Note:* Care plan oversight is eligible for payment on case management exceptions authorized by Patient Management.

Concierge Medicine or Boutique Medicine	
Concierge Medicine or Boutique Medicine	Concierge medicine, also called boutique medicine is a fee charged for services a patient receives outside of direct patient contact. These services are considered above and beyond the usual, such as scheduling preference or return phone calls from the provider. These services do not represent treatment of disease or injury. They are standard administrative services that are included in the evaluation & management service, we don't allow separate payment. No specific code exists for these services. Services may be billed with a written description, such as "Concierge Services" or "Administrative Services."

Missed Appointments	
Missed Appointments	We don't cover missed appointments because no direct or indirect medical care was rendered to the patient. Charges due to a missed appointment are the responsibility of the member.

List of Eligible CPT/HCPCs for two-way, synchronous

Eligible Code Description	Eligible CPT/HCPCS
Psychiatric diagnostic interview examination	90791, 90792
Individual psychotherapy	90832, 90833, 90834, 90836, 90837, 90838
Psychotherapy for crisis; first 60 minutes; or each additional 30 minutes	90839, 90840
Psychoanalysis	90845
Family or group psychotherapy	90846, 90847, 90853
Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	90863
End-Stage renal disease (ESRD) related services	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964,

	90965, 90966, 90967, 90968, 90969, 90970
Remote imaging for detection of retinal disease	92227
External mobile cardiovascular telemetry with ECG recording	93228, 93229
External patient and when performed auto activated ECG rhythm derived event recording	93268, 93270, 93271, 93272
Medical genetics and genetic counseling services	96040
Neurobehavioral status examination	96116
Administration of patient-focused health risk assessment instrument with scoring and documentation or for the benefit of the patient, per standardized instrument	96160, 96161
Individual and group medical nutrition therapy	97802, 97803, 97804; G0270
Education and training for patient self-management by a qualified, non-physician health care professional	98960, 98961, 98962
Office or other outpatient visits or consults	99201 – 99205, 99211 – 99215, 99241 – 99245
Subsequent hospital care services, with the limitation of 1 Telehealth visit every 3 days	99231, 99232, 99233
Inpatient consultation for a new or established patient	99251 - 99255
Subsequent nursing facility care services, with the limitation of 1 Telehealth visit every 30 days	99307, 99308, 99309, 99310
Prolonged service, inpatient or office	99354, 99355, 99356, 99357
Smoking and tobacco use cessation counseling visit	99406, 99407, G0436, G0437
Alcohol and substance screen and intervention	99408, 99409
Transitional care management services	99495, 99496
Advanced care planning	99497, 99498
Interactive complexity	90785
Individual and group diabetes self-management training services	G0108, G0109
Counseling visit to discuss need for lung cancer screening using low dose CT scan	G0296
Alcohol and/or substance abuse structured assessment	G0396, G0397
Follow-up inpatient Telehealth consultations furnished to beneficiaries in hospitals or SNFs	G0406*, G0407*, G0408*
Telehealth consultations, emergency department or initial inpatient	G0425*, G0426*, G0427*
Annual Wellness Visit, includes a personalized prevention plan of service	G0438, G0439
Alcohol misuse screening, counseling	G0442, G0443
Annual depression screening	G0444

High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior	G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease	G0446
Face-to-face behavioral counseling for obesity	G0447
Telehealth Pharmacologic Management	G0459
Comprehensive assessment of and care planning for patients requiring chronic care management services	G0506
Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient via telehealth; subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	G0508*, G0509*
Prolonged preventive service	G0513, G0514
Opioid treatment	G2086, G2087, G2088

*Modifier GT, 95 not required

Questions and Answers

Updated April 21, 2020

Commercial:

For the next 90 days, until June 4, 2020, Aetna will waive member cost sharing for any covered telemedicine visit - regardless of diagnosis. Aetna members should use telemedicine as their first line of defense in order to limit potential exposure in physician offices. For all Aetna plans offering Teladoc® coverage, cost sharing will be waived for all Teladoc virtual visits. Cost sharing will also be waived for covered real-time virtual visits* offered by in-network providers (live video-conferencing and telephone-only telemedicine services) for all Commercial plan designs. Members may use telemedicine services for any reason, not just COVID-19 diagnosis. Self-insured plan sponsors will be able to opt-out of this program at their discretion.

Medicare:

Until further notice, Aetna will offer zero co-pay for covered telemedicine visits for any diagnosis to all Individual and Group Medicare Advantage members. Aetna Medicare Advantage members should use telemedicine as their first line of defense to limit potential exposure in physician offices. Cost sharing will be waived for all Teladoc® virtual visits. Cost sharing will also be waived for covered real-time virtual visits offered by in-network providers (live video conferencing or telephone-only telemedicine services). Medicare Advantage members may use telemedicine for any reason, not just COVID-19 diagnosis.

*In addition to the covered Two-way, Synchronous (i.e. real-time) Audiovisual Interactive Medical Services – Modifier GT/95, the codes below will allow and waive cost share during the 90-day period.

The following codes require an audiovisual connection:

Eligible Code Description	Eligible CPT/HCPCS

Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes	G0410 GT or 95
Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes; 11 – 20 minutes; or 21 or more minutes **These services may also be performed through HIPAA compliant secure platforms, such as electronic health record portals, secure email, or other digital applications, which allow digital communication with the physician or other QHP.*	G2061*, G2062*, G2063*
Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	H0015 GT or 95
Mental health partial hospitalization, treatment, less than 24 hours.	H0035 GT or 95
Behavioral health day treatment, per hour.	H2012 GT or 95
Alcohol and/or other drug treatment program, per diem	H2036 GT or 95
Intensive outpatient psychiatric services, per diem	S9480 GT or 95
Radiation treatment management, 5 treatments	77427 GT or 95
End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month.	90953 GT or 95
End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month.	90959 GT or 95
End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month.	90962 GT or 95
Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	92065 GT or 95
Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	92507 GT or 95
Evaluation of speech fluency (e.g., stuttering, cluttering).	92521 GT or 95
Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria).	92522 GT or 95
Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language).	92523 GT or 95
Behavioral and qualitative analysis of voice and resonance.	92524 GT or 95
Treatment of swallowing dysfunction and/or oral function for feeding	92526 GT or 95

Therapeutic service(s) for the use of non-speech-generating device, including programming and modification	92606 GT or 95
Therapeutic services for the use of speech-generating device, including programming and modification	92609 GT or 95
Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure).	96121 GT or 95
Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour; + each additional hour (List separately in addition to code for primary procedure)	96130, 96131 GT or 95
Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour; + each additional hour (List separately in addition to code for primary procedure)	96132, 96133 GT or 95
Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes. + each additional 30 minutes (List separately in addition to code for primary procedure).	96136, 96137 GT or 95
Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes. + Each additional 30 minutes (List separately in addition to code for primary procedure)	96138, 96139 GT or 95
Health behavior intervention, individual, face-to-face; initial 30 minutes. + each additional 15 minutes (List separately in addition to code for primary service).	96158, 96159 GT or 95
Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes. + each additional 15 minutes (List separately in addition to code for primary service).	96164, 96165 GT or 95
Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes. + each additional 15 minutes (List separately in addition to code for primary service).	96167, 96168 GT or 95
Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes + each additional 15 minutes (List separately in addition to code for primary service).	96170, 96171 GT or 95
Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.	97110 GT or 95

Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.	97112 GT or 95
Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing).	97116 GT or 95
Behavior identification assessment, administered by a QHP, face to face with patient and/or guardians administering assessments and discussing findings and recommendations. Includes non-face-to-face analyzing of past data, scoring/interpreting the assessment, and preparing the report/treatment plan.	97151 GT or 95
Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes.	97153 GT or 95
Adaptive behavior treatment with protocol modification, administered by QHP, which may include simultaneous direction of a technician working face to face with a patient.	97155 GT or 95
Family adaptive behavior treatment guidance administered by QHP, with parent/guardian	97156 GT or 95
Multiple-family group adaptive behavior treatment guidance, administered by QHP, with multiple sets of parents/guardians	97157 GT or 95
Physical therapy evaluation: low, moderate, or high complexity	97161, 97162, 97163 GT or 95
Re-evaluation of physical therapy established plan of care	97164 GT or 95
Occupational therapy evaluation, low, moderate, or high complexity	97165, 97166, 97167 GT or 95
Re-evaluation of occupational therapy established plan of care	97168 GT or 95
Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes.	97535 GT or 95
Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes.	97755 GT or 95
Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes.	97760 GT or 95
Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes.	97761 GT or 95
Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10; 11-20; or 21 or more minutes.	98970*, 98971*, 98972*
Observation care discharge day management	99217 GT or 95

Initial observation care, per day, for the evaluation and management of a patient	99218, 99219, 99220 GT or 95
Initial hospital care, per day, for the evaluation and management of a patient,	99221, 99222, 99223 GT or 95
Subsequent observation care, per day, for the evaluation and management of a patient	99224, 99225, 99226 GT or 95
Subsequent hospital care services *The limitation of 1 Telehealth visit every 3 days will be waived during the 90 day period.	99231, 99232, 99233 GT or 95
Observation or inpatient hospital care, for the evaluation and management of a patient	99234, 99235, 99236 GT or 95
Hospital discharge day management; 30 minutes or less; or more than 30 minutes	99238, 99239 GT or 95
Emergency department visit for the evaluation and management of a patient	99281, 99282, 99283, 99284, 99285 GT or 95
Critical care, evaluation and management of the critically ill or critically injured patient	99291, 99292 GT or 95
Initial nursing facility care, per day, for the evaluation and management of a patient	99304, 99305, 99306 GT or 95
Subsequent nursing facility care services *The limitation of 1 Telehealth visit every 30 days will be waived during the 90 day period	99307, 99308, 99309, 99310 GT or 95
Nursing facility discharge day management	99315, 99316 GT or 95
Domiciliary or rest home visit for the evaluation and management of a new or established patient	99327, 99328, 99334, 99335, 99336, 99337 GT or 95
Home visit for the evaluation and management of a new or established patient	99341, 99342, 99343; 99344, 99345, 99347, 99348, 99349, 99350 GT or 95
Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10; 11-20; or 21 or more minutes. **These services may also be performed through HIPAA compliant secure platforms, such as electronic health record portals, secure email, or other digital*	99421*, 99422*, 99423*

applications, which allow digital communication with the physician or other QHP.	
Initial or Subsequent inpatient neonatal critical care	99468, 99469 GT or 95
Initial or Subsequent inpatient pediatric critical care	99471, 99472, 99475, 99476 GT or 95
Initial hospital care, per day, for the evaluation and management of the neonate	99477 GT or 95
Subsequent intensive care, per day, for the evaluation and management of the recovering infant	99478, 99479, 99480 GT or 95
Assessment of and care planning for a patient with cognitive impairment	99483 GT or 95

*Modifier GT, 95 not required

The following codes require an audiovisual connection or telephone:

Eligible Code Description	Eligible CPT/HCPCS
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.	G2010*
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.	G2012*
Health behavior assessment or re-assessment (e.g., health-focused clinical interview, behavioral observations, clinical decision making)	96156*
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; 11-20; or 21-30 minutes of medical discussion.	98966*, 98967*, 98968*
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; 11-20; or 20-30 minutes of medical discussion.	99441*, 99442*, 99443*
Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes; 11-20 minutes; 21-30 minutes; or 31 minutes of more of medical consultative discussion and review	99446*, 99447*, 99448*, 99449*

Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time.	99451*
Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes.	99452*
Psychiatric diagnostic interview examination	90791, 90792 GT or 95
Individual psychotherapy	90832, 90833, 90834, 90836, 90837, 90838 GT or 95
Psychotherapy for crisis; first 60 minutes; or each additional 30 minutes	90839, 90840 GT or 95
Psychoanalysis	90845 GT or 95
Family or group psychotherapy	90846, 90847, 90853 GT or 95
Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	90863 GT or 95
Neurobehavioral status examination	96116 GT or 95

*Modifier GT, 95 not required

For more information, see our press release.

COVID-19 Updates - Commercial

- 04/21/20 Update: Added 92065, 92526, 92606, and 92609 to coverage. Added clarification for 99421-99423 and G2061-G2063.
- 04/09/20 Update: Added G0410 to coverage

Additional References

N/A

Policy Revision Date

- Effective 03/06/20: Added coverage details for the temporary COVID-19 liberalization in the Questions and Answers section.
- Effective 01/01/20: Added coverage details for Commercial Plans and Medicare Advantage Plans.
- 08/30/18 Update: Removed "Telemedicine for Consumer Business/Aetna Leap℠ Plans"

section. Plans are no longer active as of 01/01/2018.

- 07/05/18 Update: Removed Medicare from the "Applies to" section. Medicare Advantage follows CMS guidelines for telemedicine as of January, 2012.
- Effective 03/08/17: Existing stand-alone policy "Concierge Medicine or Boutique Medicine" added to Telemedicine and Direct Patient Contact Policy. No change in policy.
- Effective 01/26/17: Added Modifier 95.
- Effective 01/01/17: Added Telemedicine Policy for Consumer Business/Aetna Leap℠ Plans.
- Effective 05/01/12: Exception removed from Direct Patient Contact Policy to allow payment when precertified.
- Effective 07/23/09: Charges for coordination of care under the "Patient-Centered Medical Home" model are eligible for payment.
- Effective 05/22/07: Charges for an online medical evaluation (e.g., eHealth visit) may be eligible for payment.

COVID-19 provider FAQs
New FAQs on telemedicine

Telemedicine – Policy Liberalization Effective March 6,2020 through June 4, 2020

Is Aetna waiving member cost share for telemedicine?

- Yes. Effective March 6, 2020, Aetna started offering $0 copays and cost sharing for covered telemedicine visits for any reason for 90 days. This includes all video and telephone visits through the Aetna®-covered Teladoc® telemedicine offerings, as well as in-network providers delivering synchronous virtual care (live video conferencing) for commercial and Medicare. Note: Commercial self-insured plan sponsors can opt out of this program at their discretion.

Does Aetna's telemedicine policy apply to provider types such as Physical Therapy, Occupational Therapy, Speech Therapy, etc.?

- Aetna's telemedicine policy is not limited by provider type. Providers must be licensed to render the service and eligible to bill specific codes for the service to be covered. Codes include:
    - 98970: Qualified non-physician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
    - 98971: Qualified non-physician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11–20 minutes
    - 98972: Qualified non-physician health care professional 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
    - G2061: Qualified non-physician health care professional online assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes

- G2062: Qualified non-physician health care professional online assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11–20 minutes
- G2063: Qualified non-physician qualified health care professional assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
- CPT 98966: Telephone assessment and management service provided by a qualified non-physician 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
- CPT 98967: Telephone assessment and management service provided by a qualified non-physician 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; 11–20 minutes of medical discussion
- CPT 98968: Telephone assessment and management service provided by a qualified non-physician 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; 21–30 minutes of medical discussion
- Check our updated telemedicine policy, available via our provider portal Availity®, to confirm the specific services/codes that are covered.

Will Aetna reimburse for billed telehealth services even if the provider is not participating in Teladoc®?

- Yes. Effective January 1, 2020, Aetna has expanded its telemedicine policy to allow billing of certain telemedicine CPT codes by any in-network provider.
- Use of Teladoc is not required; in-network providers may directly provide care from any location. However, they must abide by our telemedicine policy and follow HIPAA regulations — including the use of a HIPAA-compliant platform — in order to be reimbursed. Aetna does not cover services outsourced to other telemedicine vendors.

- Out-of-network providers may render services but will be reimbursed according to the member's out-of-network benefits coverage. The $0 copay is not applicable to out-of-network providers.

Is Aetna expanding virtual care guidelines to include physicians working from their home (telehealth and telemedicine)?

- Yes. Physicians may provide care from any location if they abide by our telemedicine policy and follow HIPAA regulations, including the use of a HIPAA-compliant platform. Also, some telephone services are now covered; codes for those services are in our updated telemedicine policy, available on our provider portal Availity.

Can we continue to bill Aetna through already-established provider enrollment?

- Yes. Currently we do not anticipate any changes in billing requirements.

Is Aetna requiring the use of Teladoc?

- No. In-network providers may directly provide care from any location if they abide by our telemedicine policy and follow HIPAA regulations, including the use of a HIPAA-compliant platform. Aetna does not cover services outsourced to other telemedicine vendors.

Is there rate parity for a face-to-face visit vs. a telemedicine visit?

- Yes. Effective January 1, 2020, Aetna introduced an updated payment policy. It allows providers in all 50 states to be reimbursed for telemedicine services (interactive audiovisual), as if the service was rendered face-to-face. In or out of network benefit levels will apply, depending on the provider's network participation status.
- Asynchronous telemedicine services such as email, fax, text and store and forward will not be covered unless state-mandated or included in a custom plan sponsor exception.

Can telemedicine codes be billed via HCFA?

- Yes. Providers should bill on HCFA 1500.

Will telehealth/telemedicine services pay as a bill above to capitation?

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

Will Aetna follow CMS's lead and allow providers to be reimbursed for telemedicine for Medicare Advantage members?

- Yes. In response to COVID-19, we have expanded telemedicine benefits for our Medicare Advantage members.

Can behavioral health providers be reimbursed for telemedicine services?

- Yes. Our Aetna's updated telemedicine policy, available via our provider portal Availity, is not limited by specialty. So, if the provider is licensed to render the service, and provides/bills the service according to policy, the service will be covered.
- Behavioral health codes covered for counseling — televideo and audio:
    - 90791, 90792: Psychiatric diagnostic interview examination
    - 90832, 90833, 90834, 90836, 90837, 90838: Individual psychotherapy
    - 90839, 90840: Psychotherapy for crisis; first 60 minutes; or each additional 30 minutes
    - 90845: Psychoanalysis
    - 90846, 90847, 90853: Family or group psychotherapy
    - 90863: Pharmacologic management, including prescription and review of medication when performed with psychotherapy services

Are providers (both behavioral health and primary care) required to see a member face-to-face before being able to provide telemedicine services?

- No. A prior face-to-face visit is not required for a provider to provide telemedicine services.

Is the state licensing requirement waived at this time for behavioral health and medical providers?

- Cross state-coverage is temporarily waived as long as the state has not restricted services.

Physical Health

Codes for telemedicine services in response to COVID-19

Updated April 16, 2020

In response to COVID-19, CareOregon is temporarily adjusting Telemedicine requirements per CMS and OHA guidance. It is imperative during this public health emergency that members avoid travel, when possible, to providers' offices, clinics, hospitals or other health care facilities, where they could risk their own or others' exposure to further illness. Accordingly, providers may deliver services to members via telephone or telemedicine, in any geographic area and from a variety of places, including members' homes. With this flexibility, CareOregon members can receive clinically appropriate services without coming into the clinic or office.

Operational definition of telemedicine: The use of telephonic or electronic communications of medical information from one site to another regarding a patient's health status, including but not limited to:

Patient-to-clinician services via:	Clinician-to-clinician consultations via:
• Telephone • Telehealth – synchronous audio and video • E-visits (online services)	• Telephone • Electronic communication (online services) • Asynchronous e-consults (online services)

Guidance for delivering services via telemedicine modalities

1. CareOregon can adjudicate all telemedicine claims that are properly submitted per temporary CMS and OHA guidelines.
    a. Providers can be reimbursed for services delivered to established and unestablished members.
    b. Providers will be reimbursed for services provided via telemedicine at the same rate as when such services are provided in-person.
2. Providers are responsible and accountable for appropriate use of CPT and HCPCS codes, diagnosis codes, modifiers and claim form completion that support the provided services.
3. Provider contracts do not need to be updated or amended to allow for reimbursement of telemedicine services.
4. Providers are encouraged to proactively make members aware of the availability of telemedicine visits, following similar processes and guidelines used for contacting members for regular visits. However, the member must request or consent to the visit delivered via telemedicine modality.

Modality: Two-way audio and video visit in real time (synchronous)

1. The services listed below can be provided either two-way audio and visual or by telephone, when appropriate, as medically or clinically appropriate during the COVID-19 crisis.
2. Providers should use the richest, most secure platform that is available to them and the patient. Telephonic communications can be used only if audio/video communications are not available or are refused by patients.
3. Authorized providers include qualified health care professionals and qualified non-physicians (where appropriate).
4. Qualified health care professionals (those who can bill for evaluation and management services) and qualified non-physician health care professionals (those who can bill incident-to) may deliver services, using the same CPT and HCPCS codes from the OHA approved list as they would normally use for in-person services.
    a. A member's medical record must include a note explaining the extenuating circumstances that prevent the member from accessing services in person. When in-person services resume, update the medical record again to reflect that.
5. Documentation must meet the same standards as face-to-face visits.
6. A claim with appropriate CPT/HCPCS and any appropriate modifiers and/or place of services for each service — submitted by an authorized provider — is required.
    a. Telehealth services professional claims should reflect the designated POS code 02- Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site.

Physical Health

Codes for telemedicine services in response to COVID-19

Updated April 16, 2020

Physical health: Approved telehealth services for COVID-19 response							
Code	Short descriptor	CMS	OHA	Code	Short descriptor	CMS	OHA
90951	Esrd serv 4 visits p mo <2yr	X	X	99233	Subsequent hospital care	X	X
90952	Esrd serv 2-3 vsts p mo <2yr	X	X	99307	Nursing fac care subseq	X	X
90954	Esrd serv 4 vsts p mo 2-11	X	X	99308	Nursing fac care subseq	X	X
90955	Esrd srv 2-3 vsts p mo 2-11	X	X	99309	Nursing fac care subseq	X	X
90957	Esrd srv 4 vsts p mo 12-19	X	X	99310	Nursing fac care subseq	X	X
90958	Esrd srv 2-3 vsts p mo 12-19	X	X	99354	Prolonged service office	X	X
90960	Esrd srv 4 visits p mo 20+	X	X	99355	Prolonged service office	X	X
90961	Esrd srv 2-3 vsts p mo 20+	X	X	99356	Prolonged service inpatient	X	X
90963	Esrd home pt serv p mo <2yrs	X	X	99357	Prolonged service inpatient	X	X
90964	Esrd home pt serv p mo 2-11	X	X	99406	Behav chng smoking 3-10 min	X	X
90965	Esrd home pt serv p mo 12-19	X	X	99407	Behav chng smoking > 10 min	X	X
90966	Esrd home pt serv p mo 20+	X	X	99495	Trans care mgmt 14 day disch	X	X
90967	Esrd home pt serv p day <2	X	X	99496	Trans care mgmt 7 day disch	X	X
90968	Esrd home pt serv p day 2-11	X	X	99497	Advncd care plan 30 min	X	X
90969	Esrd home pt serv p day 12-19	X	X	99498	Advncd are plan addl 30 min	X	X
90970	Esrd home pt serv p day 20+	X	X	G0108	Diab manage trn per indiv	X	X
96116	Neurobehavioral status exam	X	X	G0109	Diab manage trn ind/group	X	X
96156	Hlth bhv assmt/reassessment	X	X	G0270	Mnt subs tx for change dx	X	X
96158	H&B indv interv initial 30 min		X	G0296	Visit to determ ldct elig	X	X
96159	Hlth bhv ivntj indiv ea addl	X	X	G0396	Alcohol/subs interv 15-30mn	X	X
96160	Pt-focused hlth risk assmt	X	X	G0397	Alcohol/subs interv >30 min	X	X
96161	Caregiver health risk assmt	X	X	G0406	Inpt/tele follow up 15	X	X
96164	Hlth bhv ivntj grp 1st 30	X	X	G0407	Inpt/tele follow up 25	X	X
96165	Hlth bhv ivntj grp ea addl	X	X	G0408	Inpt/tele follow up 35	X	X
96167	Hlth bhv ivntj fam 1st 30	X	X	G0420	Ed svc ckd ind per session	X	X
96168	Hlth bhv ivntj indiv 1st 30	X	X	G0421	Ed svc ckd grp per session	X	X
96168	Hlth bhv ivntj fam ea addl	X	X	G0425	Inpt/ed teleconsult30	X	X
96170	H&B family interv w/o pt initial 30 min		X	G0426	Inpt/ed teleconsult50	X	X
96171	H&B family interv w/o pt ea add 15 min		X	G0427	Inpt/ed teleconsult70	X	X
97802	Medical nutrition indiv in	X	X	G0436	Tobacco-use counsel 3-10 min	X	X
97803	Med nutrition indiv subseq	X	X	G0437	Tobacco-use counsel>10min	X	X
97804	Medical nutrition group	X	X	G0438	Ppps, initial visit	X	X
99201	Office/outpatient visit new	X	X	G0439	Ppps, subseq visit	X	X
99202	Office/outpatient visit new	X	X	G0442	Annual alcohol screen 15 min	X	X
99203	Office/outpatient visit new	X	X	G0443	Brief alcohol misuse counsel	X	X
99204	Office/outpatient visit new	X	X	G0444	Depression screen annual	X	X
99205	Office/outpatient visit new	X	X	G0445	High inten beh couns std 30m	X	X
99211	Office/outpatient visit est	X	X	G0446	Intens behave ther cardio dx	X	X
99212	Office/outpatient visit est	X	X	G0447	Behavior counsel obesity 15m	X	X
99213	Office/outpatient visit est	X	X	G0459	Telehealth inpt pharm mgmt	X	X
99214	Office/outpatient visit est	X	X	G0506	Comp asses care plan ccm svc	X	X
99215	Office/outpatient visit est	X	X	G0508	Crit care telehea consult 60	X	X
99224	Subsequent observation care	X		G0509	Crit care telehea consult 50	X	X
99225	Subsequent observation care	X		G0513	Prolong prev svcs, first 30m	X	X
99226	Subsequent observation care	X		G0514	Prolong prev svcs, addl 30m	X	X
99231	Subsequent hospital care	X	X	G2086	Off base opioid tx first m	X	X
99232	Subsequent hospital care	X	X	G2087	Off base opioid tx, sub m	X	X
				G2088	Off opioid tx month add 30	X	X

Physical Health

Codes for telemedicine services in response to COVID-19

Updated April 16, 2020

Expanded List - CMS Public Health Emergency (PHE) Non-Traditional Telehealth Services							
Code	Short descriptor	CMS	OHA	Code	Short descriptor	CMS	OHA
77427	Radiation tx management X5	X		99236	Obser/hosp same date	X	
90853	Group psychotherapy	X		99238	Hospital discharge day	X	
90953	Esrd serv 1 visit p mo <2yr	X		99239	Hospital discharge day	X	
90959	Esrd serv 1 vst p mo 12-19	X		99281	Emergency dept visit	X	
90962	Esrd serv 1 visit p mo 20+	X		99282	Emergency dept visit	X	
92507	Speech/hearing therapy	X		99283	Emergency dept visit	X	
92521	Evaluation of speech fluenc	X		99284	Emergency dept visit	X	
92522	Evaluation speech production	X		99285	Emergency dept visit	X	
92523	Speech sound lang comprehen	X		99291	Critical care first hour	X	
92524	Behavral qualit analys voic	X		99292	Critical care addl 30 min	X	
96130	Psycl tst eval phys/qhp 1st	X		99304	Nursing facility care init	X	
96131	Psycl tst eval phys/qhp ea	X		99305	Nursing facility care init	X	
96132	Nrpsyc tst eval phys/qhp 1st	X		99306	Nursing facility care init	X	
96133	Nrpsyc tst eval phys/qhp ea	X		99315	Nursing fac discharge day	X	
96136	Psycl/nrpsyc tst phy/qhp 1s	X		99316	Nursing fac discharge day	X	
96137	Psycl/nrpsyc tst phy/qhp ea	X		99327	Domicil/r-home visit new pa	X	
96138	Psycl/nrpsyc tech 1st	X		99328	Domicil/r-home visit new pa	X	
96139	Psycl/nrpsyc tst tech ea	X		99334	Domicil/r-home visit est pa	X	
97110	Therapeutic exercises	X		99335	Domicil/r-home visit est pa	X	
97112	Neuromusulcar reeducation	X		99336	Domicil/r-home visit est pa	X	
97116	Gait training therapy	X		99337	Domicil/r-home visit est pa	X	
97161	PT Eval low complex 20 min	X		99341	Home visit new patient	X	
97162	PT Eval mod complex 30 min	X		99342	Home visit new patient	X	
97163	PT Eval high complex 45 min	X		99343	Home visit new patient	X	
97164	PT re-eval est plan care	X		99344	Home visit new patient	X	
97165	OT eval low complex 30 min	X		99345	Home visit new patient	X	
97166	OT eval mod complen 45 min	X		99347	Home visit est patient	X	
97167	OT eval high complex 60 min	X		99348	Home visit est patient	X	
97168	OT re-eval est plan care	X		99349	Home visit est patient	X	
97535	Self care mngment training	X		99350	Home visit est patient	X	
97750	Physical Performance Test	X		99468	Neonate crit care initail	X	
97755	Assistive Technology Assess	X		99469	Neonate crit care subsq	X	
97760	Orthotic mgmt&traing 1st en	X		99471	Ped critical care initial	X	
97761	Prosthetic traing 1st enc	X		99472	Ped critical care subsq	X	
99217	Observation care discharge	X		99473	Self-meas bp pt educaj/trai	X	
99218	Initial observation care	X		99475	Ped crit care age 2-5 init	X	
99219	Initial observation care	X		99476	Ped crit care age 2-5 subsq	X	
99220	Initial observation care	X		99477	Init day hosp neonate care	X	
99221	Initial hospital care	X		99478	Ic lbw inf < 1500 gm subsq	X	
99222	Initial hospital care	X		99479	Ic lbw inf 1500-2500 g subs	X	
99223	Initial hospital care	X		99480	Ic inf pbw 2501-5000 g subs	X	
99234	Obser/hosp same date	X		99483	Assmt & care pln cog imp	X	
99235	Obser/hosp same date	X					

When billing professional claims for non-traditional telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with the Place of Service (POS) equal to what it would have been in the absence of a PHE, along with a modifier 95, indicating that the service rendered was actually performed via telehealth.

Physical Health

Codes for telemedicine services in response to COVID-19

Updated April 16, 2020

Modality: Telephone and online services:

1. Authorized providers include qualified health care professionals and qualified non-physicians (where appropriate).
2. Qualified health care professionals (those who can bill for evaluation and management services) and qualified non-physician health care professionals (those who can bill incident-to) may deliver services via telephone, as medically or clinically appropriate.
3. A claim with the appropriate CPT/HCPCS code and any appropriate modifiers and/or place of service codes for each service, submitted by an authorized provider, is required.
    a. Submit claims with the Place of Service (POS) that corresponds to the rendering provider's location. If a provider is working remotely from their own home, they would use their customary Place of Service Code that corresponds to their customary location. For example, if a provider customarily works in-clinic, they would use office: POS 11.

CPT and HCPCS codes for authorized providers

Qualified health care professionals – Those who can bill for E&M services			
Code	Description	CMS	OHA
99441	Telephone evaluation and management service provided by a physician to an established patient, parent or guardian not originating from a related E/M service provided within the previous seven 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.	X	X
99442	Telephone evaluation and management service provided by a physician to an established patient, parent or guardian not originating from a related E/M service provided within the previous seven 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.	X	X
99443	Telephone evaluation and management service provided by a physician to an established patient, parent or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.	X	X
G2012	Brief communication technology-based service, e.g., virtual check-in [by phone or audio/video connection] 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 seven 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.	X	X
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.	X	
99421	Online digital evaluation and management service, for an established patient for up to seven days, cumulative time during the seven days 5-10 minutes.	X	X
99422	Online digital evaluation and management service, for an established patient for up to seven days, cumulative time during the seven days 11-20 minutes.	X	X
99423	Online digital evaluation and management service, for an established patient for up to seven days, cumulative time during the seven days 21 or more minutes.	X	X
Preventive medicine visits (when appropriate and possible without physical exam)			
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)		X
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor		X

Physical Health

Codes for telemedicine services in response to COVID-19

Updated April 16, 2020

Qualified health care professionals – Those who can bill for E&M services			
Code	Description	CMS	OHA
	reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)		
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)		X
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)		X
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years		X
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years		X
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older		X
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)		X
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)		X
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)		X
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)		X
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years		X

Physical Health

Codes for telemedicine services in response to COVID-19

Updated April 16, 2020

Qualified non-physicians – Those who bill incident to			
Code	Description	CMS	OHA
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 seven 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.	X	X
98967	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 seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.	X	X
98968	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 seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.	X	X
98970	Online digital E/M service, for an established patient for up to seven days, cumulative time during the seven days 5-10 minutes.		X
98971	Online digital E/M service, for an established patient for up to seven days, cumulative time during the seven days 11-20 minutes.		X
98972	Online digital E/M service, for an established patient for up to seven days, cumulative time during the seven days 21 minutes or more.		X
G2061	Qualified non-physician health care professional online assessment and management service, for an established patient for up to seven days, cumulative time during the 7 days 5-10 minutes.	X	
G2062	Qualified non-physician health care professional online assessment and management service, for an established patient for up to seven days, cumulative time during the 7 days 11-20 minutes.	X	
G2063	Qualified non-physician health care professional online assessment and management service, for an established patient for up to seven days, cumulative time during the 7 days 21 or more minutes.	x	
Clinician-to-clinician consultations			
Code	Description	CMS	OHA
99451	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time.		X
99452	Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes.		X
99446	Interprofessional telephone/internet assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional, and involves 5 to 10 minutes of medical consultative discussion and review.		X
99447	Interprofessional telephone/Internet assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional, and involves 11 to 20 minutes of medical consultative discussion and review.		X
99448	Interprofessional telephone/Internet assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional, and involves 21 to 30 minutes of medical consultative discussion and review.		X
99449	Interprofessional telephone/Internet assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional, and involves 31 minutes or more of medical consultative discussion and review.		X

Physical Health

Codes for telemedicine services in response to COVID-19

Updated April 16, 2020

Additional information on modifiers and Place of Service codes:

1. OHA and CMS asks providers who submit professional (CMS-1500 or 837P) or institutional (UB-04 or 837I) claims add the following codes for each service related to COVID-19 prevention, identification, diagnosis or treatment. Please report these codes for COVID-19-related services in addition to any other codes required by your program-specific rules and guidelines for the services billed.
    a. Enter modifier CR (catastrophe/disaster) for professional claims
    b. Enter condition code DR (disaster-related) for institutional claims.

2. A Place of Service (POS) code is required on professional claims for all services, telehealth or otherwise.

3. FOR PHYSICAL HEALTH TELEMEDICINE SERVICES:
    a. FOR CRITICAL ACCESS HOSPITALS (CAHs), ALL MEMBERS: Critical access hospitals (CAHs) billing for distant site practitioners under Method II must continue to use the GT modifier on institutional claims, because institutional claims do not use a POS code.
        - The GQ modifier is used to indicate telemedicine services delivered via asynchronous telecommunications systems. Except for demonstrations in Alaska and Hawaii, all telehealth must be interactive.
        - The GT modifier is used to indicate telemedicine services rendered via synchronous telecommunication. Except for demonstrations in Alaska and Hawaii, all telehealth must be interactive.

4. For Medicare providers: Please see new CMS guidance regarding modifiers and Place of Service codes: cms.gov/files/document/mln-connects-special-edition-3-31-2020.pdf

Emergency waivers and other information

During this public health emergency, the requirement for synchronous audio and video platform to be HIPAA compliant has been waived.

a. **A message from the Federal Department of Health and Human Services (HHS):** "Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency." For more information: hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

For telehealth claims submitted during this public health emergency, the requirement for a prior established relationship with a particular practitioner previously required for telehealth services has been waived.

a. **A message from the Federal Department of Health and Human Services (HHS):** "HHS is announcing a policy of enforcement discretion for telehealth services furnished pursuant to the waiver under section 1135(b)(8) of the Act. To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency." For more information: cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

If you have questions about OHA's fee-for-service coverage of telephone/telemedicine services, contact Provider Services at 800-336-6016 or dmap.providerservices@dhsoha.state.or.us.

Physical Health

Codes for telemedicine services in response to COVID-19

Updated April 16, 2020

Summary of updates to this guidance document	
Date	Updates
4/10/20	1. Rearranged "Guidance for delivering services vis telemedicine modalities" for readability. 2. Merged CMS and OHA approved Telephone services into one table that denotes if Medicare (CMS) or Medicaid (OHA) covers the services. Ensured that all OHA and CMS codes that we know of are on the lists. 3. Added Preventative Codes via phone for Medicaid members 4. Merged CMS and OHA approved Telehealth (audio & visual) services into one table that denotes if Medicare (CMS) or Medicaid (OHA) covers the services. 5. Added CMS expanded Physical Health Emergency (PHE) list of non-traditional telehealth services with modifier 95 and POS guidance for these codes. 6. Moved Telehealth (video/audio) modality section before Telephone and other online services. 7. Added OHA guidance on which modality to use to provide member richest most secure platform that they have available. 8. Updated "Additional information on modifiers and POS" section to include most recent information from CMS and OHA on POS and modifiers.
4/16/20	1. Updated codes that CMS allows for phone services, 99441-99443 and 98966-98968.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

mlnconnects
Official CMS news from the Medicare Learning Network®

SPECIAL EDITION

Tuesday, March 31, 2020

News

News

Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Health Care System Address COVID-19 Patient Surge

At President Trump's direction, the Centers for Medicare & Medicaid Services (CMS) issued an unprecedented array of temporary regulatory waivers and new rules to equip the American health care system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. CMS sets and enforces essential quality and safety standards for the nation's health care system and is the nation's largest health insurer serving more than 140 million Americans through Medicare, Medicaid, the Children's Health Insurance Program, and Federal Exchanges.

Made possible by President Trump's recent emergency declaration and emergency rule making, these temporary changes will apply immediately across the entire U.S. health care system for the duration of the emergency declaration. This allows hospitals and health systems to deliver services at other locations to make room for COVID-19 patients needing acute care in their main facility.

The changes complement and augment the work of FEMA and state and local public health authorities by empowering local hospitals and health care systems to rapidly expand treatment capacity that allows them to separate patients infected with COVID-19 from those who are not affected. CMS's waivers and flexibilities will permit hospitals and health care systems to expand capacity by triaging patients to a variety of community-based locales, including ambulatory surgery centers, inpatient rehabilitation hospitals, hotels, and dormitories. Transferring uninfected patients will help hospital staffs to focus on the most critical COVID-19 patients, maintain infection control protocols, and conserve Personal Protective Equipment (PPE).

"Every day, heroic nurses, doctors, and other health care workers are dedicating long hours to their patients. This means sacrificing time with their families and risking their very lives to care for coronavirus patients," said CMS Administrator Seema Verma. "Front line health care providers need to be able to focus on patient care in the most flexible and innovative ways possible. This unprecedented temporary relaxation in regulation will help the health care system deal with patient surges by giving it tools and support to create non-traditional care sites and staff them quickly."

CMS's announcement will also waive certain requirements to enable and encourage hospitals to hire local physicians and other providers to address potential surges. New rules allow hospitals to support physician practices by transferring critical equipment, including items used for telehealth, as well as providing meals and childcare for their health care workers.

Other temporary CMS waivers and rule changes dramatically lessen administrative burdens, knowing that front line providers will be operating with high volumes and under extraordinary system stresses.

CMS recently approved hundreds of waiver requests from health care providers, state governments, and state hospital associations in the following states: Ohio, Tennessee, Virginia, Missouri, Michigan, New Hampshire, Oregon, California, Washington, Illinois, Iowa, South Dakota, Texas, New Jersey, and North Carolina. With this announcement of blanket waivers, other states and providers do not need to apply for these waivers and can begin using the flexibilities immediately.

Administrator Verma added that she applauds the March 23, 2020, pledge by America's Health Insurance Plans (AHIP) to match CMS's waivers for Medicare beneficiaries in areas where in-patient capacity is under strain. "It's a terrific example of public-private partnership and will expand the impact of Medicare's changes," Verma said.

CMS's temporary actions empower local hospitals and health care systems to:

Increase Hospital Capacity – CMS Hospitals Without Walls

CMS will allow communities to take advantage of local ambulatory surgery centers that have canceled elective surgeries, per federal recommendations. Surgery centers can contract with local health care systems to provide hospital services, or they can enroll and bill as hospitals during the emergency declaration as long as they are not inconsistent with their state's Emergency Preparedness or Pandemic Plan. The new flexibilities will also leverage these types of sites to decant services typically provided by hospitals such as cancer procedures, trauma surgeries, and other essential surgeries.

CMS will now temporarily permit non-hospital buildings and spaces to be used for patient care and quarantine sites, provided that the location is approved by the state and ensures the safety and comfort of patients and staff. This will expand the capacity of communities to develop a system of care that safely treats patients without COVID-19 and isolate and treat patients with COVID-19.

CMS will also allow hospitals, laboratories, and other entities to perform tests for COVID-19 on people at home and in other community-based settings outside of the hospital. This will both increase access to testing and reduce risks of exposure. The new guidance allows health care systems, hospitals, and communities to set up testing sites exclusively for the purpose of identifying COVID-19-positive patients in a safe environment.

In addition, CMS will allow hospital emergency departments to test and screen patients for COVID-19 at drive-through and off-campus test sites.

During the public health emergency, ambulances can transport patients to a wider range of locations when other transportation is not medically appropriate. These destinations include community mental health centers, federally qualified health centers, physician's offices, urgent care facilities, ambulatory surgery centers, and any locations furnishing dialysis services when an ESRD facility is not available.

Physician-owned hospitals can temporarily increase the number of their licensed beds, operating rooms, and procedure rooms. For example, a physician-owned hospital may temporarily convert observation beds to inpatient beds to accommodate patient surge during the public health emergency.

In addition, hospitals can bill for services provided outside their four walls. Emergency departments of hospitals can use telehealth services to quickly assess patients to determine the most appropriate site of care, freeing emergency space for those that need it most. New rules ensure that patients can be screened at alternate treatment and testing sites which are not subject to the Emergency Medical Labor and Treatment Act (EMTALA) as long as the national emergency remains in force. This will allow hospitals, psychiatric hospitals, and critical access hospitals to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19.

Rapidly Expand the Health Care Workforce

Local private practice clinicians and their trained staff may be available for temporary employment since nonessential medical and surgical services are postponed during the public health emergency. CMS's temporary requirements allow hospitals and health care systems to increase their workforce capacity by removing barriers for physicians, nurses, and other clinicians to be readily hired from the local community, as well as those licensed from other states without violating Medicare rules.

These health care workers can then perform the functions they are qualified and licensed for, while awaiting completion of federal paperwork requirements.

CMS is issuing waivers so that hospitals can use other practitioners, such as physician assistants and nurse practitioners, to the fullest extent possible, in accordance with a state's emergency preparedness or pandemic plan. These clinicians can perform services such as order tests and medications that may have previously required a physician's order where this is permitted under state law.

CMS is waiving the requirements that a Certified Registered Nurse Anesthetist (CRNA) is under the supervision of a physician. This will allow CRNAs to function to the fullest extent allowed by the state and free up physicians from the supervisory requirement and expand the capacity of both CRNAs and physicians.

CMS also is issuing a blanket waiver to allow hospitals to provide benefits and support to their medical staffs, such as multiple daily meals, laundry service for personal clothing, or child care services while the physicians and other staff are at the hospital and engaging in activities that benefit the hospital and its patients.

CMS will also allow health care providers (clinicians, hospitals and other institutional providers, and suppliers) to enroll in Medicare temporarily to provide care during the public health emergency.

Put Patients over Paperwork

CMS is temporarily eliminating paperwork requirements and allowing clinicians to spend more time with patients. Medicare will now cover respiratory-related devices and equipment for any medical reason determined by clinicians so that patients can get the care they need; previously Medicare only covered them under certain circumstances.

During the public health emergency, hospitals will not be required to have written policies on processes and visitation of patients who are in COVID-19 isolation. Hospitals will also have more time to provide patients a copy of their medical record.

CMS is providing temporary relief from many audit and reporting requirements so that providers, health care facilities, Medicare Advantage health plans, Medicare Part D prescription drug plans, and states can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

This is being done by extending reporting deadlines and suspending documentation requests which would take time away from patient care.

Further Promote Telehealth in Medicare

Building on prior action to expand reimbursement for telehealth services to Medicare beneficiaries, CMS will now allow for more than 80 additional services to be furnished via telehealth. During the public health emergencies, individuals can use interactive apps with audio and video capabilities to visit with their clinician for an even broader range of services. Providers also can evaluate beneficiaries who have audio phones only. These temporary changes will ensure that patients have access to physicians and other providers while remaining safely at home.

Providers can bill for telehealth visits at the same rate as in-person visits. Telehealth visits include emergency department visits, initial nursing facility and discharge visits, home visits, and therapy services, which must be provided by a clinician that is allowed to provide telehealth. New as well as established patients now may stay at home and have a telehealth visit with their provider.

CMS is allowing telehealth to fulfill many face-to-face visit requirements for clinicians to see their patients in inpatient rehabilitation facilities, hospice and home health.

CMS is making it clear that clinicians can provide remote patient monitoring services to patients with acute and chronic conditions and for patients with only one disease. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry.

In addition, CMS is allowing physicians to supervise their clinical staff using virtual technologies when appropriate, instead of requiring in-person presence.

For additional background information on the waivers and rule changes, go to: https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient

For more information on the COVID-19 waivers and guidance, and the Interim Final Rule, please go to the CMS COVID-19 flexibilities webpage: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers.

These actions, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit www.coronavirus.gov. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

Billing for Professional Telehealth Services During the Public Health Emergency

Building on prior action to expand reimbursement for telehealth services to Medicare beneficiaries, CMS will now allow for more than 80 additional services to be furnished via telehealth. When billing professional claims for non-traditional telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with the Place of Service (POS) equal to what it would have been in the absence of a PHE, along with a modifier 95, indicating that the service rendered was actually performed via telehealth. As a reminder, CMS is not requiring the "CR" modifier on telehealth services. However, consistent with current rules for traditional telehealth services, there are two scenarios where modifiers are required on Medicare telehealth professional claims:

- Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier
- Furnished for diagnosis and treatment of an acute stroke, use G0 modifier

Traditional Medicare telehealth services professional claims should reflect the designated POS code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site. There is no change to the facility/non-facility payment differential applied based on POS. Claims submitted with POS code 02 will continue to pay at the facility rate.

There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

New Specimen Collection Codes for Laboratories Billing for COVID-19 Testing

Clinical diagnostic laboratories: To identify and reimburse specimen collection for COVID-19 testing, CMS established two Level II HCPCS codes, effective with line item date of service on or after March 1, 2020:

- G2023 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
- G2024 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source

These codes are billable by clinical diagnostic laboratories.

Like the newsletter? Have suggestions? Please let us know!

Subscribe to MLN Connects. Previous issues are available in the archive.
This newsletter is current as of the issue date. View the complete disclaimer.

Follow the MLN on Twitter #CMSMLN, and visit us on YouTube.

View in browser

COVID-19 TELEHEALTH GUIDANCE

Thank you for your continued partnership with Health Net Health Plan of Oregon (Health Net). In order to ensure that all Health Net members have needed access to care, we are increasing the scope and scale of our use of telehealth services for all products for the duration of the COVID-19 emergency. These coverage expansions will benefit not only members who have contracted or been exposed to the novel coronavirus, but also those members who need to seek care unrelated to COVID-19 and wish to avoid clinical settings and other public spaces.

Effective immediately, the policies we are implementing include:

- Continuation of zero member liability (copays, cost sharing, etc.) for care delivered via telehealth*
- Any services that can be delivered virtually will be eligible for telehealth coverage
- All prior authorization requirements for telehealth services will be lifted for dates of service from March 17, 2020 through June 30, 2020
- Telehealth services may be delivered by providers with any connection technology to ensure patient access to care**

**Please note: For Health Savings Account (HSA)-Qualified plans, IRS guidance is pending as to deductible application requirements for telehealth/telemedicine related services.*
***Providers should follow state and federal guidelines regarding performance of telehealth services including permitted modalities.*

Providers who have delivered care via telehealth should reflect it on their claim form by following standard telehealth billing protocols in their state.

We believe that these measures will help our members maintain access to quality, affordable healthcare while maintaining the CDC's recommended distance from public spaces and groups of people.

Again, we thank you for your commitment to the care and wellbeing of our members, as well as to the communities we share. Please don't hesitate to reach out to Provider Services at the numbers below with any questions you may have.

Commercial: 1.888.802.7001 Medicare Advantage: 1.888.445.8913 HealthNetOregon.com

---

Oregon Health Plan coverage of telephone/telemedicine/telehealth services

Information for Oregon Health Plan physical and behavioral health providers

What's new?

OHA is expanding coverage of telehealth and telephone services in light of the COVID-19 outbreak. This document summarizes existing and new coverage. New coverage includes:

- A new Health Evidence Review Commission (HERC) guideline clarifying expanded coverage of synchronous audio and video, telephone, online (e.g., patient portal) services and provider-to-provider consultations for physical and behavioral health (Guideline Note A5).
- Fee-for-service Medicaid is opening additional codes to payments:
  - telephone service evaluation/assessment and management codes for behavioral health providers (retroactive to January 1, 2020)
  - synchronous audio/video visits, online (e.g. patient portal) services and provider-to-provider consultations for physical health providers
- CCOs shall cover telemedicine services identified in HERC guideline note A5 effective March 13, 2020, but OHA encourages CCOs to make this coverage retroactive to January 1, 2020.
- OAR 410-130-0610 rule language is being revised and vetted through OHA to remove barriers to telemedicine services. A link to the new rule will be provided when published.
- OAR 410-146-0085 and 410-147-0120 rule language is being revised to clarify telemedicine encounters for FQHCs and RHCs. A link to the new rule will be provided when published.
- Fee-for-service Medicaid changes are pending claims system configuration. Please allow up to one week to MMIS changes to take effect.
- OHA is actively looking into ways to allow additional services to be provided so that members can access important services for physical and behavioral health.

Telemedicine/telehealth (e.g., video and patient portal)

What is telemedicine/telehealth?

Telemedicine or telehealth services are health care services rendered to patients using electronic communications such as secure email, patient portals and online audio/video conferencing.

Does the Oregon Health Plan cover telemedicine services?

To be eligible for coverage, telemedicine services must comply with:

- Oregon Administrative Rules (OAR) 410-120-1200 (excluded services and limitations),
- OAR 410-130-0610 (Telemedicine). *This rule is being updated and will be linked to this communication when published with the Secretary of State.*
- OAR 410-172-0850 (Telemedicine for behavioral health) and
- Guideline Note A5 (Teleconsultations and non-face-to-face telehealth services) from the Prioritized List of Health Services. *This guideline note was updated March 13, 2020.*

Does the Oregon Health Plan cover telephone services?

Yes. Telephone calls can be billed for the following services:

- 99441-99443 for providers who can provide evaluation and management services;
- 98966-98968 for other types of providers, including nonphysician behavioral health providers

What about CCOs? Does OHA allow CCOs to cover telehealth and telemedicine services?

Yes, subject to Guideline Note A5 for services that are already covered for in-person visits, such as:

- Evaluation and management services (for providers who can perform these services, such as physicians, physician assistants or nurse practitioners), or
- Assessment and management services (for other types of providers including behavioral health providers and dietitians).
- Consultations between providers in a variety of settings (by telephone or other electronic forms of communication)

This is true for both physical health and behavioral health services. CCO contracts require CCOs to ensure that telemedicine credentialing requirements are consistent with OAR 410-130-0610(5).

Can I provide telephone/telemedicine services to a CCO member?

Yes. If the service falls under those described in Guideline Note A5 in the HERC guidelines. CCOs may cover additional telephone/telemedicine services. Contact the patient's CCO for specific guidance on their telephone/telemedicine/telehealth services and policies.

What telephone/telemedicine codes are covered for physical health services?

- Audio/video telemedicine services with synchronous audio and video, regardless of the location of the patient (inpatient, outpatient or community) using ordinary evaluation and management codes. For instance, 99201-99215 are covered. See HERC Guideline Note Guideline Note A5 (Teleconsultations and non-face-to-face telehealth services) for a list of services that can be covered
- Online services (e.g. electronic patient portals). CPT codes include 99421-99423 for physicians, 98970-98972 for non-physicians who can bill evaluation and management services, and G2061-G2063 for assessment and management services by other provider types.
- CPT 99451-99452 and 99446-99449 are available for provider-to-provider consultations.
- Telephone services (CPT codes include 99441-99443 for providers who can provide evaluation and management services; 98966-98968 for other types of providers, including nonphysician behavioral health providers)

Some of these codes have other limitations, such as being only for established patients and not being related to an in-person visit. See industry coding resources for details. Online communications must by encrypted (HIPAA-compliant).

What codes are covered for behavioral health providers?

Telemedicine services (synchronous audio and video)

The fee-for service behavioral health fee schedule lists all codes that include telemedicine reimbursement when billed with modifier GT. These services have been covered for several years. These codes include:

- Psychotherapy,

- Team conferences,
- Crisis psychotherapy,
- Team psychotherapy,
- Mental health assessments and
- Service plan development.

To be eligible for telemedicine reimbursement, the services must be provided using a synchronous audio-video platform compliant with HIPAA and 42 CFR part 2. Reimbursement will be the same as for services provided in-person.

Telephone services (99441-99433, 98966-98968) are new codes for behavioral health providers during the COVID-19 crisis and will be configured in MMIS by Tuesday, March 17, 2020.

These codes are newly eligible for payment (retroactive to January 1, 2020) when the service is:

- Provided by a qualified nonphysician health care professional to an established patient, parent, or guardian,
- Not related to an assessment and management service provided within the previous 7 days,
- Not related to an assessment and management service or procedure scheduled to occur within the next 24 hours or soonest available appointment.

If there is a related visit, billing for that visit should suffice.

As part of the COVID-19 crisis, OHA is investigating ways to allow behavioral health providers to provide services via telephone. Additional guidance will be forthcoming as we receive approval from the Centers for Medicare & Medicaid Services (CMS).

I have more questions about telemedicine/telehealth. Who do I call?

If you have questions about OHA's fee-for-service coverage of telephone/telemedicine services, contact Provider Services at 800-336-6016 or dmap.providerservices@dhsoha.state.or.us.

If you have questions about CCO coverage of telephone/telemedicine services, contact the CCO.

Humana. Claims Payment Policy

Subject: COVID-19 Telehealth and Other Virtual Services

Application: Medicare Advantage, Commercial and Medicaid Products

Published date: 04/09/2020

Policy number: CP2020002

Related policies: Telehealth Services

Overview

The 2019 novel coronavirus, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), causes the disease known as coronavirus disease 2019 (COVID-19). In response to the increased spread of COVID-19, Humana announced expanded access to *telehealth* and other virtual services such as virtual check-ins, e-visits and telephone evaluation and management (E/M) services.

This policy outlines Humana's billing expectations and reimbursement for *telehealth* and other virtual services during the COVID-19 Public Health Emergency (PHE).

Medicare Advantage and Commercial Payment Policy

In addition to the policy, claims payments are subject to other plan requirements for the processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements.

The following policy applies only to professional services rendered during the COVID-19 PHE. This guidance will not necessarily apply beyond the PHE. For guidance applicable to dates of service before and after the PHE, refer to Humana's standard Telehealth Services Claims Payment Policy.

This policy is based on federal and state guidance published as of April 9, 2020. This policy is subject to change as such guidance changes.

PHE Telehealth and Other Virtual Services Coverage Criteria

Humana Medicare Advantage (MA) and commercial plans allow *telehealth* and other virtual services as follows:

- The Humana member is not required to be located in a rural or other specific area of the United States.
- The Humana member may access the service from their home.
- The Humana member does not need to be an established patient of the provider.
- The provider must satisfy applicable federal and state qualified health care practitioner requirements including, but not limited to, licensure, certification and registration requirements.
- If the service can appropriately be furnished without real-time interactive video, the service can be provided as audio-only.
- Other plan coverage rules and limitations, including medical necessity, still apply.

Unless prohibited by applicable federal or state statute or regulation, Humana plans allow *telehealth* and other virtual services if it is medically appropriate to furnish the service via telecommunications-based technology, the service is coverable by the plan, and all applicable coding requirements are satisfied. For further information on the service codes that may generally be reported as *telehealth* and other virtual services, see the PHE Telehealth and Other Virtual Services Code List section of this policy.

Note: Humana MA plans are applying the same coverage-related waivers to *Original Medicare telehealth services* that the Centers for Medicare & Medicaid Services (CMS) has announced in response to the COVID-19 PHE. Humana will also apply those waivers to commercial plans, except as prohibited under state statute or regulation. See the relevant guidance from CMS on these waivers available in the References section of this policy.

PHE Waivers

In response to the increased spread of COVID-19, Humana is making the following waivers to claims processing for *telehealth* and other virtual services.

Telehealth Waivers Effective March 6, 2020

- Humana is reimbursing the full amount allowed for all covered *telehealth* and other virtual services outlined in this policy rendered by an in-network provider. This includes any *member cost-sharing* that would have otherwise applied.
- Humana is reimbursing an office visit furnished via *telehealth* by an in-network practitioner at the same rate as an in-person office visit.

To enable such claims processing, Humana strongly recommends that a provider submit a charge for a *telehealth* service with the place of service (POS) code that would have been reported had the service been furnished in person and append *modifier 95* to identify that the service was furnished via *telehealth*. If a provider has already submitted a claim to Humana, before the publication of this policy, for a *telehealth* service provided during the PHE with *POS code 02*, it is not necessary to submit a corrected claim; Humana will apply waivers and calculate reimbursement as stated in this policy to such claims.

COVID-19-Related Waiver, Effective February 4, 2020, That Affects Telehealth and Other Virtual Services

- Humana is also reimbursing the full amount allowed for all covered services, including *telehealth* and other virtual services, rendered by in-network and out-of-network providers, billed with a COVID-19 related diagnosis code. This includes any *member cost-sharing* that would have otherwise applied.

Medicaid Payment Policy

In addition to the policy, claims payments are subject to other plan requirements for the processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements.

Humana Medicaid plans allow *telehealth* and other virtual services consistent with federal law and state Medicaid agency requirements.

Florida
Humana Florida Medicaid plans allow *telehealth* and other virtual services according to the applicable Agency for Health Care Administration (AHCA) guidance. Refer to the AHCA for the latest guidance on billing and reimbursement for *telehealth* and other virtual services during the PHE.

Illinois
Humana Illinois Medicaid plans allow *telehealth* and other virtual services according to the applicable Illinois Department of Healthcare and Family Services (IHFS) guidance. Refer to the IHFS for the latest guidance on billing and reimbursement for *telehealth* and other virtual services during the PHE.

Kentucky
Humana Kentucky Medicaid plans allow *telehealth* and other virtual services according to the applicable Kentucky Department for Medicaid Services (DMS) guidance. Refer to the DMS for the latest guidance on billing and reimbursement for *telehealth* and other virtual services during the PHE.

Definitions of *Italicized* Terms

- ***Member cost-sharing:*** Any portion of the amount allowed for a covered service that the member must pay the provider, including deductible, co-pay, and coinsurance.
- ***Original Medicare telehealth services:*** Telehealth services covered by Original Medicare under Section 1834(m) of the Social Security Act.
- ***Place of service (POS) code 02:*** The location where health services and health related services are provided or received, through a telecommunication system.
- ***Telehealth:*** A means to deliver health care services to a patient at a different physical location than the health professional using electronic information or telecommunications technologies consistent with applicable state and federal law. Telehealth services include telemedicine services and are also known as virtual visits.

References

- Centers for Medicare & Medicaid Services website. Coronavirus (COVID-19) Partner Toolkit. https://www.cms.gov.
- Centers for Medicare & Medicaid Services website. Coronavirus Waivers & Flexibilities. https://www.cms.gov.
- Centers for Medicare & Medicaid Services website. MLN Connects: Special Edition – Friday, April 3, 2020. https.//www.cms.gov.
- Centers for Medicare & Medicaid Services website. MLN Matters® Number: SE20011. https://www.cms.gov.
- Centers for Medicare & Medicaid Services website. Medicare Telemedicine Health Care Provider Fact Sheet. https://www.cms.gov.

- Centers for Medicare & Medicaid Services website. Medicare Telehealth Frequently Asked Questions (FAQs). https://edit.cms.gov.
- Centers for Medicare & Medicaid Services website. Additional Background: Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge. https://www.cms.gov.
- Centers for Medicare & Medicaid Services website. List of Telehealth Services. https://www.cms.gov.
- Centers for Medicare & Medicaid Services website. Medicare Learning Network. Telehealth Services. https://www.cms.gov.
- Centers for Medicare & Medicaid Services website. Place of Service Code Set - Place of Service Codes for Professional Claims. https://www.cms.gov.
- Centers for Medicare & Medicaid Services HCPCS Level II and associated publications and services.
- Centers For Disease Control And Prevention website. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). https://www.cdc.gov.
- Florida Agency for Health Care Administration website. Welcome to Medicaid. https://ahca.myflorida.com.
- Illinois Department of Healthcare and Family Services website. Ilinois Department of Healthcare and Family Services. https://www.illinois.gov.
- Kentucky Cabinet for Health and Family Services website. Department for Medicaid Services. https://chfs.ky.gov.
- Humana website. Coronavirus disease 2019 (COVID-19). https://www.humana.com.
- Humana website. Telehealth - Expanding access to care. https://www.humana.com.
- American Medical Association's CPT® and associated publications and services.
- World Health Organizations International Classification of Diseases, 10th Revision, Clinical Modification and associated publications and services.

General Humana Resources

- Availity – Providers can register for access to information on a variety of topics such as eligibility, benefits, referrals, authorizations, claims and electronic remittances.
- Claims processing edit notifications – Alerts of upcoming claims payment changes are posted on the first Friday of each month.
- Claims resources – Providers can find information on referrals, authorizations, electronic claim submissions and more.
- Education and news – This page can help you find clinical guidelines, educational tools, Medicare and Medicaid resources, our provider magazine and other resources to help you do business with us.
- Making it easier – This page contains an educational series for providers and healthcare professionals.
- Medical and pharmacy coverage policies – Humana publishes determinations of coverage of medical procedures, devices and medications for the treatment of various conditions. There may be variances in coverage among plans.

Note: Links to sources outside of Humana's control are verified at the time of publication. Please report broken links.

PHE Telehealth and Other Virtual Services Code List

The following list of procedure codes serves as a guide to assist providers in determining which services may be reimbursable during the PHE as telehealth or other virtual services. Additional services may also be provided via telehealth as required by relevant state statue or regulation.

This list is subject to termination or modification by Humana at any time, without notice. Printed versions of this document may be out of date and do not control. For the most current and only controlling version of this guide, refer to the most current version of this policy published at the following website: Humana.com/ClaimPaymentPolicies.

This list does not constitute medical advice, guarantee of payment, plan pre-authorization, an explanation of benefits, or a contract. It does not govern whether a procedure is covered under a specific member plan or policy, nor is it intended to address every claim situation. Claims payment and coverage may be affected by other factors, including but not limited to federal and

state laws and regulations, the member's Certificate of Insurance or Evidence of Coverage, provider contract terms, coverage policies, medical necessity, and Humana's professional judgment. Humana has full and final discretionary authority for its interpretation and application. No part of this may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, electronic, mechanical, photocopying or otherwise without express written permission from Humana.

A charge for any code in this list will not be reimbursed if any applicable PHE telehealth and other virtual services coverage criterion is not satisfied. Likewise, a charge for any code in this list will not be reimbursed if any applicable criterion of that code is not satisfied.

Code Type	Code	Description
CPT	77427	Radiation treatment management, 5 treatments
CPT	90785	Interactive complexity (List separately in addition to the code for primary procedure)
CPT	90791	Psychiatric diagnostic evaluation
CPT	90792	Psychiatric diagnostic evaluation with medical services
CPT	90832	Psychotherapy, 30 minutes with patient and/or family member
CPT	90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
CPT	90834	Psychotherapy, 45 minutes with patient and/or family member
CPT	90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
CPT	90837	Psychotherapy, 60 minutes with patient and/or family member
CPT	90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
CPT	90839	Psychotherapy for crisis; first 60 minutes
CPT	90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)
CPT	90845	Psychoanalysis
CPT	90846	Family psychotherapy (without the patient present)
CPT	90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
CPT	90853	Group psychotherapy (other than of a multiple-family group)
CPT	90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)
CPT	90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers
CPT	90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
CPT	90952	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
CPT	90953	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
CPT	90954	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
CPT	90955	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include

Code Type	Code	Description
		monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
CPT	90957	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
CPT	90958	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
CPT	90959	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
CPT	90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
CPT	90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
CPT	90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month
CPT	90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
CPT	90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
CPT	90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
CPT	90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older
CPT	90967	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age
CPT	90968	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age
CPT	90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age
CPT	90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older
CPT	92227	Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
CPT	92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral
CPT	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
CPT	92521	Evaluation of speech fluency (eg, stuttering, cluttering)
CPT	92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);
CPT	92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)
CPT	92524	Behavioral and qualitative analysis of voice and resonance
CPT	93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized

Code Type	Code	Description
		real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional
CPT	93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional
CPT	93268	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional
CPT	93270	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection)
CPT	93271	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis
CPT	93272	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional
CPT	93298	Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional
CPT	93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results
CPT	96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family
CPT	96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
CPT	96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional
CPT	96127	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument
CPT	96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
CPT	96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)
CPT	96132	Neuropsychological testing evaluation services by physician or other qualified health care professional,

Code Type	Code	Description
		including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
CPT	96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)
CPT	96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
CPT	96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
CPT	96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
CPT	96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
CPT	96150	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment
CPT	96151	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment
CPT	96152	Health and behavior intervention, each 15 minutes, face-to-face; individual
CPT	96153	Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)
CPT	96154	Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)
CPT	96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
CPT	96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
CPT	96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
CPT	96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
CPT	96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
CPT	96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
CPT	96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
CPT	96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
CPT	96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
CPT	97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
CPT	97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
CPT	97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
CPT	97151	Behavior identification assessment, administered by a physician or other qualified health care

Code Type	Code	Description
		professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
CPT	97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes
CPT	97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
CPT	97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
CPT	97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
CPT	97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
CPT	97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
CPT	97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes
CPT	97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
CPT	97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
CPT	97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
CPT	97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.
CPT	97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy

Code Type	Code	Description
		records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
CPT	97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
CPT	97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
CPT	97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
CPT	97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
CPT	97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes
CPT	97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
CPT	97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes
CPT	97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes
CPT	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
CPT	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

Code Type	Code	Description
CPT	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes
CPT	98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
CPT	98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients
CPT	98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients
CPT	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
CPT	98967	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; 11-20 minutes of medical discussion
CPT	98968	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; 21-30 minutes of medical discussion
CPT	98970	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
CPT	98971	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
CPT	98972	Qualified nonphysician health care professional 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
CPT	99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
CPT	99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
CPT	99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

Code Type	Code	Description
CPT	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
CPT	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
CPT	99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
CPT	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
CPT	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
CPT	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
CPT	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
CPT	99217	Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.])
CPT	99218	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent

Code Type	Code	Description
		with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99219	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99220	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99224	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99225	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.

Code Type	Code	Description
CPT	99226	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.

Code Type	Code	Description
CPT	99238	Hospital discharge day management; 30 minutes or less
CPT	99239	Hospital discharge day management; more than 30 minutes
CPT	99241	Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
CPT	99242	Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
CPT	99243	Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
CPT	99244	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
CPT	99245	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.
CPT	99251	Inpatient consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99252	Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99253	Inpatient consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 55 minutes are spent at the

Code Type	Code	Description
		bedside and on the patient's hospital floor or unit.
CPT	99254	Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99255	Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 110 minutes are spent at the bedside and on the patient's hospital floor or unit.
CPT	99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.
CPT	99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.
CPT	99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
CPT	99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
CPT	99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
CPT	99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
CPT	99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
CPT	99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these

Code Type	Code	Description
		3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
CPT	99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
CPT	99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.
CPT	99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.
CPT	99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.
CPT	99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
CPT	99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
CPT	99315	Nursing facility discharge day management; 30 minutes or less
CPT	99316	Nursing facility discharge day management; more than 30 minutes
CPT	99318	Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision

Code Type	Code	Description
		making that is of low to moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 30 minutes are spent at the bedside and on the patient's facility floor or unit.
CPT	99324	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent with the patient and/or family or caregiver.
CPT	99325	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient and/or family or caregiver.
CPT	99326	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient and/or family or caregiver.
CPT	99327	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent with the patient and/or family or caregiver.
CPT	99328	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent with the patient and/or family or caregiver.
CPT	99334	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.
CPT	99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.
CPT	99336	Domiciliary or rest home visit for the evaluation and management of an established patient, which

Code Type	Code	Description
		requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient and/or family or caregiver.
CPT	99337	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver.
CPT	99339	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
CPT	99340	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more
CPT	99341	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
CPT	99342	Home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
CPT	99343	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
CPT	99344	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate

Code Type	Code	Description
		complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
CPT	99345	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family.
CPT	99347	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
CPT	99348	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
CPT	99349	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
CPT	99350	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.
CPT	99354	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)
CPT	99355	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)
CPT	99356	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)
CPT	99357	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)
CPT	99358	Prolonged evaluation and management service before and/or after direct patient care; first hour
CPT	99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)
CPT	99374	Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or

Code Type	Code	Description
		equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
CPT	99375	Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more
CPT	99377	Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
CPT	99378	Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more
CPT	99379	Supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
CPT	99380	Supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more
CPT	99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older
CPT	99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and

Code Type	Code	Description
		older
CPT	99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
CPT	99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
CPT	99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
CPT	99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
CPT	99415	Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)
CPT	99416	Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service)
CPT	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
CPT	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
CPT	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
CPT	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
CPT	99442	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; 11-20 minutes of medical discussion
CPT	99443	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; 21-30 minutes of medical discussion
CPT	99446	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
CPT	99447	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review
CPT	99448	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review
CPT	99449	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review
CPT	99468	Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill

Code Type	Code	Description
		neonate, 28 days of age or younger
CPT	99469	Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger
CPT	99471	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
CPT	99472	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
CPT	99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
CPT	99475	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
CPT	99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
CPT	99477	Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or younger, who requires intensive observation, frequent interventions, and other intensive care services
CPT	99478	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)
CPT	99479	Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)
CPT	99480	Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)
CPT	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (eg, home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.
CPT	99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge
CPT	99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge
CPT	99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
CPT	99498	Advance care planning including the explanation and discussion of advance directives such as standard

Code Type	Code	Description
		forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)
CPT	0188T	Remote real-time interactive video-conferenced critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
CPT	0189T	Remote real-time interactive video-conferenced critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
CPT	0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior
CPT	0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior
HCPCS Level II	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
HCPCS Level II	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes
HCPCS Level II	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes
HCPCS Level II	G0296	Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making)
HCPCS Level II	G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes
HCPCS Level II	G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes
HCPCS Level II	G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
HCPCS Level II	G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
HCPCS Level II	G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth
HCPCS Level II	G0420	Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour
HCPCS Level II	G0421	Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour
HCPCS Level II	G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
HCPCS Level II	G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
HCPCS Level II	G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
HCPCS Level II	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes
HCPCS	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than

Code Type	Code	Description
Level II		10 minutes
HCPCS Level II	G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
HCPCS Level II	G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit
HCPCS Level II	G0442	Annual alcohol misuse screening, 15 minutes
HCPCS Level II	G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
HCPCS Level II	G0444	Annual depression screening, 15 minutes
HCPCS Level II	G0445	Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior
HCPCS Level II	G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes
HCPCS Level II	G0447	Face-to-face behavioral counseling for obesity, 15 minutes
HCPCS Level II	G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
HCPCS Level II	G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)
HCPCS Level II	G0508	Telehealth consultation, critical care, initial , physicians typically spend 60 minutes communicating with the patient and providers via telehealth
HCPCS Level II	G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth
HCPCS Level II	G0513	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)
HCPCS Level II	G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service)
HCPCS Level II	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
HCPCS Level II	G2011	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes
HCPCS Level II	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
HCPCS Level II	G2061	Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes
HCPCS Level II	G2062	Qualified nonphysician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes
HCPCS Level II	G2063	Qualified nonphysician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes

Code Type	Code	Description
HCPCS Level II	G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month
HCPCS Level II	G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month
HCPCS Level II	G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)
HCPCS Level II	H0031	Mental health assessment, by nonphysician
HCPCS Level II	H0032	Mental health service plan development by nonphysician
HCPCS Level II	H2012	Behavioral health day treatment, per hour
HCPCS Level II	H2019	Therapeutic behavioral services, per 15 minutes
HCPCS Level II	S0320	Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month
HCPCS Level II	T1014	Telehealth transmission, per minute, professional services bill separately

Telehealth

Expanding access to care virtually

Humana policy update for telehealth visits – effective March 23, 2020

To support providers with caring for their Humana patients while promoting both patient and provider safety, we have updated our existing telehealth policy. At a minimum, we will always follow CMS telehealth or state-specific requirements[1] that apply to telehealth coverage for our insurance products. This policy will be reviewed periodically for changes based on the evolving COVID-19 public health emergency and updated CMS or state specific rules based on executive orders. Please refer to the applicable CMS or state specific regulations prior to any claim submissions, and check Humana's COVID-19 Provider website regularly for the latest information.

1. **Temporary expansion of telehealth service scope and reimbursement rules**
   - To ease systemic burdens arising from COVID-19 and support shelter-in-place orders, Humana is encouraging the use of telehealth services to care for its members. Please refer to CMS, state, and plan coverage guidelines for additional information regarding services that can be delivered via telehealth
   - In response to this emergency, Humana will temporarily reimburse for telehealth visits with participating/in-network providers at the same rate as in-office visits. In order to qualify for reimbursement, telehealth visits must meet medical necessity criteria, as well as all applicable coverage guidelines

2. **Temporary expansion of telehealth channels**
   - Humana understands that not all telehealth visits will involve the use of both video and audio interactions. For providers or members who don't have access to secure video systems, we will temporarily accept telephone (audio-only) visits. These visits can be submitted and reimbursed as telehealth visits
   - Please follow CMS or state-specific guidelines and bill as you would a standard telehealth visit
   - Further information on using mobile devices for telehealth visits can be found **here**

3. **Temporary expansion of member cost share waivers for telehealth**
   - To encourage members to seek care safely while protecting the health care workforce, Humana is waiving member cost share for all telehealth services delivered by participating/in-network providers. This includes:
     - All telehealth services delivered by participating/in-network providers, either through audio or video
     - All telehealth services delivered through MDLive to Medicare Advantage members, and also to Commercial members in Puerto Rico
     - All telehealth services delivered through Doctor on Demand to Commercial members
   - Please do not collect traditional member responsibility for these services from any Humana member, as it will result in avoidable refund transactions and may inhibit members from seeking needed care

4. **Multiple practitioner types can deliver telehealth services**
   - Both participating/in-network primary care and specialty providers can render care using telehealth services, provided that CMS and state-specific guidelines are followed

- For telehealth visits with a specialist, members are encouraged to work with their primary care physician to facilitate care coordination
- Check CMS guidelines or the applicable state-specific rules for most updated list of distant site practitioners

With respect to these telehealth changes, note that all other coverage rules will continue to apply, and refer to applicable Humana policies for additional information. Please continue to check Humana's COVID-19 Provider website regularly as we will be updating our information to supplement the information provided in this update.

[1]Humana is not affiliated with the Center for Connected Health Policy. This link is provided as a resource for your convenience. Humana has not independently verified the information contained on this website.

.

Manual:	Reimbursement Policy
Policy Title:	**Telehealth and Telemedicine Expanded Services for COVID-19**
Section:	Medicine
Subsection:	None
Date of Origin:	3/6/2020
Policy Number:	RPM073
Last Updated:	4/27/2020
Last Reviewed:	4/27/2020

General Statement

Effective immediately, Moda Health is expanding our policies around telehealth services for our Medicare Advantage, Medicaid and Commercial membership, making it even easier and safer for patients to connect with their health care provider during the COVID-19 outbreak.

Scope

This policy temporarily supplements RPM052, "Telehealth And Telemedicine Services" due to the COVID-19 public health emergency (PHE). The policy is meant to outline the expanded coverages and changes, rather than going into the extent and detail contained in RPM052.

This policy is effective immediately for dates of service March 6, 2020 (CMS[1, 2]) through June 6, 2020 (90 days). This end date may be extended longer depending upon the status of the PHE as that time draws near.

This policy applies to Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

This policy does not apply to:

- Dental-only plans.
- Vision-only plans.

Reimbursement Guidelines

A. Commercial Plans

1. Telehealth services have been expanded to include communication methods that are not real-time and/or do not include audio-visual communication. Many of these are not normally a covered benefit on our standard plans. This includes:
    a. Telephone calls.

b. Email.
c. Provider portal communication.
d. Instant messaging.

2. The federal government has waived HIPAA privacy requirements, so services such as Google Hangouts, FaceTime, Skype, and similar applications and services may be used during this crisis.

3. Expanded telehealth services are available for all diagnoses, not just for COVID-19 or suspected COVID-19.

4. Providers may perform telehealth services from their own home, if able and appropriate. (OHA[11])

5. The usual telehealth cost-sharing requirements apply.
   a. Telehealth cost-sharing is never more than if the service was performed in person.
   b. Exception: No cost share for the visit when COVID-19 testing is performed or ordered.

6. The use of telehealth services is strongly encouraged to contain the spread of this new virus and the COVID-19 outbreak.

B. Medicare Advantage Plans

1. The patient does not have to reside in a rural location to receive telehealth services. Effective March 6, 2020. (CMS[1, 2])

2. The patient can receive telehealth services in their home or any setting of care. March 6, 2020. (CMS[1, 2])

3. Telephones that have audio and video capabilities may be used for telehealth.

4. Everyday communication technologies, such as FaceTime and Skype may be used during this PHE crisis.

   HIPAA violation penalties against providers using everyday communication technologies will be waived by the HHS Office for Civil Rights.

5. The list of telehealth services covered under Medicare has been expanded as of March 30, 2020. Medicare has added 85 new procedure codes that will be covered for telehealth services, retroactive to date of service March 1, 2020. (CMS[16])
   a. Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services can be paid for as Medicare telehealth services.
   b. The updated complete list of regular telehealth codes and the temporary additions for the PHE for the COVID-19 Pandemic has been posted at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes .

c. For the codes which CMS has temporarily added, CMS instructs to not use POS 02, but instead to:
    i. Bill with the Place of Service (POS) equal to what it would have been in the absence of a PHE.
    ii. Append modifier 95 (which CMS does not otherwise accept).
    iii. This will indicate that the service rendered was actually performed via telehealth during the PHE. (CMS[16])
d. Continue to use POS 02 for the telehealth codes that CMS approved before the PHE.
e. Modifiers for Medicare telehealth services:
    i. Use modifier 95 as instructed above for the temporarily added telehealth codes.
    ii. CMS is not requiring the "CR" modifier on telehealth services.
    iii. Continue to use modifiers GQ and G0 when required by current Medicare rules for traditional telehealth services:
        1) Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier
        2) Furnished for diagnosis and treatment of an acute stroke, use G0 modifier.
    iv. Critical access hospital method II claims should continue to bill with modifier GT. (CMS[18])
    v. Cost-sharing does not apply for COVID-19 testing-related services (both telehealth and non-telehealth).
        1) Use modifier CS for all medical visits (telehealth or non-telehealth) related to COVID-19 testing for dates of service between March 18, 2020 and the end of the Public Health Emergency (PHE).
        2) For detailed information about what qualifies a visit to be related to COVID-19 testing, see 2020-04-07-MLNC-SE. (CMS[19])

6. E-visits are not considered telehealth by CMS; they are covered by Medicare separately from the telehealth rules.
    a. E-visit procedure code descriptions state "established patients" but during the COVID-19 PHE these codes may be used for new patient visits also. (CMS[17])
    b. E-visits do not have rural location requirements.
    c. Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits and report them using HCPCS codes G2061-G2063.
    d. A broad range of clinicians, including physicians can report telephone evaluation and management services using codes that have temporarily been changed to a status A (Active): (CMS[17])
        i. 99441-99443 for scheduled or provider-initiated telephone contact.

ii. 98966-98968 for telephone contact initiated by the patient, parent, or guardian.

7. Virtual check-ins (G2010, G2012) are not considered telehealth services by CMS; they are covered by Medicare separately from the telehealth rules.
    a. Virtual check-in services can be provided to new patients in addition to established patients. (CMS[16])
    b. Virtual check-ins do not have a rural location requirement.
    c. Virtual check-ins do not have specific originating site limitation.
8. CMS is allowing telehealth to fulfill many face-to-face visit requirements for clinicians to see their patients in inpatient rehabilitation facilities, hospice and home health. (CMS[16])
9. The usual telehealth cost-sharing requirements apply.
    a. Telehealth cost-sharing is never more than if the service was performed in person.
    b. Exception: No cost share for the visit when COVID-19 testing is performed or ordered.
10. These relaxed telehealth requirements apply to telehealth services for all diagnoses, not just for COVID-19 or suspected COVID-19.
11. Other related expanded permissions:
    a. Remote patient monitoring is not considered telehealth by CMS; it is covered by Medicare separately from the telehealth rules. CMS is making it clear that clinicians can provide remote patient monitoring services to patients with acute and chronic conditions and for patients with only one disease. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry. (CMS[16])
    b. CMS is allowing physicians to supervise their clinical staff using virtual technologies when appropriate, instead of requiring in-person presence. (CMS[16])

C. Medicaid Plans

1. Telehealth visits can be provided by telephone when appropriate during the COVID-19 crisis. The requirement for synchronous visits with both audio and video capability is temporarily waived.
2. Everyday communication technologies, such as FaceTime and Skype may be used for patient contact during this PHE crisis.
    a. Certain requirements for encryption and HIPAA violation penalties will not be enforced by federal authorities during this crisis.
    b. HIPAA compliant platforms are of course preferred when available.
3. The patient may be at home or in a health care setting.

4. CPT codes 99441-99443 & 98966-98968 (Telephone assessment and management service) are temporarily open for use by Behavioral Health providers.

5. Telehealth visits are covered for inpatient and outpatient services for new or established patients.

6. Telehealth consultations are covered for emergency and inpatient services.
   a. Limited information provided by one clinician to another that does not contribute to collaboration (e.g., interpretation of an electroencephalogram, report on an x-ray or scan, or reporting the results of a diagnostic test) is not considered a consultation. (OHA[3])
   b. Consultation requirements of request from and report back to another provider must be documented to report a telehealth consultation service.

7. Providers may perform telehealth services from their own home, if able and appropriate. (OHA[11])

8. The usual telehealth cost-sharing requirements apply.
   a. Telehealth cost-sharing is never more than if the service was performed in person.
   b. Exception: No cost share for the visit when COVID-19 testing is performed or ordered.

9. These relaxed telehealth requirements apply to telehealth services for all diagnoses, not just for COVID-19 or suspected COVID-19.

10. **Important information related to COVID-19 claims tracking:**

    OHA would like to track claims related to COVID-19. Please use the following modifiers for all COVID-19 related claims (telehealth or non-telehealth services):
    a. Modifier CR: Professional claims
    b. Condition code DR: Institutional claims

Codes, Terms, and Definitions

Acronyms Defined

Acronym		Definition
ABA	=	Applied Behavior Analysis
AHA	=	American Hospital Association

Acronym		Definition
AMA	=	American Medical Association
ASO	=	Administrative Services Only
CDC	=	Centers for Disease Control
CKD	=	Chronic Kidney Disease
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
ED	=	Emergency Department (also known as/see also ER)
EOCCO	=	Eastern Oregon Coordinated Care Organization
ER	=	Emergency Room (also known as/see also ED)
ESRD	=	End Stage Renal Disease
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HHS	=	The U.S. Department of Health and Human Services (HHS)
HIPAA	=	Health Insurance Portability and Accountability Act
ICD-10-CM	=	International Classification of Diseases, Tenth Edition, Clinical Modification
PHE	=	Public Health Emergency
PHEIC	=	Public Health Emergency of International Concern
WHO	=	World Health Organization

Definition of Terms

Term	Definition
Pandemic	A global outbreak of disease.
Public Health Emergency	An extraordinary event which is determined to constitute a public health risk through the spread of disease and requires a coordinated response.
Public Health Emergency of International Concern (PHEIC)	A formal declaration by the World Health Organization (WHO) of a public health emergency of international scale. (Wiki[10])

Procedure codes (CPT & HCPCS):

For a list of telehealth services covered under Medicare, see:
https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

(Note the CMS list at this link was updated as of March 30, 2020 @ 6:15 PM to include 85 codes temporarily added for use during the COVID-19 PHE.)

For a list of telehealth services covered under Medicaid/EOCCO, see:
https://www.eocco.com/eocco/-/media/eocco/pdfs/providers/eocco-medicaid-telemedicine-overview.pdf

For Commercial plans, here is the list of procedure codes:
(codes & key changes related to the PHE are in red font)

Type of Service	What is the Service?	HCPCS/CPT Code	Coding & Helpful Information
Commercial Telehealth Visits	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201 – 99215 (Office or other outpatient visits) See also separate listings for: • Consultation services, pages 2 & 3. • Telehealth visit at hospital or facility, page 3.	Use POS 02. Modifier 95 is optional.
Specific Type of Visits, done by Telehealth	A visit with a provider for a specific purpose (see each code description) with the use of telecommunication systems between a provider and a patient.	• 96040 • 99473 • G0372 • G9156	Use POS 02. Modifier 95 is optional.
Virtual Check-in	A brief (5-10 minutes) check-in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or pictures/images submitted by an established patient. This is NOT an advice nurse call, this is communication with the provider themselves.	• G2012 • G2010 • G0071 (RHC/FQHC equivalent of G2012 or G2010)	Use POS 02. (Audio-visual requirement is waived for the PHE.) Modifier 95 is optional. Expanded coverage during PHE for most/standard Commercial plans. Moda accepts Medicare HCPCS codes for Commercial plans when they are the most accurate and detailed code for the service (as in this case).

Type of Service	What is the Service?	HCPCS/CPT Code	Coding & Helpful Information
E-visits	A communication between a patient and their provider through an online patient portal.	• 99421, 99422, 99423 • 98970, 98971, 98972 (preferred codes) • G2061, G2062, G2063 (acceptable codes)	Use POS 02. (Audio-visual requirement is waived for the PHE.) Modifier 95 is optional. Expanded coverage during PHE for most/standard Commercial plans. Code descriptions require an established patient relationship. For new patients, use 99201 – 99205.
Telephone E/M unrelated to face-to-face E/M (established patient)	Telephone communication between a patient and their provider. This is NOT an advice nurse call, this is communication with the provider themselves.	• 98966 – 98968 • 99441 – 99443	Use POS 02. (Audio-visual requirement is waived for the PHE.) Modifier 95 is optional. Expanded coverage during PHE for most/standard Commercial plans. Code descriptions require an established patient relationship. Code description requires call not be related to another E/M in past 7 days or lead to E/M next 24 hours or soonest available.
Interprofessional consult/referral	Professional to professional communication about a patient for the purpose of making a referral or obtaining a consult on the patient's condition and care. The patient is not present for the communication.	• 99446 – 99449 • 99451 • 99452	Do not use POS 02; code description is specific. No need to use modifier 95. Consultation requirements of request from and report back to another provider must be documented to use 99446 – 99449, 99451.

Type of Service	What is the Service?	HCPCS/CPT Code	Coding & Helpful Information
Telehealth Office Consultation	A consultation at the request of another provider that uses telecommunication systems between a provider and a patient, with a report back to the requesting provider.	• 99241 – 99245	Use POS 02. Modifier 95 is optional. Moda Health Commercial plans accept consultation procedure codes. Consultation requirements of request from and report back to another provider must be documented to use a consultation code.
Telehealth visit at hospital, SNF, or other facility	A visit that uses telecommunication systems between a provider and a patient in a hospital, SNF, or other facility environment.	• 99217 – 99220 • 99221 - 99223 • 99224 – 99226 • 99231 – 99233 • 99234 – 99236 • 99238 – 99239 • 99281 – 99285 • 99291 - 99292 • 99304 - 99306 • 99307 – 99310 • 99315 – 99316 • 99356, 99357 • 99468 – 99469 • 99471 – 99472 • 99475 – 99480	Use POS 02. Modifier 95 is optional. Prolonged services require clear time and content documentation.
Telehealth hospital consultation	A consultation at the request of another provider that uses telecommunication systems between a provider and a patient at a facility (inpatient, emergency department, etc.), with a report back to the requesting provider.	• 99251 – 99255 • G0406 – G0408 • G0425 – G0427 • G0508 – G0509	Use POS 02. Modifier 95 is optional. Moda Health Commercial plans accept consultation procedure codes. Consultation requirements of request from and report back to another provider must be documented to use a consultation code.
Telehealth visit, Home	A visit that uses telecommunication systems between a provider and a patient in a hospital or facility environment.	• 99327 – 99337 • 99341 - 99350	Use POS 02. Modifier 95 is optional.

Type of Service	What is the Service?	HCPCS/CPT Code	Coding & Helpful Information
Care Planning & Care Management Services	A care planning or care management service performed with the use of telecommunication systems between a provider and a patient.	• 99366 • 99495, 99496 • 99497, 99498 • G0506	Use POS 02. Modifier 95 is optional.
Preventive E/M	A preventive visit with a provider with the use of telecommunication systems between a provider and a patient.	• 99381 – 99397 • G0438, G0439 • G0513, G0514	Use POS 02. Modifier 95 is optional. Expanded coverage during PHE for most/standard Commercial plans. To the extent that preventive services can and are performed during the PHE, if able to be effectively performed by telecommunications technology, they are covered and allowed as telehealth.
Specific screening or preventive service, mandated or recommended	One of a variety of screening or preventive services with the use of telecommunication systems between a provider and a patient.	• 96127 • 96160, 96161 • 99406 – 99407 • 99408 – 99409 • 0488T • G0296 • G0396, G0397 • G0442, G0443, G0444, G0445, G0446, G0447	Use POS 02. Modifier 95 is optional.
Radiation Treatment Management	Radiation Treatment Management with the use of telecommunication systems between a provider and a patient.	• 77427	Use POS 02. Modifier 95 is optional.

Type of Service	What is the Service?	HCPCS/CPT Code	Coding & Helpful Information
Mental Health or Chemical Dependency service	A mental health or chemical dependency service that uses telecommunication systems between a provider and a patient.	• 90791, 90792 • 90832 – 90838 • 90785 • 90839, 90840 • 90845 • 90846 – 90853 • 90863 • 90887 • 99354, 99355 • G2086 – G2088 • G0459	Use POS 02. Modifier 95 is optional. Prolonged services require clear time and content documentation.
Nutrition Therapy	A medical nutrition therapy service that uses telecommunication systems between a provider and a patient.	• 97802 – 97804 • G0270	Use POS 02. Modifier 95 is optional.
Disease management	A disease management service that uses telecommunication systems between a provider and a patient.	• 98960 – 98962 • G0108 – G0109 • G0245 – G0246 • S0320	Use POS 02. Modifier 95 is optional.
Neuro/Cognitive Services	A Neuro/Cognitive exam or testing with the use of telecommunication systems between a provider and a patient.	• 96116 • 96125 • 96130 – 96139	Use POS 02. Modifier 95 is optional.
Speech Therapy	A speech therapy service that uses telecommunication systems between a provider and a patient.	• 92507 – 92508 • 92521 – 92524 • 96105 • S9152	Use POS 02. Modifier 95 is optional.
Physical Medicine and Rehabilitation (PT, OT, etc.)	A physical medicine & rehabilitation service that uses telecommunication systems between a provider and a patient.	• 97110, 97112, 97116 • 97161 – 97168 • 97535, 97750, 97755, 97760, 97761	Use POS 02. Modifier 95 is optional.
Applied Behavior Analysis (ABA) services	An Applied Behavior Analysis (ABA) service that uses telecommunication systems between a provider and a patient.	• 97151-97158	Use POS 02. Modifier 95 is optional. Expanded coverage during PHE for most/standard Commercial plans.

Type of Service	What is the Service?	HCPCS/CPT Code	Coding & Helpful Information
Dialysis Service End Stage Renal Disease (ESRD) Service Chronic Kidney Disease (CKD) Service	A Dialysis, ESRD, or CKD service with the use of telecommunication systems between a provider and a patient.	• 90935, 90937 • 90945, 90947 • 90951 – 90962 • 90963 – 90966 • 90967 – 90970 • 90989, 90993 • G0420, G0421 • G0492	Use POS 02. Modifier 95 is optional.
Other miscellaneous services	Services performed with the use of telecommunication systems between a provider and a patient.	• G0337 • H2000 • S0257, S0260 • T1001 • T1024	Use POS 02. Modifier 95 is optional.
Remote patient monitoring	These remote patient monitoring services *are not considered telehealth services.* In general, these services are covered (subject to basic medical necessity criteria) under the member's regular medical benefits.	• 92227 – 92228 • 93228 – 93229 • 93268 – 93272 • 99091 • 99453 – 99454 • 99457 - 99458	Do not use POS 02. POS based on patient location. Use of modifier 95 not appropriate beginning 1/1/2020.

Modifier Definitions:

Modifier CS is shown below. For a list of the remainder of telehealth modifiers, please see "Telehealth and Telemedicine Services." Moda Health Reimbursement Policy Manual, RPM052.

Modifier	Modifier Description
Modifier CR	Catastrophe/disaster related
Modifier CS	Covid-19 testing related service

Diagnosis codes (ICD-10):

Code	Code Description	
B97.21	SARS-associated coronavirus as the cause of diseases classified elsewhere	
B97.29	Other coronavirus as the cause of diseases classified elsewhere	For confirmed cases of COVID-19 for DOS 3/31/2020 and earlier
U07.1	COVID-19 [acute respiratory disease]	Effective for DOS 4/1/2020 and following (CDC[15])
Z03.818	Encounter for observation for suspected exposure to other biological agents ruled out	
Z20.828	Contact with and (suspected) exposure to other viral communicable diseases	

Place of Service code:

Code	Short Description	Place of Service Code Long Description
02	Telehealth	The location where health services and health related services are provided or received, through telecommunication technology. (Does not apply to originating site facilities billing a facility fee.)

Condition code:

Condition Code	Condition Code Description
DR	Disaster related

External Links & Coding Resources

AAPC. "Coronavirus: What Every Medical Coder Needs to Know." Last updated March 16, 2020; Last accessed March 26, 2020.

AMA. "Special coding advice during COVID-19 public health emergency." Includes coding scenarios.

CDC. "ICD-10-CM Coding encounters related to COVID-19 Coronavirus Outbreak." (Applies for dates of service March 31, 2020 and prior.)

For a list of telehealth services covered under Medicare, see:

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

For additional information about CMS changes and COVID-19 telehealth expansion, see:

https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-03-31-mlnc-se

List of links about CMS Coronavirus Waivers & Flexibilities: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

For a list of telehealth services covered under Medicaid/EOCCO, see:

https://www.eocco.com/eocco/-/media/eocco/pdfs/providers/eocco-medicaid-telemedicine-overview.pdf

Cross References

"Telehealth and Telemedicine Services." Moda Health Reimbursement Policy Manual, RPM052.

References & Resources

1. CMS. “Medicare Telehealth Frequently Asked Questions (FAQs).” March 17, 2020; Last accessed March 23, 2020. https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf .

2. CMS. “Medicare Telemedicine Health Care Provider Fact Sheet.” March 17, 2020; Last accessed March 24, 2020. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet .

3. OHA. “Health Evidence Review Commission (HERC) guideline Note A5.” March 20, 2020; Last accessed March 25, 2020. https://www.oregon.gov/oha/HPA/DSI-HERC/SearchablePLdocuments/Prioritized-List-GN-A005.docx .

4. OHA. “Public Notice, OHA State Plan Amendment.” March 20, 2020; Last accessed March 25, 2020. https://www.oregon.gov/oha/HSD/OHP/Announcements/Public%20notice%20-%20State%20Plan%20Amendment%20to%20expand%20Medicaid%20coverage%20of%20telehealth%20services.pdf?fbclid=IwAR2um1xHr-llLP96FlbzM9OTYuO1Bl8SxJN-42y4jqK9nTMstxwtgrAEIu8 .

5. WHO. “Naming the coronavirus disease (COVID-19) and the virus that causes it.” Last accessed March 23, 2020. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it .

6. CDC. “Situation Summary - COVID-19 Emergence.” Last updated March 21, 2020; Last accessed March 23, 2020. https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html

7. WHO. “Rolling updates on coronavirus disease (COVID-19) - Summary.” Last updated March 20, 2020; Last accessed: March 23, 2020. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen .

8. Ducharme, Jamie. “World Health Organization Declares COVID-19 a 'Pandemic.' Here's What That Means.” Time. March 11, 2020; Last accessed March 23, 2020. https://time.com/5791661/who-coronavirus-pandemic-declaration/ ,

9. OHA. “Oregon Health Authority | COVID-19 Updates |Situation in the U.S. and Globally.” Last updated March 24, 2020; Last accessed March 25, 2020. https://govstatus.egov.com/OR-OHA-COVID-19 .

10. Wiki. “Public Health Emergency of International Concern.” Last updated March 23, 2020; Last accessed March 25, 2020. https://en.wikipedia.org/wiki/Public_Health_Emergency_of_International_Concern

11. OHA. “Oregon Division of Financial Regulation & Oregon Health Authority Telehealth Guidance Final.” Last updated March 24, 2020; Last accessed March 25, 2020. https://dfr.oregon.gov/insure/health/understand/Documents/DFR-OHA%20Telehealth%20Guidance.pdf .

12. OHA. “Announcement: Oregon Health Plan coverage of telephone/telemedicine/telehealth services.” Last updated March 20, 2020; Last accessed March 25, 2020. https://www.oregon.gov/oha/HSD/OHP/Announcements/Oregon%20Health%20Plan%20coverage%20of%20telemedicine%20services.pdf .

13. AMA. “AMA quick guide to telemedicine in practice.” American Medical Association. Last accessed March 25, 2020. https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice?utm_source=twitter&utm_medium=social_ama&utm_term=3207044834&utm_campaign=Public+Health .

14. AK DOI. “Changes to Coverage For Telehealth.” Alaska Division of Insurance, Bulletin 20-07. March 17, 2020; Last accessed March 25, 2020. https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=121909 .

15. CDC. “New ICD-10-CM code for the 2019 Novel Coronavirus (COVID-19), April 1, 2020.” Last updated March 18, 2020; Last accessed March 26, 2020. https://www.cdc.gov/nchs/data/icd/Announcement-New-ICD-code-for-coronavirus-3-18-2020.pdf .

16. CMS. “COVID-19: Billing for Professional Telehealth Services During the Public Health Emergency.” MLNConnects. 2020-03-31-MLNC-SE. March 31, 2020; Last accessed March 31, 2020. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-03-31-mlnc-se .

17. CMS. “Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19.” Last updated March 30, 2020; Last accessed April 13, 2020. https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf .

18. CMS. “COVID-19: Billing for Professional Telehealth Distant Site Services During the Public Health Emergency — Revised.” MLNConnects, 2020-04-03-MLNC-SE. April 3, 2020; Last accessed April 3, 2020. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-03-31-mlnc-se .

19. CMS. “COVID-19: Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services.” MLNConnects, 2020-04-07-MLNC-SE. April 7, 2020; Last accessed April 8, 2020. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se .

Background Information

The SARS-CoV-2 virus is a coronavirus that causes the disease COVID-19. (WHO[5]) The initial outbreak was identified in Wuhan, Hubei Province, China and later spread internationally. (CDC[6]) The World Health Organization (WHO) declared the outbreak a Public Health Emergency of International Concern on January 30, 2020. (WHO[7]) Then on March 11, 2020 the WHO declared COVID-19 a pandemic. (Ducharme[8])

The Centers for Disease Control and Prevention (CDC) leads the U.S. response. The World Health Organization (WHO) guides the global response. (OHA[9])

The Coronavirus Preparedness and Response Supplemental Appropriations Act, as signed into law by the President on March 6, 2020, includes a provision allowing the Secretary of the Department of Health and Human Services to waive certain Medicare telehealth payment requirements during the Public Health Emergency (PHE) declared by the Secretary of Health and Human Services January 31, 2020 to allow beneficiaries in all areas of the country to receive telehealth services, including at their home. (CMS[1])

IMPORTANT STATEMENT

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI/NCCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.

Medicaid Telemedicine and Telehealth Overview and Guidelines as of 3/26/2020

OVERVIEW

In light of the COVID-19 pandemic, the Oregon Health Authority has expanded coverage of telehealth services. The following telehealth and telemedicine services are covered through Eastern Oregon Coordinated Care Organization (EOCCO):

- Evaluation and management services
- Assessment and management services
- Consultations between providers in a variety of settings (by telephone or other electronic forms of communication)

EOCCO follows Ancillary Guideline A5, telehealth, teleconsultations and electronic/telephonic services guidelines as well as OHA guidance related to coding and billing. Please visit the *Ancillary/Diagnostic Guideline Notes* for additional information.

During the COVID-19 pandemic, the federal government has waived certain HIPAA privacy requirements, so services such as Google Hangouts, FaceTime, and Skype can be used during this crisis. For additional information, please visit HHS.gov.

IMPORTANT: If the condition is funded per the prioritized list or medically appropriate with a covered condition, the service is reimbursable for active members under EOCCO and no prior authorization is needed. Below you will find a comprehensive list of codes currently covered by the Oregon Health Authority. EOCCO will cover and reimburse all services allowed within the scope of the providers individual agreement.

BILLING FOR TELEMEDICINE/TELEHEALTH

To receive reimbursement	• Bill covered telemedicine procedure codes with place of service 02. The use of telehealth POS 02 certifies that the service meets the telehealth requirements. • Modifier GT is required when applicable (see fee schedules). • The GQ modifier is still required when applicable. GQ modifier means; via Asynchronous Telecommunication systems. • Do not use modifier 95 for telemedicine services. • Bill with the transmission site code Q3014; (where the patient is located).

	• The evaluating practitioner at the distant site may bill for the evaluation, but not for the transmission site code. For Behavioral Health Providers, please review the fee-for-service behavioral health fee schedule for all codes and required GT modifiers that allow for telemedicine reimbursement (listed here). **Important information related to COVID-19 claims tracking:** OHA would like to track claims related to COVID-19. Please use the following modifiers for all claims: • Modifier CR: Professional claims • Condition code DR: Institutional claims

TELEHEALTH (SYNCHRONOUS AUDIO/VIDEO VISITS)

What are the CPT codes that are allowed for Synchronous audio/video visits?	90785, 90791, 90792, 90832-90834, 90836, 90837-90840, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964-90970, 96116, 96171, 96160, 96161, 97802-4, 99201-99205, 99211-99215, 99231- 99233, 99307-99310, 99354-99357, 99406-99407, 99495-99498, G0108-G0109, G0270, G0296, G0396, G0397, G0406-G0408, G0420, G0421, G0425-G0427, G0436-G0439, G0442-G0447, G0459, G0506, G0508, G0509, G0513, G0514, G2086-G2088. The originating site code Q3014 may only be used by appropriate health care sites. **These services can be provided by telephone when appropriate during the COVID-19 crisis.**
What are the criteria?	• Telehealth visits are defined as synchronous visits with both audio and video capability. The patient may be at home or in a health care setting. • Telehealth visits are covered for inpatient and outpatient services for new or established patients. • Telehealth consultations are covered for emergency and inpatient services. • Billing for telehealth visits requires the same level of documentation, medical necessity and coverage determinations as in-person visits.

PATIENT TO CLINICIAN SERVICES (VIA TELEPHONE OR ELECTRONIC)

What are the CPT codes that are allowed for patient to clinical services?	Telephonic and electronic services, including services related to diagnostic workup:
	• CPT 99441-99443 (for providers who can provide evaluation and management services)
	  ○ Temporarily open for Behavioral Health
	• CPT 98966-98968 (for other types of providers)
	  ○ Temporarily open for Behavioral Health
	• 99421-99423, 98970-98972, G2012 (brief virtual check in) and G2061-G2063

What are the criteria?	• Ensure pre-existing relationship as demonstrated by at least one prior office visit within the past 36 months. **This requirement is waived during the COVID-19 pandemic**.
	• Documentation must:
	  ○ model SOAP charting, or be as described in program's OAR;
	  ○ include patient history, provider assessment, treatment plan and follow-up instructions;
	  ○ support the assessment and plan;
	  ○ be retained in the patient's medical record and be retrievable.
	• Medical decision making (or behavioral health intervention/psychotherapy) is necessary.
	• Ensure permanent storage (electronic or hard copy) of the encounter.
	• Meet HIPAA standards for privacy.
	• Include a patient-clinician agreement of informed consent, which is discussed with and signed by the patient and documented in the medical record. In the context of the COVID-19 epidemic, verbal approval is sufficient.
	• Not be billed when the same services are billed as care plan oversight or anticoagulation management (CPT codes 99339-99340, 99374-99380 or 99363-99364).
	• When a telephone or electronic service refers to an E/M service performed and billed by the physician within the previous seven days, it is not separately billable, regardless of whether it is the result of patient-initiated or physician-requested follow-up.
	• This service is not billed if the service results in the patient being seen within 24 hours or the next available appointment.
	• If the service relates to and takes place within the postoperative period of a procedure provided by the physician, the service is considered part of the procedure and is not to be billed separately.

	Additional information specific to Behavioral Health Providers: The codes outlined above are newly open to Behavioral Health providers during the COVID-19 crisis when the service is: • Provided by a qualified nonphysician health care professional (98966-98968), physician, or other professional qualified to perform evaluation and management services (99441-99443) to a patient, parent, or guardian. • Not related to an assessment and management service provided and/or within the previous 7 days.
What are examples of these visits?	Examples of reimbursable telephone or electronic services include: • Extended counseling when person-to-person contact would involve an unwise delay. • Treatment of relapses that require significant investment of provider time and judgment. • Counseling and education for patients with complex chronic conditions. Examples of non-reimbursable telephone/electronic consultations include but are not limited to: • Prescription renewal. • Scheduling a test. • Reporting normal test results. • Requesting a referral. • Follow up of medical procedure to confirm stable condition, without indication of complication or new condition. • Brief discussion to confirm stability of chronic problem and continuity of present management.

CLINICIAN-TO-CLINICIAN CONSULTATIONS (TELEPHONIC AND ELECTRONIC)

What are the CPT codes that are allowed for consulting providers?	99451, 99446-9

What are the criteria?	• Consult must be requested by another provider. • Can be for a new or exacerbated condition. • Cannot be reported more than 1 time per 7 days for the same patient. • Cumulative time spent reported, even if time occurs over multiple days. • Cannot be reported if a transfer of care or request for face-to-face visit occurs as a result of the consultation within the next 14 days. • Cannot be reported if the patient was seen by the consultant within the past 14 days. • Request and reason for consultation request must be documented in the patient's medical record. • Requires a minimum of 5 minutes.
What are the CPT codes that are allowed for requesting providers?	99452
What are the criteria?	• eConsult must be reported by requesting provider (not for the transfer of a patient or request for face-to-face consult). • Reported only when the patient is not on-site and with the provider at the time of consultation. • Cannot be reported more than 1 time per 14 days per patient. • Requires a minimum of 16 minutes. Includes time for referral prep and/or communicating with the consultant. • Can be reported with prolonged services, non-direct. Limited information provided by one clinician to another that does not contribute to collaboration (e.g., interpretation of an electroencephalogram, report on an x-ray or scan, or reporting the results of a diagnostic test) is not considered a consultation.

-O

Date of Change	Correction/Addition/Clarification	Source
3/20/2020	**Addition:** New Codes for BH providers according to Lori Coyner memo and BH fee schedule	Oregon Health Authority
3/23/2020	**Correction:** Correct the Health Behavior Assessment/Intervention codes (previously listed CPT codes 96150-96154 have been replaced with CPT 96171)	Oregon Health Authority
3/23/2020	**Clarification:** Specific to 99441-99443 and G2012, these codes can be used when: ○ The patient, family member or guardian initiates the call	

	○ The call is for telephone evaluation & management services, and ○ The call is not related to an in-person visit scheduled for the next 24 hours The call is not related to an in-person visit that has occurred during the previous 7 days.	Oregon Health Authority
3/23/2020	**Addition:** added annotations from Prioritized List-GN	Oregon Health Authority
3/24/2020	**Addition:** Telehealth guidance related to HIPAA	Department of Consumer and Business Services (DCBS)
3/24/2020	**Addition:** COVID-19 Claim Tracking- implement the use of modifier CR and condition code DR	Oregon Health Authority

Telehealth

State(s):	LOB(s):
☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*	☒ *Commercial* ☒ *Medicare* ☒ *Medicaid*

Enterprise Policy

PURPOSE

This policy describes reimbursement for Telehealth services which occur when a qualified health care professional and member are not at the same site. This policy is meant to outline medical and behavioral telehealth services. Services regarding dental or other services are addressed in other policies.

General Guidelines and Information

- This is a general reference regarding PacificSource's reimbursement policy for the services described and is not intended to address every reimbursement situation.
- PacificSource recognizes federal and state mandates in regards to Telehealth and Telemedicine. Any terms not otherwise defined in this policy is directed by the federal and state mandates.
- Other factors affecting reimbursement may supplement, modify or supersede this policy which include, but are not limited to the following:
    - Legislative mandates
    - Provider contracts
    - Benefit and coverage documentation
    - Other medical or drug policies
- This policy may not be implemented exactly the same way as written due to system constraints and limitations, however, PacificSource will attempt to limit these discrepancies.
- Services are subject to medical necessity, evidence-based protocols, and member's eligibility and benefit at time of service.

DEFINITIONS

Telehealth or Telemedicine–refers to consultations with a qualified healthcare professional provided in real-time over an electronic mechanism. These services are rendered to patients using electronic communications such as secure email, patient portals and online audio and/or video conferencing.

E-visits –refers to communication between a patient and providers through an online patient portal or e-mail, not in real time. Email visits must meet the following criteria: The provider must use encrypted or authenticated email for online medical evaluation visits as described in current CMS criteria.

- Standard email is not acceptable, as it is not secure, has no "terms of use" or legal disclaimers in place to protect the patient or provider, and can easily expose patient PHI including email addresses and contents of consultation discussion to unintended third parties.

Virtual Check In – for established patients to have a brief communications with practitioners via telephone or other telecommunication devices to decide if an office visit or other services are needed.

Originating Site - The physical location of the patient receiving telemedical health services. Eligible originating sites are limited to:

- Office of a qualified health care professional
- A hospital (Inpatient or Outpatient)
- Critical Access Hospital (CAH)
- Rural Health Clinic (RHC)
- Federal Qualified Health Center (FQHC)
- A hospital based or critical access hospital based renal dialysis center
    - Independent Renal Dialysis facilities are not eligible originating sites
- Skilled Nursing Facility (SNF)
- Mobile Stroke Unit
- Patient Home (Commercial and Medicaid)

Distant Site – The physical location of the eligible health care provider.

COMMERCIAL COVERAGE CRITERIA

Criteria for Tele-Video and Telephonic Services

Preauthorization to use a telehealth service is not required unless the service requires preauthorization when performed in-person.

Services must meet ***all*** of the following to in order to qualify for coverage under the health plan:

- Limited to two-way real time video and phone communication as defined by state and/or federal mandates.
- Services must be medically necessary and eligible for coverage Providers and originating site must be eligible for reimbursement.
- Telemedical video and telephonic communication and other consultation services are subject to all terms and conditions of the plan and member benefit.

Eligible Practitioners: PacificSource recognizes the following practitioners types as qualified health professionals eligible for reimbursement for tele-video and telephonic services:

- Physicians
- Nurse Practitioners
- Nurse-Midwife
- Physician Assistants
- Clinical Nurse Specialists
- Registered Dietitian or Nutrition Professional
- Clinical Psychologists
- Clinical Social Workers and other mental health providers as outlined in member's benefit
- Certified Registered Nurse Anesthetist
- FQHC and RHC Providers

MEDICARE COVERAGE CRITERIA

PacificSource follows the Center for Medicare and Medicaid Services (CMS) for coverage of Telehealth and Telemedicine services. Please refer to CMS.gov for coverage criteria.

In addition to what is covered under CMS, PacificSource Medicare allows for Licensed Professional Counselors, Licensed Marital and Family Therapists, Licensed Clinical Professional Counselors, Licensed Mental Health Counselors, FQHC, RHC to be eligible practitioners for Tele-video and Telephonic Services as appropriate with state law.

MEDICAID COVERAGE CRITERIA

PacificSource Medicaid follows Oregon Health Plan (OHP) per Oregon Administrative Rules (OAR) s 410-130-0610, 410-146-0085, 410-147-0120, 410-172-0850 for coverage of Telehealth and Telemedicine services.

REIMBURSEMENT AND CLAIM INFORMATION

Reimbursement Information

- All Lines of Business
    - Qualified services are paid at non-facility RVU based rates for all lines of business.
    - Telehealth visits will be subject to retrospective review, as appropriate
- Commercial Lines of Business
    - Fees for originating site are ineligible for reimbursement

Claim Information

- Place of Service code 02 is required on CMS HCFA 1500 form
- Modifier –GT and additional modifiers may be appended when appropriate to the CPT or HCPCS for telemedicine consultations.

Coding Information

All covered face to face services usually done in the office setting, including evaluation and management codes, are eligible to be performed via Tele-video and/or Telephone when criteria is met. Please see current AMA and CMS coding guidelines.

Commonly used Telehealth Codes may include but not limited to:

98966	Telephone assessment and management services provided by a qualified non-physician health care professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management services or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion.
98967	11-20 minutes of medical discussion
98970	Qualified Nonphysician health care professional online digital evaluation and management service, for established patient for up to 7 days, cumulative
98971	Qualified Nonphysician health care professional online digital evaluation and management service, for established patient for up to 7 days, cumulative
98972	Qualified Nonphysician health care professional online digital evaluation and management service, for established patient for up to 7 days, cumulative
99091	Collection & Interpretation Physiologic Data,(e.g. ECG, blood pressure, glucose monitoring) digitally stored &/OR Transmitted, requiring a minimum of 30 minute of time, each 30 days
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
99441	Telephone evaluation and management services provided by a physician 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
99446	Interprofessional telephone/Internet/EHR assessment and management service provided by consultative physician; 5-10 minutes
99447	Interprofessional telephone/Internet/EHR assessment and management service provided by consultative physician; 11-20 minutes
99448	Interprofessional telephone/Internet/EHR assessment and management service provided by consultative physician; 11-20 minutes
99449	Interprofessional telephone/Internet/EHR assessment and management service provided by consultative physician; >31 minutes
99451	Interprofessional telephone/Internet/EHR assessment and management service provided by consultative physician, incl written report to patient's treating physician, 5+ of med consultative time
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or QHC professional, 30 minutes
99453	Remote monitoring of physiologic parameter(s) (eg weight, blood pressure, pulse oximetry, respiratory flow rate) initial ; set-up and patient education on use of equipment
99454	Remote monitoring of physiologic parameter(s), initial device(s) supply with daily recordings(s) or programmed alert(s) transmission, each 30 days
99457	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician time in a calendar month requires interactive communication with the patient/caregiver
99484	Behavioral health condition 20min clinical staff time per calendar month with required assessment/rating scales continuity of care with a designated member of the care team
99487	Complex Chronic Care Coordination Services; first hour with no face-to-face visit, per calendar month
99489	Complex Chronic Care Coordination Services; each additional 30 minutes, per calendar month
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99491	Chronic care management services, provided personally by a physician or other QHC professional, at least 30 minutes of physician or other QHC professional time
99492	Initial psychiatric collaborative care manager 70 min/1 month behavioral health care manager activities in consult with psychiatric consult & directed by treating physician other focused treatment strategies

99493	Subsequent psychiatric collaborative care 60 minutes subsequent month other treatment goals and are prepared for discharge from active treatment
99494	Int/subsequent psychiatric collaborative care manager, each additional 30 minutes/calendar month behavioral health care manager activities in consultation with a psychiatric consultant & directed by treating physician
99495	Transitional Care management Services, moderate complexity, within 14 calendar days
99499	Unlisted Evaluation & management Service
G0406	Follow-up inpatient telehealth consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth (modifier GT--Via interactive audio and video telecommunications systems
G0407	Follow-up inpatient telehealth consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
G0408	Follow-up inpatient telehealth consultation, complex, physicians typically spend 35 minutes or more communicating with the patient via telehealth
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes communicating with the patient via telehealth
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
Q3014	Telehealth originating site facility fee (ineligible code for commercial)

Appendix

Policy Number: [Policy Number]

Effective: 3/1/2020 **Next review:** 3/1/2021

Policy type: Enterprise

Author(s): Lucia LaFerriere, Hilary Klarc

Telehealth Addendum

State(s):	LOB(s):
☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*	☒ *Commercial* ☒ *Medicare* ☒ *Medicaid*

Enterprise Policy

BACKGROUND

Purpose:
The purpose of this Telehealth Addendum is to address additional coverage of Telehealth Services and to provide additional access to care in response to the disasters and emergencies resulting from COVID-19.

Subject Area	PacificSource Commercial	PacificSource Medicare	PacificSource Community Solutions and Legacy IDS
Originating Site: Patient Home	Covered	Covered during COVID-19	Covered
Additional Eligible Providers for Tele-video/ Telephonic Services	Covered during COVID-19: Speech Therapists, Occupational Therapists, Physical Therapists *(Please note FQHC and RHC Providers are covered permanently in PacificSource Telehealth policy)*		
Telephonic Services where state regulation is currently not prohibited	Covered during COVID-19		
Telehealth Modality such as FaceTime or Skype, during the COVID-19 nationwide public health emergency.	Covered during COVID-19		

Resources: CMS Fact Sheet Medicare FAQ OHA Fact Sheet

Medicare Annual Wellness Visit (AWV) Telehealth Component and Billing Guide

Expanded Benefit during the COVID-19 outbreak

During the COVID-19 outbreak providers can perform AWVs via telehealth and file appropriate codes related to these services. Telehealth AWV claims must include HCPCS code G0438 or G0439 (FQHC: G0468), with place of service code 02 – telehealth. *Body mass index and blood pressure results for the patient will not be required for telehealth AWV claims. Weight, blood pressure, or other routine measurements can be self-reported or deferred.*

- Providers should already have an established relationship with the patient in order to do a wellness visit via telehealth.
- The patient must virtually consent to using telehealth for a wellness visit and the consent must be documented within the medical record prior to the visit.
- Visits are covered once per calendar year.
- Additional E and M codes can be added with no copay for patients with PacificSource Medicare Advantage.

Acceptable non-compliant platforms to conduct AWVs

During this time, acceptable non-HIPAA-compliant, non-public platforms to conduct AWVs include, but are not limited to:

- Apple FaceTime
- Skype
- Facebook Messenger video chat
- Standard telephone visit if video platforms are not available or accessible for the patient
- Google Hangouts video

Continued >

Contact our Customer Service team

Oct. 1 – Mar. 31:
8:00 a.m. – 8:00 p.m.,
seven days a week

Apr. 1 – Sept. 30:
8:00 a.m. – 5:00 p.m.,
Monday – Friday

Phone

Toll-free (888) 863-3637
TTY: (800) 735-2900
En Español: (866) 281-1464

Email:

MedicareCS
@pacificsource.com

www.Medicare.PacificSource.com

PacificSource Medicare

HIPAA-compliant platforms to conduct AWVs

AWVs can also be conducted through the following HIPAA-compliant platforms:

- Skype for Business
- Updox
- VSee
- Zoom for Healthcare
- Doxy.me
- Google G Suite Hangouts Meet

Things to remember

- Ask the patient to gather all prescribed and over-the-counter medications and supplements prior to the visit.
- Ask the patient to have a pen or pencil and paper ready for the visit if completing a Mini-Cog to assess cognitive impairment.

Components of the Telehealth Annual Wellness Visit	Component Description	Notes
1. Perform a Health Risk Assessment (HRA).	Self-reported information from the member includes demographics, self-assessment on health status, psychosocial risks, behavioral risks, ADLs, and SDoH. (If you haven't already created this, we can provide resources.)	• Can be completed by a medical assistant or other staff member and reviewed by the provider during the visit if preferred. • Add self-reported height and weight.
2. Establish the beneficiary's medical and family history.	Review past medical and surgical history, recent ED or hospital stays, operations/ procedures, allergies, injuries, and treatments.	• Can be added to the HRA and reviewed during the visit.
3. Establish a list of current providers and suppliers.	Include current beneficiary providers and suppliers that regularly provide medical care.	• Can be added to the HRA and reviewed during the visit.
4. Review current medications.	Document patient's current medications, including drug name, dosage, frequency, and route.	• Can be included in HRA and reviewed during the visit. • Add CPT code 1111F—bill with $10 amount for PacificSource for reimbursement.
5. Detect any cognitive impairment the beneficiary may have.	Assess the beneficiary's cognitive function by direct observation, while considering information from beneficiary reports and concerns raised by family members, friends, caregivers, and others.	• Consider the Mini-Cog test to assess cognitive impairment. • **https://mini-cog.com/mini-cog-instrument/standardized-mini-cog-instrument/** *or* • **https://patient.info/doctor/six-item-cognitive-impairment-test-6cit**

Components of the Telehealth Annual Wellness Visit	Component Description	Notes
6. Review the beneficiary's potential risk factors for depression, including current or past experiences with depression or other mood disorders.	Use any appropriate screening instrument. You may select from various available standardized screening tests designed for this purpose.	• Consider the PHQ2 or PHQ9 screening tests.
7. Review the beneficiary's functional ability and level of safety.	Select appropriate questions from various available screening questionnaires, or use standardized questionnaires recognized by national professional medical organizations to perform ADLs and assess (at minimum): • Fall risk • Hearing impairment • Home safety	• Topics can be added to the HRA and reviewed during the visit. • Fall-risk resources: **https://www.cdc.gov/steadi/materials.html**
8. Establish a list of beneficiary risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway.	Include the following: • Mental health conditions including depression, substance use disorder, and cognitive impairment • Treatment options and their associated risks and benefits	
9. Provide a personalized care plan to the patient.	Provide a care plan to the patient with recommended follow-up care, referrals for disease management programs, preventive screenings needed, community-based lifestyle interventions, and other necessary services.	• Base written screening schedule on recommendations from the USPSTF and the ACIP. • Plan can be provided via your Electronic Health Record (EHR) portal or snail mail.
10. Optional **At the patient's discretion, provide Advanced Care Planning services.**	Include discussions about: • Future care decisions that may need to be made • How the beneficiary can let others know about care preferences • Caregiver identification • Explanation of advance directives, which may involve the completion of standard forms	99497 and 99498

AWV HCPCS Codes and Descriptors

Add place of service code 02 – telehealth – to the appropriate code below for billing telehealth AWVs.

AWV HCPCS Codes	Billing Code Descriptors
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
G0439	Annual wellness visit; includes a personalized prevention plan of service (PPS), subsequent visit
G0468*	Federally Qualified Health Center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a customary bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV

Documenting Preventive Screenings

Breast Cancer Screenings

Discussion of last screening, recommendations for next screening and documentation of patient exclusions due to bilateral mastectomy

- **CPT codes**
  Z-codes: Z90.13 Bilateral Mastectomy, Z12.3 Encounter for malignant neoplasm of breast

Colorectal Cancer Screenings

Documentation of patient exclusions due to total colectomy or colorectal cancer diagnosis. (Documentation of patient reported screening that includes month and year of colon screening closes the HEDIS care gap.)

- **CPT codes**: 3017F Colorectal cancer screening results documented and reviewed
  Z-codes: Z12.11 Encounter for screening for malignant neoplasm of colon

PacificSource Additional Resources

Commercial: https://pacificsource.com/providers/

Medicaid: https://communitysolutions.pacificsource.com/Providers/Notices

Medicare Advantage: https://medicare.pacificsource.com/Providers

PacificSource Medicare

March 24, 2020

Providers' COVID-19 Benefit and Reimbursement Policy Frequently Asked Questions (FAQs)

This document is intended to answer the most common benefit and coding questions we've received from our provider community in response to the COVID-19 pandemic. Statements in this document address the most urgent needs of our provider community. This FAQ will be updated as additional information is available.

Q. Is PacificSource covering the cost of COVID-19 diagnosing and tests with no member cost share (deductible, coinsurance, copay)?

A. Yes, PacificSource is covering the cost of COVID-19 testing performed byin network providers with no member cost share.
Tests provided by out of network providers will be paid at the same benefit as our in-network benefit.

Q. What HCPCS/CPT codes should be billed for COVID-19 test?

A. Please use the following codes to report COVID-19 laboratory tests

Code	Description
U0001	Test for SARS-CoV-2 (CDC laboratory test)
U0002	Test for SARS-CoV-2 (non-CDC laboratory test)
87635	Infection agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique

Q. Should I administer the COVID-19 test to any of my patients who request it?

A. No. As with all medically necessary services, patients should present with appropriate signs and symptoms prior to being considered for COVID-19 testing. Tests should be administered to those who meet your screening protocol.

Q. Is PacificSource covering any other COVID-19 related services with no member cost share?

A. PacificSource is waiving member out-of-pocket costs for COVID-19 testing and diagnosis-related office visits, urgent care visits, telemedicine visits, ER visits, testing and radiology if billed with one of the COVID DX codes. PacificSource providers are instructed to not collect copay/coinsurance or deductibles for visiting and testing services. Other services not specified above will adhere to the member's cost share under their standard benefit.

Services provided by out of network providers will be paid at the same benefit as our in-network benefit.

Q. If a lab bills for the COVID-19 test, how will PacificSource know that the doctor's office visit on a separate claim is related to the COVID-19 test?

A. PacificSource is recognizing claims with a combination of any of the following diagnosis and procedure codes for full coverage with no member cost share. The complete CDC update is available for download here.

Condition	ICD-10 Diagnosis Codes
Pneumonia, confirmed as due to COVID-19	J12.89, B97.29
Acute bronchitis, confirmed as due to COVID-19	J20.8, B97.29
Bronchitis NOS, confirmed as due to COVID-19	J40, B97.29
Acute/lower respiratory infection NOS, confirmed as due to COVID-19	J22, B97.29
Respiratory infection NOS, confirmed as due to COVID-19	J98.8, B97.29
Acute respiratory distress syndrome, confirmed as due to COVID-19	J80, B97.29
Possible exposure to COVID-19, condition ruled-out	Z03.818
Exposure to confirmed COVID-19	Z20.828
Coronavirus infection, unspecified	B342
nCoV acute respiratory disease	U071

Q. How long will PacificSource be extending these member benefits with no member cost share?

A. PacificSource will be extending these member benefits with nocost share until further notice.

Q. How is PacificSource addressing the needs of your members who choose to practice social distancing by not visiting clinics, yet need to seek medical or behavioral help?

A. PacificSource has expanded coverage to allow the following provider types to bill appropriate Evaluation and Management type services that can be performed inreal time via telehealth.

- Physicians
- Nurse Practitioners
- Nurse-Midwife
- Physician Assistants
- Clinical Nurse Specialists
- Registered Dietitians or Nutrition Professionals
- Clinical Psychologists
- Clinical Social Workers and other mental health providers as outlined in member's benefit
- Certified Registered Nurse Anesthetists
- FQHC and RHC Providers
- Speech Therapists, Occupational Therapists, and Physical Therapists

Q. How does PacificSource reimburse for telehealth services?

A. PacificSource reimburses for telehealth services as if the service was done in the clinic setting (for services appropriate for telehealth delivery).

Q. How do you define 'telehealth' services?

A. Telehealth or Telemedicine–refers to consultations with a qualified healthcare professional provided in real-time over an electronic mechanism. These services are rendered to patients using electronic communications such as telephone, online audio and/or video conferencing.

Q. Given the broad range of services for which patients may need telehealth coverage and the various mediums for telehealth delivery, how can Iindicate telehealth services on my claim?

A. Professional claims for telehealth services should be submitted with a Place of Service code '02' on your claim. Modifier GT is also recognized, but not required. Facility claims for telehealth services should be submitted with a Modifier GT to identify the claim as a telehealth service.

Q. Are self-insured companies offering the same benefits through PacificSource to their members?

A. Self-insured companies determine if they will provide the same benefit that PacificSource is providing for fully insured groups. Most of our self-insured groups have decided to provide the same benefits. Providers can contact PacificSource Customer Service for questions about specific groups.

Q. What is PacificSource doing to ensure access to medications for your members?

A. PacificSource is taking additional steps to support our members filling prescriptions, including:

- PacificSource is increasing access to prescription medications by waiving early medication refill limits on 30-day prescription maintenance medications (consistent with a member's benefit plan)
- PacificSource is encouraging members to take advantage of their ability to obtain a 90-day prescription supply via mail order or approved retail pharmacies.

Q. How do I know if a service or medication requires a prior authorization?

A. To determine if a service and or medication requires preauthorization, consult our Prior Authorization Grid (https://authgrid.pacificsource.com/). If the service requires preauthorization when done in-person, then preauthorization is required when done as telehealth. Medication coverage status and prior authorization requirements by line of business can be found here:
Commercial: https://pacificsource.com/drug-list/
Medicare Advantage: https://medicare.pacificsource.com/Search/Drug
Medicaid: https://communitysolutions.pacificsource.com/Search/Drug

Q. How do I know if a service is covered under the Oregon Health Plan (OHP)?

A. This can be identified by using LineFinder. LineFinder is an online tool to assist providers in determining what is covered by OHP. OHP generally updates the information quarterly. (https://intouch.pacificsource.com/LineFinder)

Q. Who can I contact if I have additional questions about PacificSource's coverage of my COVID-19 related services or other needs during this pandemic?

A. Our Provider Service Team stands by ready to talk through your concerns. You can contact us at:

- Idaho and Montana: (541) 246-1459, or toll-free (855) 247-7579
- Oregon and Washington: (541) 246-1457, or toll-free (855) 247-7575

Resources: CMS Fact Sheet Medicare FAQ OHA Fact Sheet CMS Provider Quality Reporting FAQ

PROVIDENCE HEALTH PLANS PAYMENT POLICY	
SUBJECT: Online Digital Evaluation and Management Services (Formerly E-Visits)	**DEPARTMENT**: Coding Compliance
ORIGINAL EFFECTIVE DATE: 01/04	**DATE(S) REVIEWED / REVISED:** 10/04 - 01/09, 03/09, 01/10, 01/11, 01/12, 01/13, 07/13, 11/13, 01/14, 01/15, 01/16, 04/16, 05/16, 01/17, 01/18, 01/19, 01/20, 03/20
APPROVED BY: PPRC: 03/20	**NUMBER:** 53.0 **PAGE:** 1 of 4

POLICY:
Online digital evaluation and management services are patient-initiated services. Patients initiate these services through Health Insurance Portability and Accountability Act (HIPAA)-compliant secure platforms, such as electronic health record (EHR) portals, secure email, or other digital applications which allow digital communication with the provider. PHP allows these services to be paid for new or established patients, as long as all other criteria listed on the policy are met.

APPLIES TO:
All lines of business
Participating providers only

REFERENCE:
PHP Payment Policies
Current Procedural Terminology (CPT)
HIPAA Rules and Regulations

PROCEDURE:
Online digital E/M services billed with CPT codes 99421-99423 may be billed only by physicians or non-physician practitioners (NPP) who may report E/M codes. These codes require physician or NPP evaluation, assessment, and management of the patient.

Online digital assessment services billed with HCPCS codes G2061-G2063 may be billed by qualified non-physician health care professionals who are credentialed with PHP and who bill PHP directly. These codes may not be reported as “incident to” services under a different provider’s name.

CPT codes 99421-99423 and HCPCS codes G2061-G2063 may NOT be used to report non-evaluative electronic services such as communication of test results, scheduling of appointments, or other communication that does not include evaluation and/or assessment. Online digital services are not covered for patients who are hospitalized, including inpatient, outpatient, or observation status.

Criteria for Payment:

1. The digital online service must be provided in response to the patient's online inquiry.
2. Online digital services may be billed by qualified healthcare professionals who are performing services within their scope of license. Only providers who are credentialed with PHP and who are billing PHP directly may report these services. The services may not be billed as "incident-to" under another provider's name.
3. Documentation should model SOAP charting; must include patient history, provider assessment, treatment plan, and follow-up instructions; must be adequate so the information provided supports the assessment and plan; must be retained in the patient's medical record and be retrievable.
4. The provider's response must be by end of next business day following the patient's inquiry.
5. Clinical responses must be clearly identified by the provider of service, including the provider's credentials.
6. The provider must confirm member eligibility.
7. Online digital services must involve permanent storage (electronic or hard copy) of the encounter.

Billing Guidelines:

Only providers who may report E/M services may bill CPT codes 99421, 99422, and 99423. HCPCS codes G2061, G2062, and G2063 may be reported for online digital assessments performed by qualified health care providers who may not report E/M services, as long as these providers are credentialed with PHP and are billing PHP directly, i.e., not "incident-to." PHP allows codes 99421-99423 and G2061-G2063 for both new and established patients, despite the reference to "established patient" in the code descriptions.

CPT codes 98970, 98971, and 98972 (Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days) are not accepted by PHP and are listed on Payment Policy 13.0 (Bundled or Adjunct Services.)

CPT code 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

CPT code 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

CPT code 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

HCPCS code G2061: Qualified nonphysician healthcare professional online assessment, for an established** patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes

HCPCS code G2062: Qualified nonphysician healthcare professional online assessment service, for an established** patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes

HCPCS code G2063: Qualified nonphysician qualified healthcare professional assessment service, for an established** patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes

** NOTE: PHP allows these visits for both new and established patients, despite the code descriptions.

PHP follows CPT guidelines for use of CPT codes 99421-99423 and HCPCS codes G2061-G2063, including the following:

1. Online digital services are reported once for the provider's cumulative time devoted to the service during a seven-day period. The seven-day period begins with the provider's personal review of the patient-generated inquiry. All professional decision making, assessment, and subsequent management by other providers in the same group practice contribute to the cumulative service time of the patient's online digital E/M service.
2. If a separately reported E/M visit occurs within the seven days of initiation of an online digital E/M service, the provider's work devoted to the online digital E/M service is incorporated into the separately reported E/M visit. The online digital E/M visit may not be reported separately with the face-to-face E/M visit.
3. If the patient initiates an online digital inquiry for the same or related problem within seven days of a previous E/M service, the online digital visit is not reported.
4. If the online digital inquiry is related to a surgical procedure and occurs during the postoperative period of a previously completed procedure, the online digital E/M service is not reported separately.
5. If the patient presents a new, unrelated problem during the seven-day period of an online digital E/M service, then the provider's time spent on evaluation, assessment, and management of the additional problem is added to the cumulative service time of the original online digital E/M service for that seven-day period.

Use **location code "99"** for reporting online digital E/M services. **Do not append modifier GT or modifier 95**. Modifier 95 is not accepted by PHP. Modifier GT is not accepted with these codes.

Medicolegal and Administrative Guidelines:

1. To ensure information security procedures are followed, PHP requires use of a Secure Messaging System, either through a vendor-supported system or an EMR-embedded system.
2. Online digital services must meet HIPAA standards for privacy.
3. Online digital services must require member-specific login.
4. The patient and provider must use the secure messaging portal to communicate, as this ensures that safety and security procedures are followed.
5. Online digital services require patient-clinician agreement of informed consent for online digital services. The agreement must be signed by the patient and documented in the medical record.
6. Privacy statements must be visible or accessible to the member.
7. Directions must be user-friendly and easy to follow.
8. Access for online digital service must be member-specific, i.e., health information available to the member only, with exceptions for children.
9. Provider of service must be clearly identified so that the member knows who they are contacting with health information.
10. Expected provider response time must be stated prior to member obtaining access to online digital service.
11. Directions for emergency care must be stated prior to member obtaining access to online digital service.
12. Provider must confirm member information prior to responding to patient inquiry.
13. The administration of online digital services must meet the criteria contained in this payment policy. PHP may perform an audit of online digital services to ensure the service meets the intent of this policy. Providers will receive advance notice of any such audit.

PROVIDENCE HEALTH PLANS PAYMENT POLICY	
SUBJECT: Telehealth Services DURING COVID-19 CRISIS FOR COMMERCIAL LINES OF BUSINESS ONLY	**DEPARTMENT**: Coding Compliance
ORIGINAL EFFECTIVE DATE: 3/6/20	**DATE(S) REVIEWED / REVISED: 3/15/20; 4/6/20**
APPROVED BY: PHP ADMIN COUNCIL: 4/6/20	**NUMBER**: 67.0.B **PAGE:** 1 of 7

POLICY:
This policy (67.0.B) "Telehealth Services During COVID-19 Crisis Commercial Lines of Business Only" APPLIES ONLY TO TWO-WAY VIDEO VISITS FOR COMMERCIAL LINES OF BUSINESS FOR SERVICES DURING THE COVID-19 CRISIS. For two-way video visits prior to March 6, 2020, providers are referred to PHP Payment Policy 67.0.B (Telehealth Services Requiring an Originating Site), which is available on ProvLink.

NOTE: EFFECTIVE MARCH 6, 2020, THROUGH JUNE 30, 2020, OR UNTIL FURTHER NOTICE, SERVICES LISTED ON THIS POLICY WILL NOT REQUIRE AN ORIGINATING SITE. THIS IS AN EMERGENCY PROVISION SUBJECT TO CANCELLATION AT THE SOLE DISCRETION OF PROVIDENCE HEALTH PLANS.

The Office for Civil Rights at the Department of Health and Human Services (HHS) has temporarily waived the requirement for HIPAA-compliant connections for two-way video services "..in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency." (https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html) For the duration of this emergency provision, codes listed on this policy may be paid for services performed by two-way video connections where the patient and/or provider is calling from a personal device. No contract amendment or attestation is required.

ONLY SERVICES PERFORMED BY TWO-WAY VIDEO CONNECTIONS ARE COVERED BY THIS POLICY. For **telephone visits** see Payment Policy 92.0. For **online digital E&M services,** see Payment Policy 53.0. PHP also pays virtual check-in services (HCPCS code G2012) for both new and established patients.

Services covered by this policy are listed on pages 3-4 of this policy. Additional services listed on Appendix B of this policy may be billed when performed by two-way video connection for dates of service on or after March 6, 2020, and until further notice.

Submit telehealth claims with the appropriate CPT code for the professional service provided and **location code 02** (see next two paragraphs for temporary exceptions to these instructions).** Modifiers GT and 95 are not required for services billed with location code 02 and will not affect payment if used. For services with a site of service payment differential billed with location code 02, PHP uses the facility payment rate.

** **For services between March 30, 2020, and May 31, 2020, PHP will allow telehealth services with a site of service payment differential to be billed with location code 11 (office) and Modifier 95 or GT**. (See APPENDIX A at the end of the this policy for a listing of codes on this policy that qualify.) For the duration of this emergency provision, location code 11 may be for used for the specified telehealth services listed on Appendix A if billed with Modifier 95 or GT, regardless of the patient's location or the provider's location. Services on this policy with a site of service payment differential billed with location code 11 and Modifier 95 or GT will be paid at the non-facility payment rate. **Either Modifier 95 or Modifier GT is <u>required</u> for services billed with location code 11.**

** **For dates of service on or after March 6, 2020, and until further notice, PHP will allow codes listed on Appendix B of this policy to be paid when performed by two-way video connections**. When billing professional claims for services on Appendix B with dates of service on or after March 6, 2020, and until further notice, **providers may use the same Place of Service (POS) that would be used for a face-to-face service, with the addition of Modifier 95 or Modifier GT** to indicate that the service was actually performed via telehealth.

Telehealth services are services delivered via an electronic two-way communication system. PHP provides coverage for telehealth services when the service is medically necessary and supported by evidence-based medical criteria. Coverage for telehealth services includes payment for consultations, office visits, individual psychotherapy, and pharmacologic management. (Specific services covered by this policy are listed on pages 3-4 of this policy and Appendix B for dates of service on or after March 6, 2020.) All providers (including chiropractors and naturopaths) who are credentialed with PHP and who are performing services within their scope of license may perform telehealth services listed on this policy.

Effective March 6, 2020, through June 30, 2020, or until further notice, PHP will allow payment for medically appropriate services performed using two-way video connections where the patient is calling from a personal device. Providers may also use a personal device to perform these services. The following conditions must be met for PHP to make payments for telehealth services listed on this policy:

- The service must be furnished via an interactive video telecommunications system;
- The service must be furnished by a physician or authorized practitioner credentialed with PHP;
- The service must be furnished to an eligible telehealth individual;
- **For services on or after March 6, 2020, through June 30, 2020, or until further notice, services are expanded to allow two-way video conferencing when the patient is using a personal device.**

APPLIES TO:
Health Plan Providers
Commercial Lines of Business

REFERENCE:
Current Procedural Terminology (CPT)
CMS Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

PROCEDURE:
The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy, medical nutrition therapy and pharmacologic management. These services and corresponding CPT/HCPCS codes are listed below and on Appendix B.

- Initial consult codes for emergency telehealth services only (HCPCS codes G0425-G0427)**(See notes on Page 4)
- Follow-up inpatient consultations for telehealth services only (HCPCS codes G0406-G0408)**(See notes on Page 4)
- Critical care telehealth consultation (HCPCS codes G0508-G0509)
- Subsequent hospital care services (limited to one every three days) (CPT codes 99231-99233)
- Subsequent nursing facility care services (limited to one every 30 days) (CPT codes 99307-99310)
- Office or other outpatient visits (CPT codes 99201-99215)
- Advanced care planning (CPT codes 99497-99498)
- Psychotherapy (CPT codes 90832-90834, 90836-90838, 90845-90847)
- Medical nutrition therapy (HCPCS/CPT codes G0270, 97802, 97803, 97804)
- Inpatient pharmacologic management (HCPCS code G0459)
  Psychiatric diagnostic interview examination (CPT codes 90791-90792)
- Neurobehavioral status exam (CPT code 96116)
- End stage renal disease related services (CPT codes 90951-90952, 90954-90955, 90957-90958, 90960-90961, 90963-90970)
- Chronic kidney disease educational services (G0420-G0421)
- Diabetic self-management training services (G0108-G0109)
- Health and behavior assessments (CPT codes 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171)
- Alcohol and/or substance (other than tobacco) abuse assessment and brief intervention (HCPCS codes G0396-G0397)
- Annual alcohol misuse screening (HCPCS code G0442)
- Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes (HCPCS code G0443)

- Smoking and tobacco use cessation counseling (CPT codes 99406-99407, HCPCS codes G0436-G0437)
- Annual depression screening, 15 minutes (HCPCS code G0444)
- High-intensity behavioral counseling to prevent STD (HCPCS code G0445)
- Annual face-to-face intensive behavioral therapy for cardiovascular disease (HCPCS code G0446)
- Face-to-face behavioral counseling for obesity (HCPCS code G0447)
- Transitional care management (CPT codes 99495-99496)
- Prolonged services codes, by review only (CPT codes 99354-99355 and 99356-99357)
- Annual wellness visits (HCPCS codes G0438-G0439)
- Counseling visit to discuss need for lung cancer screening using low dose CT scan (G0296)
- Interactive complexity psychiatry services and procedures (90785)
- Health risk assessment (96160-96161)
- Comprehensive assessment of and care planning for patients requiring chronic care management (G0506)
- Psychotherapy for crisis (90839-90840)
- Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling (G2086, G2087, and G2088)
- **FOR DATES OF SERVICE ON OR AFTER MARCH 6, 2020, THROUGH JUNE 30, 2020, OR UNTIL FURTHER NOTICE, THESE ADDITIONAL CODES FOR PHYSICAL THERAPY, SPEECH THERAPY, OCCUPATIONAL THERAPY WILL BE COVERED AS TELEHEALTH SERVICES :** CPT codes 92507, 92526, 92609, 97110, 97112, 97129, 97130, 97161, 97162, 97163, 97530, 97535 may be used to report two-way video services performed by physical therapists, occupational therapists, or speech and language pathologists for services within that practitioner's scope of license.
- **FOR DATES OF SERVICE ON OR AFTER MARCH 6, 2020, THROUGH JUNE 30, 2020, OR UNTIL FURTHER NOTICE, PREVENTIVE SERVICES CODES WITH MODIFIER 52 WILL BE COVERED AS TELEHEALTH SERVICES.** CPT codes 99381-99387 and 99391-99397 with Modifier 52 and either Modifier 95 or Modifier GT will be covered as telehealth services. Location code 11 may be used for these services.
    - Note: Modifier 52 and either Modifier 95 or Modifier GT are required for preventive services performed by two-way video connection.

** Inpatient telehealth consultations are furnished to PHP members in hospitals or skilled nursing facilities via telehealth at the request of the physician of record, the attending physician, or other appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner.

Submit telehealth claims with the appropriate CPT code for the professional service provided and **location code 02 (telehealth)**. Modifiers GT and 95 are not required for services billed with location 02 and will not affect payment if used.

- For services between March 30, 2020, and May 31, 2020, PHP will allow services listed on Appendix A of this policy to be billed with **location code 11 (office) and Modifier 95 or GT. Either Modifier 95 or Modifier GT is required for telehealth services billed with location code 11.**
- For services on or after March 6, 2020, and until further notice, PHP will allow services listed on Appendix B of this policy to be billed with the same location code that would have been used for a face-to-face service and Modifier 95 or GT. **Either Modifier 95 or Modifier GT is required for telehealth services billed under this exception.**

When store and forward technologies are used, submit the appropriate CPT code with location code 02 and telehealth **Modifier GQ**, "via asynchronous telecommunications system." (See “Alaska/Hawaii Demonstration Program” section.)

Effective January 1, 2019, Modifier G0 (G-zero) may be used to identify telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of acute stroke. PHP does not distinguish between originating sites that are rural or urban in providing coverage for telehealth services, so Modifier G0 is not required for these services, but it is accepted. In addition to other qualifying originating sites listed on this policy, acute stroke telehealth services may be furnished in a mobile stroke unit.

Alaska/Hawaii Demonstration Program

In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, PHP payment is permitted for telemedicine when asynchronous 'store and forward technology' in single or multimedia formats is used as a substitute for an interactive telecommunications system. The originating site and distant site practitioner must be included within the definition of the demonstration program. Store and forward technologies may be used as a substitute for an interactive telecommunications system. (See "Definition of Store and Forward" under “Conditions of Payment.”)

By using the GQ modifier, the distant site practitioner verifies that the asynchronous medical file was collected and transmitted to the physician or practitioner at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii. (See "Conditions of Payment" section.)

Conditions of Payment

For PHP payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the PHP member. As a condition of payment, the patient must be present and participating in the telehealth visit.

Definition of "store and forward": For purposes of this instruction, "store and forward" means the asynchronous transmission of medical information to be reviewed at a later time by physician or practitioner at the distant site. A patient's medical information may include, but is not limited to, video clips, still images, x-rays, MRIs, EKGs and EEGs, laboratory results, audio clips, and text. The physician or practitioner at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time. Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patient's condition and adequate for rendering or confirming a diagnosis and/or treatment plan. Dermatological photographs, e.g., a photograph of a skin lesion, may be considered to meet the requirement of a single media format under this instruction.

Professional Charges

PHP practitioners may receive payment at the distant site, i.e., at a site other than where beneficiary is. As a condition of PHP payment for telehealth services, the physician or practitioner at the distant site **must be licensed to provide the service under State law.** When the physician or practitioner at the distant site is licensed under State law to provide a covered telehealth service (i.e., professional consultation, office and other outpatient visits, individual psychotherapy, or pharmacologic management), then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

For services between March 30, 2020, and May 31, 2020, PHP will allow services listed on Appendix A of this policy to be billed with **location code 11 (office) and either Modifier 95 or Modifier GT. Either Modifier 95 or Modifier GT is required for services billed with location code 11.**

For services on or after March 6, 2020, and until further notice, PHP will allow services listed on Appendix B of this policy to be billed with the **same location code as a face-to-face service and either Modifier 95 or Modifier GT.**

Originating Site Facility Fee Payment Methodology

The term “originating site” means the location of an eligible PHP member at the time the service being furnished via a telecommunications system occurs. NOTE: For services performed on or after March 6, 2020, and until further notice, the requirement for the patient to be in an eligible originating site is temporarily waived.

For asynchronous, store and forward telecommunications technologies, an originating site is only a federal telemedicine demonstration program conducted in Alaska or Hawaii.

Originating Site Facility Fee

To receive the originating facility site payment, submit claims with HCPCS code Q3014, “telehealth originating site facility fee" (short description "telehealth facility fee"). The type of service for telehealth originating site facility fee is “9, other items and services.”

The benefit may be billed on bill types 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, and 85X. Unless otherwise applicable, report the originating site facility fee under revenue code 078X and include HCPCS code Q3014.

If the originating site is a physician’s office, the office location code (or place of service code) “11” is the only payable setting for code Q3014. The provider who bills the originating site facility fee may not be the same provider (or the same provider group or the same tax identification number) as the provider who is billing for services performed.

Modifier G0 (Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke) may be added to Q3014 to identify services furnished for treatment of acute stroke. This modifier is not required by PHP but is accepted.

APPENDIX A

THIS IS A LIST OF CODES ON PAYMENT POLICY 67.0.B WITH A SITE OF SERVICE DIFFERENTIAL. **THESE CODES MAY BE BILLED WITH MODIFIER 95 OR MODIFIER GT AND LOCATION CODE 11** FOR TELEHEALTH SERVICES FOR DATES OF SERVICE BETWEEN MARCH 30, 2020, AND MAY 31, 2020:

90785
90791
90792
90832
90833
90834
90836
90837
90838
90839
90840
90845
90846
90847
96116
96156
96158
96159
96164
96165
96167
96168
96170
96171
97129
97802
97803
97804
99201
99202
99203
99204
99205
99211
99212
99213
99214
99215

99354
99355
99406
99407
99495
99496
99497
99498
G0270
G0296
G0396
G0397
G0436
G0437
G0442
G0443
G0444
G0445
G0446
G0447
G0506
G2086
G2087
G2088

APPENDIX B

FOR DATES OF SERVICE ON OR AFTER MARCH 6, 2020, AND UNTIL FURTHER NOTICE, THE CODES LISTED ON APPENDIX B MAY BE BILLED AS TELEHEALTH SERVICES WITH MODIFIER 95 OR MODIFIER GT AND THE SAME LOCATION CODE THAT WOULD BE USED FOR A FACE-TO-FACE SERVICE.

Code	Short Descriptor
77427	Radiation tx management X5
90853	Group psychotherapy
90953	Esrd serv 1 visit p mo <2yr
90959	Esrd serv 1 vst p mo 12-19
90962	Esrd serv 1 visit p mo 20+
92521	Evaluation of speech fluenc
92522	Evaluation speech production
92523	Speech sound lang comprehen
92524	Behavral qualit analys voic
96130	Psycl tst eval phys/qhp 1st
96131	Psycl tst eval phys/qhp ea
96132	Nrpsyc tst eval phys/qhp 1st
96133	Nrpsyc tst eval phys/qhp ea
96136	Psycl/nrpsyc tst phy/qhp 1s
96137	Psycl/nrpsyc tst phy/qhp ea
96138	Psycl/nrpsyc tech 1st
96139	Psycl/nrpsyc tst tech ea
97116	Gait training therapy
97164	PT re-eval est plan care
97165	OT eval low complex 30 min
97166	OT eval mod complen 45 min
97167	OT eval high complex 60 min
97168	OT re-eval est plan care
97750	Physical Performance Test
97755	Assistive Technology Assess
97760	Orthotic mgmt&traing 1st en
97761	Prosthetic traing 1st enc
99217	Observation care discharge
99218	Initial observation care
99219	Initial observation care
99220	Initial observation care
99221	Initial hospital care
99222	Initial hospital care
99223	Initial hospital care
99234	Obser/hosp same date
99235	Obser/hosp same date
99236	Obser/hosp same date

99238	Hospital discharge day
99239	Hospital discharge day
99281	Emergency dept visit
99282	Emergency dept visit
99283	Emergency dept visit
99284	Emergency dept visit
99285	Emergency dept visit
99291	Critical care first hour
99292	Critical care addl 30 min
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99315	Nursing fac discharge day
99316	Nursing fac discharge day
99327	Domicil/r-home visit new pa
99328	Domicil/r-home visit new pa
99334	Domicil/r-home visit est pa
99335	Domicil/r-home visit est pa
99336	Domicil/r-home visit est pa
99337	Domicil/r-home visit est pa
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99345	Home visit new patient
99347	Home visit est patient
99348	Home visit est patient
99349	Home visit est patient
99350	Home visit est patient
99468	Neonate crit care initail
99469	Neonate crit care subsq
99471	Ped critical care initial
99472	Ped critical care subsq
99473	Self-meas bp pt educaj/trai
99475	Ped crit care age 2-5 init
99476	Ped crit care age 2-5 subsq
99477	Init day hosp neonate care
99478	Ic lbw inf < 1500 gm subsq
99479	Ic lbw inf 1500-2500 g subs
99480	Ic inf pbw 2501-5000 g subs
99483	Assmt & care pln cog imp

PROVIDENCE HEALTH PLANS PAYMENT POLICY	
SUBJECT: Telehealth Services DURING COVID-19 CRISIS MEDICARE ONLY	**DEPARTMENT**: Coding Compliance
ORIGINAL EFFECTIVE DATE: 3/1/2020	**DATE(S) REVIEWED / REVISED:** 3/15/20, 4/6/20
APPROVED BY: PHP ADMIN COUNCIL 4/6/20	**NUMBER: 67.0.A PAGE:** 1 of 6

POLICY:
This policy (67.0.A) "Telehealth Services During COVID-19 Crisis Medicare Only" APPLIES ONLY TO TWO-WAY VIDEO VISITS ON OR AFTER MARCH 1, 2020 AND ONLY TO MEDICARE LINES OF BUSINESS. For two-way video visits prior to March 1, 2020, providers are referred to PHP Payment Policy 67.0 (Telehealth Services Requiring an Originating Site), which is available on ProvLink.

EFFECTIVE MARCH 1, 2020, THROUGH JUNE 30, 2020, OR UNTIL FURTHER NOTICE, SERVICES LISTED ON THIS POLICY WILL NOT REQUIRE AN ORIGINATING SITE. THIS IS AN EMERGENCY PROVISION SUBJECT TO CANCELLATION AT THE SOLE DISCRETION OF PROVIDENCE HEALTH PLANS.

The Office for Civil Rights at the Department of Health and Human Services (HHS) has temporarily waived the requirement for HIPAA-compliant connections for two-way video services "..in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency." (https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html) For the duration of this emergency provision, codes listed on this policy may be paid for services performed by two-way video connections where the patient and/or provider is using a personal device. No contract amendment or attestation is required.

ONLY SERVICES PERFORMED BY TWO-WAY VIDEO CONNECTIONS ARE COVERED BY THIS POLICY. For **telephone visits** see Payment Policy 92.0. For **online digital E&M services,** see Payment Policy 53.0. PHP also pays virtual check-in services (HCPCS code G2012) for both new and established patients.

For dates of service on or after March 1, 2020, services listed on pages 3-4 of this policy and on Appendix A may be paid **when performed by two-way video connection.**

Professional claims for services on this policy for dates of service on or after March 1, 2020, may be billed:

- With the same place of service (POS) code that would have been used had the service been furnished in person.
- Modifier 95 or GT to indicate the service was performed via two-way video connection.

Telehealth services are services delivered via an electronic two-way communication system. PHP provides coverage for telehealth services when the service is medically necessary and supported by evidence-based medical criteria. Coverage for telehealth services includes payment for consultations, office visits, individual psychotherapy, and pharmacologic management. Specific services covered by this policy during the COVID-19 crisis are listed on pages 3-4 of this policy and on Appendix A. All providers (including chiropractors and naturopaths) who are credentialed with PHP and who are performing services within their scope of license may perform two-way video services listed on this policy.

Effective March 1, 2020, through June 30, 2020, or until further notice, PHP will allow payment for medically appropriate services performed using two-way video connections where the patient is calling from a personal device. Providers may also use a personal device to perform these services. The following conditions must be met for PHP to make payments for telehealth services listed on this policy:

- The service must be furnished via an interactive video telecommunications system;
- The service must be furnished by a physician or authorized practitioner credentialed with PHP;
- The service must be furnished to an eligible telehealth individual;
- **For services on or after March 1, 2020, through June 30, 2020, or until further notice, services are expanded to allow two-way video conferencing when the patient is using a personal device.**

APPLIES TO:
Health Plan Providers
Medicare Lines of Business Only

REFERENCE:
CMS Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

PROCEDURE:
Professional claims for services on this policy for dates of service on or after March 1, 2020, may be billed:

- With the same place of service (POS) code that would have been used had the service been furnished in person.
- Modifier 95 or GT to indicate the service was performed by two-way video connection.

Coverage of Telehealth
The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy, medical nutrition therapy and pharmacologic management. These services and corresponding CPT/HCPCS codes are listed below (pages 3-4) and on Appendix A.

- Office or other outpatient visits (CPT codes 99201-99215)
- Initial consult codes for emergency telehealth services only (HCPCS codes G0425-G0427)**(See notes on Page 4)
- Follow-up inpatient consultations for telehealth services only (HCPCS codes G0406-G0408)**(See notes on Page 4)
- Critical care telehealth consultation (HCPCS codes G0508-G0509)
- Subsequent hospital care services (CPT codes 99231-99233)
- Subsequent nursing facility care services (CPT codes 99307-99310)
- Advanced care planning (CPT codes 99497-99498)
- Psychotherapy (CPT codes 90832-90834, 90836-90838, 90845-90847)
- Medical nutrition therapy (HCPCS/CPT codes G0270, 97802, 97803, 97804)
- Inpatient pharmacologic management (HCPCS code G0459)
  Psychiatric diagnostic interview examination (CPT codes 90791-90792)
- Neurobehavioral status exam (CPT code 96116)
- End stage renal disease related services (CPT codes 90951-90952, 90954-90955, 90957-90958, 90960-90961, 90963-90970)
- Chronic kidney disease educational services (G0420-G0421)
- Diabetic self-management training services (G0108-G0109)
- Health and behavior assessments (CPT codes 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171)
- Alcohol and/or substance (other than tobacco) abuse assessment and brief intervention (HCPCS codes G0396-G0397)
- Annual alcohol misuse screening (HCPCS code G0442)
- Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes (HCPCS code G0443)
- Smoking and tobacco use cessation counseling (CPT codes 99406-99407, HCPCS codes G0436-G0437)
- Annual depression screening, 15 minutes (HCPCS code G0444)
- High-intensity behavioral counseling to prevent STD (HCPCS code G0445)
- Annual face-to-face intensive behavioral therapy for cardiovascular disease (HCPCS code G0446)
- Face-to-face behavioral counseling for obesity (HCPCS code G0447)
- Transitional care management (CPT codes 99495-99496)
- Prolonged services codes, by review only (CPT codes 99354-99355 and 99356-99357)
- Annual wellness visits (HCPCS codes G0438-G0439)
- Counseling visit to discuss need for lung cancer screening using low dose CT scan (G0296)
- Interactive complexity psychiatry services and procedures (90785)
- Health risk assessment (96160-96161)

- Comprehensive assessment of and care planning for patients requiring chronic care management (G0506)
- Psychotherapy for crisis (90839-90840)
- Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling (G2086, G2087, and G2088)
- **FOR DATES OF SERVICE ON OR AFTER MARCH 6, 2020, THROUGH JUNE 30, 2020, OR UNTIL FURTHER NOTICE, THESE ADDITIONAL CODES WILL BE COVERED AS TELEHEALTH SERVICES:** CPT codes 92526, 92609, 97129, 97130, and 97530 may be used to report two-way video services performed by physical therapists, occupational therapists, or speech and language pathologists for services within that practitioner's scope of license.
- **FOR DATES OF SERVICE ON OR AFTER MARCH 6, 2020, THROUGH JUNE 30, 2020, OR UNTIL FURTHER NOTICE, PREVENTIVE SERVICES CODES WITH MODIFIER 52 WILL BE COVERED AS TELEHEALTH SERVICES.** Preventive services codes 99381-99387 and 99391-99397 with Modifier 52 and Modifier 95 or GT will be covered as telehealth services. Location code 11 may be used for these services.
    - Note: Modifier 52 and either Modifier 95 or Modifier GT <u>are required</u> for preventive services performed by two-way video connection.

** Inpatient telehealth consultations are furnished to PHP members in hospitals or skilled nursing facilities via telehealth at the request of the physician of record, the attending physician, or other appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner.

For services on or after March 1, 2020, submit telehealth claims with the appropriate CPT or HCPCS code for the professional service provided. Use the same place of service (POS) code that would have been used if the service had been rendered in person. Append Modifier 95 or GT to the service code to indicate the service was performed by two-way video. **Either Modifier 95 or Modifier GT is required for telehealth services billed using the same POS code as a face-to-face service.**

When store and forward technologies are used, submit the appropriate CPT code with location code 02 and telehealth **Modifier GQ**, "via asynchronous telecommunications system." (See "Alaska/Hawaii Demonstration Program" section.)

Effective January 1, 2019, Modifier G0 (G-zero) may be used to identify telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of acute stroke.

PHP does not distinguish between originating sites that are rural or urban in providing coverage for telehealth services, so Modifier G0 is not required for these services, but it is accepted. In addition to other qualifying originating sites listed on Payment Policy 67.0 (Telehealth Services Requiring an Originating Site), acute stroke telehealth services may be furnished in a mobile stroke unit.

Alaska/Hawaii Demonstration Program

In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, PHP payment is permitted for telemedicine when asynchronous 'store and forward technology' in single or multimedia formats is used as a substitute for an interactive telecommunications system. The originating site and distant site practitioner must be included within the definition of the demonstration program. Store and forward technologies may be used as a substitute for an interactive telecommunications system. (See "Definition of Store and Forward" under “Conditions of Payment.”)

By using the GQ modifier, the distant site practitioner verifies that the asynchronous medical file was collected and transmitted to the physician or practitioner at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii. (See "Conditions of Payment" section.)

Conditions of Payment

For PHP payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the PHP member. As a condition of payment, the patient must be present and participating in the telehealth visit.

Definition of “store and forward”: For purposes of this instruction, “store and forward” means the asynchronous transmission of medical information to be reviewed at a later time by physician or practitioner at the distant site. A patient's medical information may include, but is not limited to, video clips, still images, x-rays, MRIs, EKGs and EEGs, laboratory results, audio clips, and text. The physician or practitioner at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time. Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patient’s condition and adequate for rendering or confirming a diagnosis and/or treatment plan. Dermatological photographs, e.g., a photograph of a skin lesion, may be considered to meet the requirement of a single media format under this instruction.

Professional Charges

PHP practitioners may receive payment at the distant site, i.e., at a site other than where beneficiary is. As a condition of PHP payment for telehealth services, the physician or practitioner at the distant site **must be licensed to provide the service under State law.** When the physician or practitioner at the distant site is licensed under State law to provide a covered telehealth service (i.e., professional consultation, office and other outpatient visits, individual psychotherapy, or pharmacologic management), then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

For services on or after March 1, 2020, PHP will allow services listed on this policy and on Appendix A to be billed using Modifier 95 or Modifier GT and the same POS code that would have been used if the service had been performed in person.

Originating Site Facility Fee Payment Methodology

For telehealth services performed to patients in an originating site, the originating facility or office may bill an originating site fee. The originating site fee does not apply to telehealth services performed for patients calling from a personal device.

Originating Site Facility Fee

To receive the originating facility site payment, submit claims with HCPCS code Q3014, “telehealth originating site facility fee" (short description "telehealth facility fee"). The type of service for telehealth originating site facility fee is “9, other items and services.”

The benefit may be billed on bill types 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, and 85X. Unless otherwise applicable, report the originating site facility fee under revenue code 078X and include HCPCS code Q3014.

If the originating site is a physician’s office, the office location code (or place of service code) “11” is the only payable setting for code Q3014. The provider who bills the originating site facility fee may not be the same provider (or the same provider group or the same tax identification number) as the provider who is billing for services performed.

Modifier G0 (Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke) may be added to Q3014 to identify services furnished for treatment of acute stroke. This modifier is not required by PHP but is accepted.

APPENDIX A

FOR DATES OF SERVICE ON OR AFTER MARCH 1, 2020, AND UNTIL FURTHER NOTICE, THE CODES LISTED ON APPENDIX A MAY BE BILLED AS TELEHEALTH SERVICES SUBJECT TO ALL REQUIREMENTS LISTED ON THIS POLICY.

Code	Short Descriptor
77427	Radiation tx management X5
90853	Group psychotherapy
90953	Esrd serv 1 visit p mo <2yr
90959	Esrd serv 1 vst p mo 12-19
90962	Esrd serv 1 visit p mo 20+
92507	Speech/hearing therapy
92521	Evaluation of speech fluenc
92522	Evaluation speech production
92523	Speech sound lang comprehen
92524	Behavral qualit analys voic
96130	Psycl tst eval phys/qhp 1st
96131	Psycl tst eval phys/qhp ea
96132	Nrpsyc tst eval phys/qhp 1st
96133	Nrpsyc tst eval phys/qhp ea
96136	Psycl/nrpsyc tst phy/qhp 1s
96137	Psycl/nrpsyc tst phy/qhp ea
96138	Psycl/nrpsyc tech 1st
96139	Psycl/nrpsyc tst tech ea
97110	Therapeutic exercises
97112	Neuromusulcar reeducation
97116	Gait training therapy
97161	PT Eval low complex 20 min
97162	PT Eval mod complex 30 min
97163	PT Eval high complex 45 min
97164	PT re-eval est plan care
97165	OT eval low complex 30 min
97166	OT eval mod complen 45 min
97167	OT eval high complex 60 min
97168	OT re-eval est plan care
97535	Self care mngment training
97750	Physical Performance Test
97755	Assistive Technology Assess
97760	Orthotic mgmt&traing 1st en
97761	Prosthetic traing 1st enc
99217	Observation care discharge
99218	Initial observation care
99219	Initial observation care
99220	Initial observation care

99221	Initial hospital care
99222	Initial hospital care
99223	Initial hospital care
99234	Obser/hosp same date
99235	Obser/hosp same date
99236	Obser/hosp same date
99238	Hospital discharge day
99239	Hospital discharge day
99281	Emergency dept visit
99282	Emergency dept visit
99283	Emergency dept visit
99284	Emergency dept visit
99285	Emergency dept visit
99291	Critical care first hour
99292	Critical care addl 30 min
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99315	Nursing fac discharge day
99316	Nursing fac discharge day
99327	Domicil/r-home visit new pa
99328	Domicil/r-home visit new pa
99334	Domicil/r-home visit est pa
99335	Domicil/r-home visit est pa
99336	Domicil/r-home visit est pa
99337	Domicil/r-home visit est pa
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99345	Home visit new patient
99347	Home visit est patient
99348	Home visit est patient
99349	Home visit est patient
99350	Home visit est patient
99468	Neonate crit care initail
99469	Neonate crit care subsq
99471	Ped critical care initial
99472	Ped critical care subsq
99473	Self-meas bp pt educaj/trai
99475	Ped crit care age 2-5 init
99476	Ped crit care age 2-5 subsq
99477	Init day hosp neonate care

99478	Ic lbw inf < 1500 gm subsq
99479	Ic lbw inf 1500-2500 g subs
99480	Ic inf pbw 2501-5000 g subs
99483	Assmt & care pln cog imp

PROVIDENCE HEALTH PLANS PAYMENT POLICY	
SUBJECT: Telehealth Services DURING COVID-19 CRISIS OHP ONLY	**DEPARTMENT**: Coding Compliance
ORIGINAL EFFECTIVE DATE: 3/1/2020	**DATE(S) REVIEWED / REVISED:** 3/15/20, 4/6/20, 4/27/20
APPROVED BY: PHP ADMIN COUNCIL 4/6/20	**NUMBER: 67.0.C PAGE:** 1 of 6

POLICY:
This policy (67.0.C) "Telehealth Services During COVID-19 Crisis OHP Only" APPLIES ONLY TO TELEHEALTH SERVICES ON OR AFTER MARCH 1, 2020 AND ONLY TO THE OREGON HEALTH PLAN (OHP) LINE OF BUSINESS. For telehealth services prior to March 1, 2020, providers are referred to PHP Payment Policy 67.0 (Telehealth Services Requiring an Originating Site), which is available on ProvLink.

EFFECTIVE MARCH 1, 2020, THROUGH JUNE 30, 2020, OR UNTIL FURTHER NOTICE, SERVICES LISTED ON THIS POLICY WILL NOT REQUIRE AN ORIGINATING SITE. THIS IS AN EMERGENCY PROVISION SUBJECT TO CANCELLATION AT THE SOLE DISCRETION OF PROVIDENCE HEALTH PLANS.

The Office for Civil Rights at the Department of Health and Human Services (HHS) has temporarily waived the requirement for HIPAA-compliant connections for two-way video services "..in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency." (https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html) For the duration of this emergency provision, codes listed on this policy may be paid for services performed by two-way video connections where the patient and/or provider is using a personal device. No contract amendment or attestation is required.

FOR DATES OF SERVICE PRIOR TO APRIL 17, 2020: ONLY SERVICES PERFORMED BY TWO-WAY VIDEO CONNECTION ARE COVERED BY THIS POLICY. For **telephone visits** see Payment Policy 92.0. For **online digital E&M services,** see Payment Policy 53.0. PHP also pays virtual check-in services (HCPCS code G2012) for both new and established patients.

FOR DATES OF SERVICE ON OR AFTER APRIL 17, 2020: For OHP members only, telehealth services listed on this policy may be performed by telephone if two-way video connection is not available or feasible.

For dates of service on or after March 1, 2020, services listed on pages 3-4 of this policy and on Appendix A may be paid **when performed by two-way video connection.** For dates of service on or after April 17, 2020, services listed on pages 3-4 of this policy and Appendix A may be paid when performed **either by two-way video connection or by telephone if two-way video is not available or feasible**. Providers may also use the CPT codes for telephone visits for telehealth services performed by telephone (see Payment Policy 92.0).

Professional claims for services on this policy for dates of service on or after March 1, 2020, may be billed:

- With the same place of service (POS) code that would have been used had the service been furnished in person.
- Modifier 95 or GT to indicate the service was performed via telehealth.

Telehealth services are services delivered via an electronic two-way communication system. PHP provides coverage for telehealth services when the service is medically necessary and supported by evidence-based medical criteria. Coverage for telehealth services includes payment for consultations, office visits, individual psychotherapy, and pharmacologic management. Specific services covered by this policy during the COVID-19 crisis are listed on pages 3-4 of this policy and on Appendix A. All providers (including chiropractors and naturopaths) who are credentialed with PHP and who are performing services within their scope of license may perform the telehealth services listed on this policy.

Effective March 1, 2020, through June 30, 2020, or until further notice, PHP will allow payment for medically appropriate services performed using two-way video connections where the patient is calling from a personal device. Providers may also use a personal device to perform these services. **Effective April 17, 2020**, these services will also be paid if performed by telephone if two-way video connection is not available or feasible. The following conditions must be met for PHP to make payments for telehealth services listed on this policy:

- The service must be furnished via an interactive video telecommunications system (or by telephone for services on or after April 17, 2020);
- The service must be furnished by a physician or authorized practitioner credentialed with PHP;
- The service must be furnished to an eligible telehealth individual;
- **For services on or after March 1, 2020, through June 30, 2020, or until further notice, services are expanded to allow telehealth services when the patient is using a personal device rather than requiring an originating site.**

APPLIES TO:
Health Plan Providers
Oregon Health Plan Line of Business Only

REFERENCE:
OHA/CMS Policy and Regulatory Revisions in Response to the COVID-19 Emergency

PROCEDURE:
Professional claims for services on this policy for dates of service on or after March 1, 2020, may be billed:

- With the same place of service (POS) code that would have been used had the service been furnished in person.
- Modifier 95 or GT to indicate the service was performed via telehealth.

Coverage of Telehealth

The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy, medical nutrition therapy and pharmacologic management. These services and corresponding CPT/HCPCS codes are listed below (pages 3-4) and on Appendix A.

- Office or other outpatient visits (CPT codes 99201-99215)
- Initial consult codes for emergency telehealth services only (HCPCS codes G0425-G0427)**(See notes on Page 4)
- Follow-up inpatient consultations for telehealth services only (HCPCS codes G0406-G0408)**(See notes on Page 4)
- Critical care telehealth consultation (HCPCS codes G0508-G0509)
- Subsequent hospital care services (CPT codes 99231-99233)
- Subsequent nursing facility care services (CPT codes 99307-99310)
- Advanced care planning (CPT codes 99497-99498)
- Psychotherapy (CPT codes 90832-90834, 90836-90838, 90845-90847)
- Medical nutrition therapy (HCPCS/CPT codes G0270, 97802, 97803, 97804)
- Inpatient pharmacologic management (HCPCS code G0459)
  Psychiatric diagnostic interview examination (CPT codes 90791-90792)
- Neurobehavioral status exam (CPT code 96116)
- End stage renal disease related services (CPT codes 90951-90952, 90954-90955, 90957-90958, 90960-90961, 90963-90970)
- Chronic kidney disease educational services (G0420-G0421)
- Diabetic self-management training services (G0108-G0109)
- Health and behavior assessments (CPT codes 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171)
- Alcohol and/or substance (other than tobacco) abuse assessment and brief intervention (HCPCS codes G0396-G0397)
- Annual alcohol misuse screening (HCPCS code G0442)
- Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes (HCPCS code G0443)
- Smoking and tobacco use cessation counseling (CPT codes 99406-99407, HCPCS codes G0436-G0437)
- Annual depression screening, 15 minutes (HCPCS code G0444)
- High-intensity behavioral counseling to prevent STD (HCPCS code G0445)
- Annual face-to-face intensive behavioral therapy for cardiovascular disease (HCPCS code G0446)
- Face-to-face behavioral counseling for obesity (HCPCS code G0447)
- Transitional care management (CPT codes 99495-99496)
- Prolonged services codes, by review only (CPT codes 99354-99355 and 99356-99357)
- Annual wellness visits (HCPCS codes G0438-G0439)

- Counseling visit to discuss need for lung cancer screening using low dose CT scan (G0296)
- Interactive complexity psychiatry services and procedures (90785)
- Health risk assessment (96160-96161)
- Comprehensive assessment of and care planning for patients requiring chronic care management (G0506)
- Psychotherapy for crisis (90839-90840)
- Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling (G2086, G2087, and G2088)
- **FOR DATES OF SERVICE ON OR AFTER MARCH 6, 2020, THROUGH JUNE 30, 2020, OR UNTIL FURTHER NOTICE, THESE ADDITIONAL CODES WILL BE COVERED AS TELEHEALTH SERVICES:** CPT codes 92526, 92609, 97129, 97130, and 97530 may be used to report telehealth services performed by physical therapists, occupational therapists, or speech and language pathologists for services within that practitioner's scope of license.
- **FOR DATES OF SERVICE ON OR AFTER MARCH 6, 2020, THROUGH JUNE 30, 2020, OR UNTIL FURTHER NOTICE, PREVENTIVE SERVICES CODES WITH MODIFIER 52 WILL BE COVERED AS TELEHEALTH SERVICES.** Preventive services codes 99381-99387 and 99391-99397 with Modifier 52 and either Modifier 95 or Modifier GT will be covered as telehealth services. Location code 11 may be used for these services.
    - Note: Modifier 52 and either Modifier 95 or Modifier GT <u>are required</u> for preventive services performed as telehealth services.

** Inpatient telehealth consultations are furnished to PHP members in hospitals or skilled nursing facilities via telehealth at the request of the physician of record, the attending physician, or other appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner.

For services on or after March 1, 2020, submit telehealth claims with the appropriate CPT or HCPCS code for the professional service provided. Use the same place of service (POS) code that would have been used if the service had been rendered in person. Append Modifier 95 or GT to the service code to indicate the service was performed as a telehealth service. **Either Modifier 95 or Modifier GT is required for telehealth services billed using the same POS code as a face-to-face service.**

When store and forward technologies are used, submit the appropriate CPT code with location code 02 and telehealth **Modifier GQ**, "via asynchronous telecommunications system." (See "Alaska/Hawaii Demonstration Program" section.)

Effective January 1, 2019, Modifier G0 (G-zero) may be used to identify telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of acute stroke. PHP does not distinguish between originating sites that are rural or urban in providing coverage for telehealth services, so Modifier G0 is not required for these services, but it is accepted. In addition to other qualifying originating sites listed on Payment Policy 67.0 (Telehealth Services Requiring an Originating Site), acute stroke telehealth services may be furnished in a mobile stroke unit.

Alaska/Hawaii Demonstration Program

In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, PHP payment is permitted for telemedicine when asynchronous 'store and forward technology' in single or multimedia formats is used as a substitute for an interactive telecommunications system. The originating site and distant site practitioner must be included within the definition of the demonstration program. Store and forward technologies may be used as a substitute for an interactive telecommunications system. (See "Definition of Store and Forward" under "Conditions of Payment.")

By using the GQ modifier, the distant site practitioner verifies that the asynchronous medical file was collected and transmitted to the physician or practitioner at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii. (See "Conditions of Payment" section.)

Conditions of Payment

For PHP payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the PHP member. As a condition of payment, the patient must be present and participating in the telehealth visit.

Definition of "store and forward": For purposes of this instruction, "store and forward" means the asynchronous transmission of medical information to be reviewed at a later time by physician or practitioner at the distant site. A patient's medical information may include, but is not limited to, video clips, still images, x-rays, MRIs, EKGs and EEGs, laboratory results, audio clips, and text. The physician or practitioner at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time. Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patient's condition and adequate for rendering or confirming a diagnosis and/or treatment plan. Dermatological photographs, e.g., a photograph

of a skin lesion, may be considered to meet the requirement of a single media format under this instruction.

Professional Charges

PHP practitioners may receive payment at the distant site, i.e., at a site other than where beneficiary is. As a condition of PHP payment for telehealth services, the physician or practitioner at the distant site **must be licensed to provide the service under State law.** When the physician or practitioner at the distant site is licensed under State law to provide a covered telehealth service (i.e., professional consultation, office and other outpatient visits, individual psychotherapy, or pharmacologic management), then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

For services on or after March 1, 2020, PHP will allow services listed on this policy and on Appendix A to be billed using Modifier 95 or Modifier GT and the same POS code that would have been used if the service had been performed in person.

Originating Site Facility Fee Payment Methodology

For telehealth services performed to patients in an originating site, the originating facility or office may bill an originating site fee. The originating site fee does not apply to telehealth services performed for patients calling from a personal device.

Originating Site Facility Fee

To receive the originating facility site payment, submit claims with HCPCS code Q3014, “telehealth originating site facility fee" (short description "telehealth facility fee"). The type of service for telehealth originating site facility fee is “9, other items and services.”

The benefit may be billed on bill types 12X, 13X, 22X, 23X, 71X, 72X, 73X, 76X, and 85X. Unless otherwise applicable, report the originating site facility fee under revenue code 078X and include HCPCS code Q3014.

If the originating site is a physician’s office, the office location code (or place of service code) “11” is the only payable setting for code Q3014. The provider who bills the originating site facility fee may not be the same provider (or the same provider group or the same tax identification number) as the provider who is billing for services performed.

Modifier G0 (Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke) may be added to Q3014 to identify services furnished for treatment of acute stroke. This modifier is not required by PHP but is accepted.

APPENDIX A

FOR DATES OF SERVICE ON OR AFTER MARCH 1, 2020, AND UNTIL FURTHER NOTICE, THE CODES LISTED ON APPENDIX A MAY BE BILLED AS TELEHEALTH SERVICES SUBJECT TO ALL REQUIREMENTS LISTED ON THIS POLICY.

Code	Short Descriptor
77427	Radiation tx management X5
90853	Group psychotherapy
90953	Esrd serv 1 visit p mo <2yr
90959	Esrd serv 1 vst p mo 12-19
90962	Esrd serv 1 visit p mo 20+
92507	Speech/hearing therapy
92521	Evaluation of speech fluenc
92522	Evaluation speech production
92523	Speech sound lang comprehen
92524	Behavral qualit analys voic
96130	Psycl tst eval phys/qhp 1st
96131	Psycl tst eval phys/qhp ea
96132	Nrpsyc tst eval phys/qhp 1st
96133	Nrpsyc tst eval phys/qhp ea
96136	Psycl/nrpsyc tst phy/qhp 1s
96137	Psycl/nrpsyc tst phy/qhp ea
96138	Psycl/nrpsyc tech 1st
96139	Psycl/nrpsyc tst tech ea
97110	Therapeutic exercises
97112	Neuromusulcar reeducation
97116	Gait training therapy
97161	PT Eval low complex 20 min
97162	PT Eval mod complex 30 min
97163	PT Eval high complex 45 min
97164	PT re-eval est plan care
97165	OT eval low complex 30 min
97166	OT eval mod complen 45 min
97167	OT eval high complex 60 min
97168	OT re-eval est plan care
97535	Self care mngment training
97750	Physical Performance Test
97755	Assistive Technology Assess
97760	Orthotic mgmt&traing 1st en
97761	Prosthetic traing 1st enc
99217	Observation care discharge
99218	Initial observation care
99219	Initial observation care
99220	Initial observation care

99221	Initial hospital care
99222	Initial hospital care
99223	Initial hospital care
99234	Obser/hosp same date
99235	Obser/hosp same date
99236	Obser/hosp same date
99238	Hospital discharge day
99239	Hospital discharge day
99281	Emergency dept visit
99282	Emergency dept visit
99283	Emergency dept visit
99284	Emergency dept visit
99285	Emergency dept visit
99291	Critical care first hour
99292	Critical care addl 30 min
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99315	Nursing fac discharge day
99316	Nursing fac discharge day
99327	Domicil/r-home visit new pa
99328	Domicil/r-home visit new pa
99334	Domicil/r-home visit est pa
99335	Domicil/r-home visit est pa
99336	Domicil/r-home visit est pa
99337	Domicil/r-home visit est pa
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99345	Home visit new patient
99347	Home visit est patient
99348	Home visit est patient
99349	Home visit est patient
99350	Home visit est patient
99468	Neonate crit care initail
99469	Neonate crit care subsq
99471	Ped critical care initial
99472	Ped critical care subsq
99473	Self-meas bp pt educaj/trai
99475	Ped crit care age 2-5 init
99476	Ped crit care age 2-5 subsq
99477	Init day hosp neonate care

99478	Ic lbw inf < 1500 gm subsq
99479	Ic lbw inf 1500-2500 g subs
99480	Ic inf pbw 2501-5000 g subs
99483	Assmt & care pln cog imp

PROVIDENCE HEALTH PLANS PAYMENT POLICY	
SUBJECT: TELEPHONE SERVICES FOR COVID-19 CRISIS	**DEPARTMENT**: Coding Compliance
ORIGINAL EFFECTIVE DATE: 01/01/2015	**DATE(S) REVIEWED / REVISED:** 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 3/6/20
APPROVED BY: PPRC: 3/6/20	**NUMBER**: 92.0 **PAGE:** 1 of 3

POLICY:

NOTE: EFFECTIVE MARCH 6, 2020, THROUGH JUNE 30, 2020, OR UNTIL FURTHER NOTICE, THIS POLICY HAS BEEN UPDATED TO SHOW THAT TELEPHONE SERVICES MAY BE REPORTED FOR BOTH NEW AND ESTABLISHED PATIENTS. IN ADDITION, THE POLICY HAS BEEN TEMPORARILY EXPANDED TO INCLUDE TELEPHONE SERVICES BY QUALIFIED NON-PHYSICIAN PRACTITIONERS WHO ARE CREDENTIALED WITH PHP AND WHO ARE BILLING PHP DIRECTLY. THIS IS AN EMERGENCY PROVISION SUBJECT TO CANCELLATION AT THE SOLE DISCRETION OF PROVIDENCE HEALTH PLANS.

Telephone services are non-face-to-face evaluation and management (E/M) services provided by a physician or other qualified health care professional to a patient using the telephone. These codes are used to report episodes of care by the physician or other qualified health care professional initiated by an established** patient or guardian of an established** patient.

If the service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the pre-service work of the subsequent E/M service and/or procedure. Likewise, if the telephone service is related to an E/M service performed and reported by the physician or other qualified health care professional within the previous seven days (either provider-requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure. All CPT guidelines for use of these codes must be followed.

** Effective for dates of service on or after March 6, 2020, through June 30, 2020, or until further notice, services covered by this policy may also be reported for services initiated by a **new patient or guardian of a new patient**.

APPLIES TO:

All lines of business
Participating providers only

REFERENCE:
Current Procedural Terminology (CPT)
CMS/Medicare Rules and Regulations
PHP Coding Edits

PROCEDURE:
The physician or other qualified health care professional may report the appropriate code based on the amount of time spent on the visit. All CPT guidelines for use of these codes must be followed:

- **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:** Telephone evaluation and management service (same as above), **11-20 minutes of medical discussion**

- **99443:** Telephone evaluation and management service (same as above), **21-30 minutes of medical discussion**

Note: **Code 99443 is used for visits of 21 minutes or longer. No additional payment is made for visits longer than 30 minutes**.

Effective March 6, 2020, through June 30, 2020, or until further notice, CPT codes 98966-98968 may be billed by qualified non-physician health care professionals who are credentialed with PHP and who bill PHP directly. These codes may not be billed as “incident to” services under a different provider’s name. Codes 98966-98968 are allowed for both new and established patients. All CPT guidelines for use of these codes must be followed.

- **98966**: Telephone assessment and management service provided by a qualified non-physician 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**: Telephone assessment and management service (same as above); 11-20 minutes of medical discussion

- **98968**: Telephone assessment and management service (same as above); 21-30 minutes of medical discussion

Note: Code 98968 is used for visits of 21 minutes or longer. No additional payment is made for visits longer than 30 minutes.

** Effective for dates of service on or after March 6, 2020, through June 30, 2020, or until further notice, services covered by this policy may also be reported for services initiated by a **new patient or guardian of a new patient.**

CPT codes 99441-99443 and 98966-98968 may NOT be used to report non-evaluative telephone services such as communication of test results, scheduling of appointments, or other communication that does not include evaluation and/or assessment. Telephone services are not covered for patients who are hospitalized, including inpatient, outpatient, or observation status.

Documentation for telephone visits should model SOAP charting and must include patient history, provider assessment, treatment plan, and follow-up instructions. Documentation must be adequate so the information provided supports the assessment and plan and must be retained in the patient's medical record and be retrievable.

Use **location code "99"** for reporting telephone services. **Do not append modifier GT or modifier 95**. Modifier 95 is not accepted by PHP. Modifier GT is not accepted with these codes.

Telehealth and Telemedicine Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations. UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

Application

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

This policy describes reimbursement for Telehealth and Telemedicine services, which occur when the Physician or Other Qualified Health Care Professional and the patient are not at the same site. Examples of such services are those that are delivered over the phone, via the Internet or using other communication devices. Note: For the purposes of this policy, the terms Telehealth and Telemedicine are used interchangeably.

Reimbursement Guidelines

UnitedHealthcare will consider for reimbursement Telehealth services which are recognized by The Centers for Medicare and Medicaid Services (CMS) and appended with modifiers GT or GQ, or G0 (numeric zero, not alpha O) for telehealth services related to acute stroke, as well as services recognized by the AMA included in Appendix P of CPT and appended with modifier 95.

In addition, UnitedHealthcare recognizes certain additional services which can be effectively performed via Telehealth/Telemedicine. These services will be considered for reimbursement when reported with modifier GT or GQ:

- Medical genetics and genetic counseling services (code 96040)
- Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum (codes 98960-98962)
- Alcohol and/or substance abuse screening and brief intervention services (codes 99408-99409)

- Remote real-time interactive video-conferenced critical care evaluation and management of the critically ill or critically injured patient, use 99499

UnitedHealthcare requires one of the telehealth-associated modifiers (GT, GQ, G0 or 95) to be reported when performing a service via Telehealth to indicate the type of technology used and to identify the service as Telehealth.

UnitedHealthcare will consider reimbursement for a procedure code/modifier combination using these modifiers only when the modifier has been used appropriately. Coding relationships for modifier GQ and modifier 95 are administered through the UnitedHealthcare Procedure to Modifier Policy.

UnitedHealthcare recognizes the CMS-designated Originating Sites considered eligible for furnishing Telehealth services to a patient located in an Originating Site.

Examples of Originating Sites are listed below:

- The office of a physician or practitioner;
- A hospital (inpatient or outpatient);
- A critical access hospital (CAH);
- A rural health clinic (RHC);
- A federally qualified health center (FQHC);
- A hospital-based or critical access hospital-based renal dialysis center (including satellites); NOTE: Independent renal dialysis facilities are not eligible Originating Sites
- A skilled nursing facility (SNF); and
- A community mental health center (CMHC)
- Mobile Stroke Unit
- Patient home - only for monthly end stage renal, ESRD-related clinical assessments, and for purposes of treatment of a substance use disorder or a co-occurring mental health disorder.

UnitedHealthcare recognizes the CMS-designated practitioners eligible to be reimbursed for Telehealth services.
Examples of practitioners are listed below:

- Physician
- Nurse practitioner
- Physician assistant
- Nurse-midwife
- Clinical nurse specialist
- Registered dietitian or nutrition professional
- Clinical psychologist
- Clinical social worker
- Certified Registered Nurse Anesthetists

UnitedHealthcare recognizes but does not require Place of Service (POS) code 02 for reporting Telehealth services rendered by a physician or practitioner from a Distant Site. Modifiers GT, GQ, GO or 95 are required instead to identify Telehealth services.

UnitedHealthcare recognizes federal and state mandates regarding Telehealth and Telemedicine.

Telehealth Transmission
UnitedHealthcare follows CMS guidelines which do not allow reimbursement for Telehealth transmission, per minute, professional services bill separately reported with HCPCS code T1014. They are non-reimbursable codes according to the CMS Physician Fee Schedule (PFS) and are considered included in Telehealth services.
Telephone Services
UnitedHealthcare follows CMS guidelines which do not allow reimbursement for telephone services which are non-face-to-face evaluation and management services by a Physician or Other Qualified Health Care Professional reported with CPT codes 98966-98968 or 99441-99443. They are non-reimbursable codes according to the CMS Physician Fee Schedule (PFS) and are considered an integral part of other services provided.
Online Digital Evaluation and Management Services
UnitedHealthcare aligns with CMS Physician Fee Schedule (PFS) guidelines and considers online digital evaluation and management services (99421-99423 and G2061-G2063) eligible for reimbursement. These codes must be reported according to the guidelines as outlined by the AMA in CPT. Note: Codes 98970-98972 are not eligible for reimbursement, according to the CMS PFS.
Interprofessional Telephone/Internet/Electronic Health Record Consultations
UnitedHealthcare follows CMS guidelines and considers interprofessional telephone/Internet assessment and management services reported by consultative physicians with CPT codes 99446-99449 and 99451-99452 eligible for reimbursement according to the CMS Physician Fee Schedule (PFS).
Digitally Stored Data Services/Remote Physiologic Monitoring/Remote Physiologic Treatment Management
UnitedHealthcare follows CMS guidelines and considers digitally stored data services or remote physiologic monitoring services reported with CPT codes 99453, 99454, 99457, 99458, 99473, 99474, and 99091 eligible for reimbursement according to the CMS Physician Fee Schedule (PFS).
Remote Evaluation of Recorded Video and/or Images
UnitedHealthcare follows CMS guidelines and considers 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 reported with HCPCS codes G2010 eligible for reimbursement according to the CMS Physician Fee Schedule (PFS).
Brief Communication Technology-based Service
UnitedHealthcare follows CMS guidelines and considers 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 reported with HCPCS code G2012 eligible for reimbursement according to the CMS Physician Fee Schedule (PFS).
Opioid Use Disorder Treatment

UnitedHealthcare follows CMS guidelines effective for services rendered on or after January 1, 2020, and considers office-based treatment for opioid use disorders, G2086-G2088, eligible for reimbursement according to the CMS Physician Fee Schedule (PFS).

Definitions	
Asynchronous Telecommunication	Medical information is stored and forwarded to be reviewed at a later time by a physician or health care practitioner at a Distant Site. The medical information is reviewed without the patient being present. Also referred to as store-and-forward Telehealth or non-interactive telecommunication.
Distant Site	The location of a Physician or Other Qualified Health Care Professional at the time the service being furnished via a telecommunications system occurs.
Originating Site	The location of a patient at the time the service being furnished via a telecommunications system occurs.
Physician or Other Qualified Health Care Professional	Per the CPT book, a Physician or Other Qualified Health Care Professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.
Telehealth/Telemedicine	Telehealth services are live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technology. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

Questions and Answers	
1	**Q:** How does UnitedHealthcare reimburse for phone calls to patients that are not associated with any other service? For example, a pediatrician receives a call from a mother at 2 A.M. regarding an asthmatic child having difficulty breathing. The physician is able to handle the situation over the phone without requiring the child to be seen in an emergency room. On what basis will the visit be denied? **A:** UnitedHealthcare will not reimburse for these services (99441-99443 or 98966-98968), as they are considered included in the overall management of the patient.
2	**Q:** A physician makes daily telephone calls to an unstable diabetic patient to check on the status of his condition. These services are in lieu of clinic visits. Will UnitedHealthcare reimburse the physician for these telephone services? **A:** No, UnitedHealthcare will not reimburse telephone services (99441-99443 or 98966-98968), as they are considered included in the overall management of the patient.
3	**Q:** What is the difference between Telehealth services and telephone calls? **A:** Telehealth services are live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technology. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology. Telephone calls, which are considered audio transmissions, per the CPT definition, are non-face-to-face evaluation and management (E/M) services provided to a patient using the telephone by a Physician or Other Qualified Health Care Professional, who may report evaluation and management services.
4	**Q:** If a provider renders the professional component for a diagnostic service, at a Distant Site from the patient, should modifier GT be reported? **A:** No. Modifier GT indicates a face-to-face encounter utilizing interactive audio-visual communication technology. Therefore, it is not appropriate to report modifier GT in this scenario since this does not represent a face-to-face encounter. However, use of modifier 26 would be appropriate to designate that the professional

	component of the diagnostic service was provided. Please refer to the Professional/Technical Component Policy for more information.

Attachments	
Codes Recognized with modifiers GT or GQ	A list of codes that UnitedHealthcare recognizes when reported with modifier GT or GQ.
Codes Recognized with modifier 95	A list of codes that UnitedHealthcare recognizes when reported with modifier 95.

Resources
American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

History	
3/6/2020	Annual Anniversary Date and Version Change Reimbursement Guidelines Section: Modifier and Place of Service tables removed and verbiage updated
1/1/2020	Policy Version Change Codes and Modifiers Section: Revised Online Evaluation and Management Evaluation codes, Interprofessional Telephone/Internet/Electronic Health Record Consultations, Digitally Stored Data Services/Remote Physiologic Monitoring/Remote Physiologic Treatment Management, Remote Evaluation of Recorded Video and/or Images, Brief Communication Technology-based Service and added Opioid Use Treatment Attachment Section: Codes Recognized with modifiers GT or GQ List and Codes Recognized with modifier 95 list updated History prior to 1/1/2018 archived
10/1/2019	Policy Version Change Attachment Section: Codes Recognized with modifiers GT or GQ List and Codes Recognized with modifier 95 list updated by removing 99241-99255 consultation services codes.
7/01/2019	Policy Version Change Codes and Modifiers Section: Clarification of GQ modifier and 95 modifier processing Added permissible conditions for home as an originating site

	Definition Section: Removal of Interactive Audio and Video Telecommunication, Interactive Audio and Visual Transmissions, Audio-Visual Communication Technology and removed capitalization throughout the policy Q&A #3: Added "audio transmission" to answer
1/25/2019	Policy Version Change Codes and Modifiers Section: Added 98960-98962, 99408, 99409 info back in Attachment Section: Codes Recognized with modifiers GT or GQ List updated
1/1/2019 – 1/24/2019	Policy Version Change Application Section: Removed Community and State and Medicare and Retirement information Reimbursement section: Added modifier G0, added originating sites and types of non-face-to-face services Definition section: Updated Telehealth/Telemedicine definition and Physician or Other Qualified Health Care Professional definition Removed previous Q&A #3. Updated definitions in current Q&A #3. Attachments Section: Lists updated. History prior to 1/1/2017 archived
9/30/2018 – 12/31/2018	Policy Version Change: Professional added to policy title Codes Recognized with Modifier GT list updated
7/11/2018	Annual Approval Date Change (no new version)
4/17/2018 – 9/29/2018	Policy Verbiage Change and Restructuring. New version. Policy List Change: Codes Recognized with Modifier 95 added
1/1/2018 – 4/16/2018	Annual Policy Version Change Policy List Change: Codes Recognized with Modifier GT list updated History Section: Entries prior to 1/1/2016 archived

.

COVID-19

UnitedHealthcare Telehealth Services: Care Provider Coding Guidance

UnitedHealthcare®

COVID-19

The following scenarios are intended as a guide to help you understand how UnitedHealthcare will reimburse telehealth services during the COVID-19 emergency period. You as a provider are responsible to ensure you submit accurate claims in accordance with state and federal laws and UnitedHealthcare's reimbursement policies. The scenarios are not intended to cover every telehealth service you may perform during the COVID-19 emergency period. As such, please see UHCprovider.com and UnitedHealthcare's reimbursement policies for Medicare Advantage, Medicaid and commercial. Medicaid state-specific coding may apply and differ from those illustrated in these examples.

The scenarios in this document apply for dates of service March 18 through June 18, 2020, unless UnitedHealthcare extends the end date.

UnitedHealthcare®

Telehealth Scenario 1: Established patient visit with a provider who uses an audio-video or audio-only telecommunications system for COVID-19 or non-COVID-19 related care.

Patient Scenario	Visit	Billing
Established patient presents for a telehealth visit using HIPAA-compliant or non-HIPAA-compliant audio-video or audio-only technology for COVID-19 or non-COVID-19 related care not resulting in COVID-19 diagnostic testing.	• Scheduled or same day telehealth visit with an established patient • Use of HIPAA-compliant or non-HIPAA-compliant audio-video or audio-only technology, such as FaceTime or Skype* • Care is delivered by a physician, nurse practitioner or physician assistant **United States Department of Health and Human Services (HHS) is exercising enforcement discretion and waiving penalties of HIPAA during the COVID-19 emergency period.*	**Step 1**. Use appropriate Office Visit E/M code (99211-99215) **Step 2**. Use place of service that would have been reported had the service been furnished in person (11, 20, 22, 23) **Step 3**. Use 95 modifier for commercial, Medicare Advantage and Medicaid* **Step 4**. Refer to Centers for Disease Control and Prevention (CDC) ICD-10-CM Official Coding Guidelines *Medicaid* state specific rules for modifiers and POS apply.*

UnitedHealthcare®

Telehealth Scenario 2: Established patient visit with a provider who uses an audio-video or audio-only telecommunications system for evaluating need for COVID-19 testing.

Patient Scenario	Visit	Billing
Established patient presents for a telehealth visit using HIPAA-compliant or non-HIPAA-compliant audio-video or audio-only technology for evaluating need for COVID-19 testing.	• Scheduled or same day telehealth visit with an established patient • Use of HIPAA-compliant or non-HIPAA-compliant audio-video or audio-only technology, such as FaceTime or Skype* • Care is delivered by a physician, nurse practitioner or physician assistant **HHS is exercising enforcement discretion and waiving penalties of HIPAA during the COVID-19 emergency period.*	**Step 1.** Use appropriate Office Visit E/M code (99211-99215) **Step 2.** Use place of service that would have been reported had the service been furnished in person (11, 20, 22, 23) **Step 3.** Use 95 modifier for commercial, Medicare Advantage and Medicaid* **Step 4.** Refer to CDC ICD-10-CM Official Coding Guidelines *Medicaid* state specific rules for modifiers and POS apply.*

UnitedHealthcare®

Telehealth Scenario 3: Established patient with COVID-19 diagnosis visits with a provider who uses an audio-video or audio-only telecommunications system.

Patient Scenario	Visit	Billing
Established patient, who has been confirmed positive for COVID-19, presents for a telehealth visit using HIPAA compliant or non-HIPAA-compliant audio-video or audio-only technology for COVID-19 related or non-COVID-19 follow-up care.	• Scheduled or same day telehealth visit with a patient that you have seen in the past three years • Use of HIPAA-compliant or non-HIPAA-compliant audio-video or audio-only technology, such as FaceTime or Skype* • Care is delivered by a physician, nurse practitioner or physician assistant **HHS is exercising enforcement discretion and waiving penalties of HIPAA during the COVID-19 emergency period.*	**Step 1.** Use appropriate Office Visit E/M code (99211-99215) **Step 2.** Use place of service that would have been reported had the service been furnished in person (11, 20, 22, 23) **Step 3.** Use 95 modifier for commercial, Medicare Advantage and Medicaid* **Step 4.** Refer to CDC ICD-10-CM Official Coding Guidelines *Medicaid* state specific rules for modifiers and POS apply.*

UnitedHealthcare®

Telehealth Scenario 4: New patient visit with a provider who uses an audio-video or audio-only telecommunications system COVID-19 or non-COVID-19 related care.

Patient Scenario	Visit	Billing
New patient* presents for a telehealth visit using HIPAA-compliant or non-HIPAA-compliant audio-video or audio-only technology for COVID-19 or non-COVID-19 related care without COVID-19 diagnostic testing. *Subject to state law requirements.*	• Scheduled or same day telehealth visit with a patient that you have seen in the past three years • Use of HIPAA-compliant or non-HIPAA-compliant audio-video or audio-only technology, such as FaceTime or Skype* • Care is delivered by a physician, nurse practitioner or physician assistant *HHS is exercising enforcement discretion and waiving penalties of HIPAA during the COVID-19 emergency period.*	**Step 1**. Use appropriate Office Visit E/M code (99201-99205) **Step 2**. Use place of service that would have been reported had the service been furnished in person (11, 20, 22, 23) **Step 3**. Use 95 modifier for commercial, Medicare Advantage and Medicaid* **Step 4**. Refer to CDC ICD-10-CM Official Coding Guidelines *Medicaid* state specific rules for modifiers and POS apply.*

UnitedHealthcare®

Telehealth Scenario 5: New patient visit with a provider who uses an audio-video or audio-only telecommunications system for evaluating need for COVID-19 testing.

Patient Scenario	Visit	Billing
New patient* presents for a telehealth visit using HIPAA compliant or non–HIPAA-compliant audio-video or audio-only technology for evaluating need for COVID-19 testing. *Subject to state law requirements.*	• Scheduled or same day telehealth visit with a patient that you have seen in the past three years • Use of HIPAA-compliant or non-HIPAA-compliant audio-video or audio-only technology, such as FaceTime or Skype* • Care is delivered by a physician, nurse practitioner or physician assistant **HHS his exercising enforcement discretion and waiving penalties of HIPAA during the COVID-19 emergency period.*	**Step 1.** Use appropriate Office Visit E/M code (99201-99205) **Step 2.** Use place of service that would have been reported had the service been furnished in person (11, 20, 22, 23) **Step 3.** Use 95 modifier for commercial, Medicare Advantage and Medicaid* **Step 4.** Refer to CDC ICD-10-CM Official Coding Guidelines *Medicaid* state-specific rules for modifiers and POS apply.*

UnitedHealthcare®

Electronic Visit (e-visit) Scenario 1: Communication between an established patient and their provider through an online patient portal for COVID-19 or non-COVID-19 related care.

Patient Scenario	Visit	Billing
Established patient sends message (e-visit) through the online patient portal or some other secure platform. (i.e., MyChart).	• Patient initiates an e-visit on an issue through the provider's online patient portal to a physician, nurse practitioner or physician assistant	**Step 1**. Use appropriate CPT code (99421-99423) **Step 2**. Use appropriate Place of Service (11, 20, 22, 23) **Step 3**. No modifiers are required for commercial, Medicare Advantage or Medicaid **Step 4**. Refer to CDC ICD-10-CM Official Coding Guidelines
Established patient sends message (e-visit) through the online patient portal or some other secure platform (i.e., MyChart).	• Patient initiates an e-visit on an issue through the provider's online patient portal to a non-qualified physician (physical, occupational and/or speech therapist)	**Step 1**. Use appropriate HCPCS code (G2061-G2063) **Step 2**. Use appropriate Place of Service (11, 20, 22, 23) **Step 3**. No modifiers are required for commercial, Medicare Advantage or Medicaid **Step 4**. Refer to CDC ICD-10-CM Official Coding Guidelines

UnitedHealthcare®

Virtual Check-In Scenario 1: A brief check-in with the provider using audio-only with established patient for COVID-19 or non-COVID-19 related care.

Patient Scenario	Visit	Billing
Established patient connects for a brief check-in by audio only (virtual check-in).	• Patient initiates a phone call with physician, nurse practitioner or physician assistant • Issue is not related to a medical visit within the previous seven days and not resulting in a medical visit within the next 24 hours (or soonest appointment available)	**Step 1**. Use appropriate HCPCS code (G2012) **Step 2**. Use appropriate Place of Service (11, 20, 22, 23) **Step 3**. No modifiers are required for commercial, Medicare Advantage or Medicaid **Step 4**. Refer to CDC ICD-10-CM Official Coding Guidelines

UnitedHealthcare®

Virtual Check-In Scenario 2: A brief check-in with the provider using a recorded video and/or images submitted by established patient for COVID-19 or non-COVID-19 related care.

Patient Scenario	Visit	Billing
Established patient sends picture for evaluation using a brief check-in (virtual check-in).	• Patient sends a picture for evaluation to a physician, nurse practitioner or physician assistant • Issue is not related to a medical visit within the previous seven days and not resulting in a medical visit within the next 24 hours (or soonest appointment available).	**Step 1**. Use appropriate HCPCS code (G2010) **Step 2**. Use appropriate Place of Service (11, 20, 22, 23) **Step 3**. No modifiers are required for commercial, Medicare Advantage or Medicaid **Step 4**. Refer to CDC ICD-10-CM Official Coding Guidelines

UnitedHealthcare®

Resources

- Find the latest UnitedHealthcare COVID-19 related resources at UHCprovider.com/covid19.
- Learn more about our reimbursement policies at UHCprovider.com/policies.
- For the most recent updates on COVID-19, visit the CDC and World Health Organization.

Information provided by the American Medical Association does not dictate payer reimbursement policy, and does not substitute for the professional judgement of the practitioner performing a procedure, who remains responsible for correct coding.

UnitedHealthcare®