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COVID-19 Virtual Visit & Reimbursement Guide - Nebraska

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ruralMED
REVENUE CYCLE RESOURCES

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VIRTUAL VISIT TYPES

TELEHEALTH

Definition: There are three types of telehealth services:

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

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

CPT/HCPCS Codes:

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

Reporting Criteria:

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

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

E-VISITS

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

CPT/HCPCS Codes:
Reportable by a Qualified Healthcare Professionals:

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

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

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

Reporting Criteria:

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

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

VIRTUAL CHECK-IN

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

CPT/HCPCS Codes:

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

- **G0071:** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only.

Reporting Criteria:

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

Documentation Requirements:

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

TELEPHONE

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

CPT/HCPCS Codes:
Reportable by Qualified Healthcare Professionals:

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

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

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

Reporting Criteria:

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

Documentation Requirements:

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

PAYOR MATRIX

PAYOR	E-VISIT	TELEHEALTH- NO ORIGINATING SITE RESTRICTION	VIRTUAL CHECK-IN	TELEPHONE
AETNA	ALLOWABLE **Coverage:** Effective: March 6th, 2020 **Patient Type**: Established Only **Billing:** 99421-99423, 98970 -98972, G2061-G2063.	ALLOWABLE **Coverage:** Effective: March 6th, 2020 **Patient Type**: New or Established **Billing:** Telehealth Eligible Code **Professional:** Modifier GT (CMS CPTs) or 95 (Appendix P CPTs) w/ POS 02. **Facility**: Modifier GT or 95.	ALLOWABLE **Coverage:** Effective: March 6th, 2020 **Patient Type**: Established Only **Billing:** G2010, G2012	ALLOWABLE **Coverage:** Effective: March 6th, 2020 **Patient Type**: Established Only **Billing:** 99441-99443, 98966-98968.
BCBS NE* * Excludes any FEP or out-of-state BCBS members.	ALLOWABLE **Coverage:** Effective: March 13th,2020 **Patient Type**: Established **Billing:** CPT 99421-99423 & 98970 -98972.	ALLOWABLE **Coverage:** Effective: March 13th,2020 **Patient Type**: New or Established Patients **Billing:** E&M, Therapy, or Telehealth code. **Professional**: Modifier 95 and POS 02. **Facility**: Not allowable	CONDITIONAL Check contracted fee schedule to see if virtual check-in codes are allowable	CONDITIONAL Check contracted fee schedule to see if telephone codes are allowable
CIGNA	NOT ALLOWABLE	ALLOWABLE **Coverage:** Effective: New Guidelines-January 1st, 2021 **Patient Type**: New or Established Patients **Billing:** Telehealth Eligible Code **Professional:** Modifier 95 or GT & POS used for in-person visit. **Facility**: Not Allowable	ALLOWABLE* **Coverage:** Effective: March 6th, 2020 **Patient Type**: Established Only **Billing:** G2012 *Note coverage will end Jan. 21st 2021	ALLOWABLE **Coverage:** Effective: January 1st, 2021 **Patient Type**: Established Only **Billing:** 99441-99443
MEDICA* *Excludes MHCP Members	ALLOWABLE **Coverage:** Effective: March 6th, 2020 **Patient Type**: Established Only **Billing:** 99421-99423, 98970 -98972, G2061-G2063.	ALLOWABLE **Coverage:** Effective: March 6th, 2020 **Patient Type**: Not Specified **Billing:** Telehealth Eligible Code **Professional:** Modifier GT (CMS CPTs) or 95 (Appendix P CPTs) & POS 02. **Facility**: Modifier GT or 95. **COVID-19 Related**: CS Modifier	ALLOWABLE **Coverage:** Effective: March 6th, 2020 **Patient Type**: Established Only **Billing:** G2010, G2012	ALLOWABLE **Coverage:** Effective: March 6th, 2020 **Patient Type**: Established Only **Billing:** 99441-99443, 98966-98968.
MEDICARE	ALLOWABLE **Coverage**: Always Covered **Patient Type**: New & Established **Billing:** CPT 99421-99423, HCPCS G2061-G2063. **RHC**: G0071	ALLOWABLE **Coverage:** Effective: March 6th 2020 **Patient Type**: New & Established **Billing:** Telehealth Eligible Code **Professional**: Modifier 95 w/ POS used for in-person visit. **Facility:** PN or PO modifier w/ DR condition code. **Method II**: Modifier GT. **RHC**: G2025 w/ CG & 95. **Facility PT/OT/ST**: Modifier 95**COVID-19 Related**: CS Modifier	ALLOWABLE **Coverage:** Always Covered **Patient Type**: New & Established **Billing:** HCPCS G2010, G2012, G2250-G2252 **RHC**: G0071	ALLOWABLE **Coverage:** Effective: March 6th 2020 **Patient Type**: New & Established **Billing:** 99441-99443, 98966-98968 w/ modifier 95. **RHC**: G2025
NE MEDICAID & MCOs	NOT ALLOWABLE	ALLOWABLE **Coverage**: Always Covered **Patient Type**: New & Established **Billing:** Code on the provider's fee schedule. **Professional**: POS 02 & GT Modifier. **Facility:** Modifier GT	ALLOWABLE **Coverage:** Effective: March 1st, 2020 **Patient Type**: Established Only **Billing:** Allowed for COVID-19 related DX only. Use HCPCS G2012.	ALLOWABLE **Coverage:** Effective: March 1st, 2020 **Patient Type**: Established Only **Billing:** Allowed for COVID-19 Non-Related DX only. CPT 99441-99443 & 98966-98969.
UHC COMMERICAL & MEDICARE ADVANTAGE	ALLOWABLE **Coverage**: Always Covered **Patient Type**: Established Only **Billing**: CPT 99421-99423, G2061-G2063.	ALLOWABLE **Coverage:** Effective: March 18th, 2020 **Patient Type**: New or Established **Billing**: Telehealth Eligible Code **Professional:** Modifier 95 w/ POS Used for In-Person Visit. **Facility:** Revenue code 780.	ALLOWABLE **Coverage:** Always Covered **Patient Type**: New or Established **Billing:** HCPCS G2010, G2012.	ALLOWABLE **Coverage:** Effective: March 18th 2020 **Patient Type**: New or Established **Billing:** 99441-99443, 98966-98968.

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes**:
  - **E-Visits**: 99421-99423, 98970-98972, G2061-G2063.
  - **Telephone**: 99441-99443, 98966-98968
  - **Virtual Check-Ins**: G2010, G2012
- **Effective Date**: March 6th, 2020-Further Notice
- **Modifier**: None
- **Patient Type**: Established
- **Telephone Reimbursement**: Telephone services (99441-99443) provided March 5th, 2020 through September 30th, 2020 were reimbursed at the same rate as a 99212-99214 E/M office visit (ex. 99441 equaled a 99212 E/M reimbursement). After September 30, 2020, telephone-only services resumed to pre-March 5, 2020 rates.

Telehealth:

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

Cost Share Waiver:

- **Commercial**:

- Effective March 6th, 2020 through June 4th, 2020, Aetna will waive member cost sharing for in-network telemedicine visits, regardless of diagnosis.
- Effective June 5th, 2020 through January 31st, 2021, Aetna will waive member cost sharing for in-network telemedicine visits for behavioral and mental health counseling services only.
- Self-insured plans can opt-out at their discretion.

- **Medicare Advantage**:
  - Effective March 6th, 2020 through May 13th, 2020, Aetna will waive member cost sharing for in-network telemedicine visits, regardless of diagnosis.
  - Effective May 13th, 2020 through January 31st, 2021 Aetna will waive member out-of-pocket costs for all in-network primary care and specialist visits, regardless of diagnosis.

AETNA ELIGIBLE TELEHEALTH CODES													
Original Telehealth Allowable Codes													
90791	90845	90960	92227	96161	99203	99243	99309	99408	G0396	G0442	G2086	90840	G0439
90792	90846	90961	93228	97802	99204	99244	99310	99409	G0397	G0443	G2087	90958	G0513
90832	90847	90963	93229	97803	99205	99245	99354	99495	G0406	G0444	G2088	90970	
90833	90853	90964	93268	97804	99211	99231	99355	99496	G0407	G0446	90955	96160	
90834	90863	90965	93270	G0270	99212	99232	99356	99497	G0408	G0447	99252	99202	
90836	90951	90966	93271	98960	99213	99233	99357	99498	G0425	G0459	99253	99242	
90837	90952	90967	93272	98961	99214	99251	99406	97085	G0426	G0506	99254	99308	
90838	90954	90968	96040	98962	99215	99255	99407	G0108	G0427	G0508	G0445	G0437	
90839	90957	90969	96116	99201	99241	99307	G0436	G0109	G0438	G0509	G0514	G0296	
Commercial Codes Effective March 6th, 2020 due to COVID-19 Pandemic													
G0410	92002	96170	97164	99217	99235	99307	99344	99476	G0408	G2010	90839	96121	96161
G2061	92012	96171	97165	99218	99236	99308	99345	99477	G0425	G2012	90840	96127	96164
G2062	92065	97110	97166	99219	99238	99309	99347	99478	G0426	G2086	90845	96130	96165
G2063	92526	97112	97167	99220	99239	99310	99348	99479	G0427	G2087	90846	96131	96167
H0015	92601	97116	97168	99221	99281	99315	99349	99480	G0442	G2088	90847	96132	96168
H0035	92602	97150	97530	99222	99282	99316	99350	99483	G0443	97085	90853	96133	97535
H2012	92603	97151	97542	99223	99283	99327	99421	G0108	G0444	90791	90863	96136	97802
H2036	92604	97153	S9443	99224	99284	99328	99422	G0109	G0445	90792	92507	96137	97803
S9480	92606	97155	97755	99225	99285	99334	99423	G0270	G0446	90832	92508	96138	97804
77427	92609	97156	97760	99226	99291	99335	99468	G0296	G0447	90833	92521	96139	G0270
90953	94664	97157	97761	99231	99292	99336	99469	G0396	G0459	90834	92522	96156	98966
90956	96110	97161	98970	99232	99304	99337	99471	G0397	G0506	90836	92523	96158	98967
90959	96112	97162	98971	99233	99305	99341	99472	G0406	G0513	90837	92524	96159	98968
90962	96113	97163	98972	99234	99306	99343	99475	G0407	G0514	90838	96116	96160	99451
99354	99355	99356	99357	99406	99407	G0436	G0437	99441	99442	99443	99446	99447	99448
99449	99497	99498	99452	H0038	G0422	G0423	G0424	99342	90875	93750	93798	95970	95791
95972	95983	95984											
Medicare Advantage Codes Effective March 6th, 2020 due to COVID-19 Pandemic													
G0071	90956	96112	97161	98972	99281	99324	99349	0362T	G0443	90791	92508	96156	98968
G0410	90959	96113	97162	99217	99282	99325	99350	0373T	G0444	90792	92521	96158	99354
G2025	90962	96170	97163	99218	99283	99326	99421	G0108	G0445	90832	92522	96159	99355
G2061	92002	96171	97164	99219	99284	99327	99422	G0109	G0446	90833	92523	96160	99356
G2062	92004	97110	97165	99223	99285	99328	99423	G0296	G0447	90834	92524	96161	99357
G2063	92014	97112	97166	99224	99291	99334	99468	G0396	G0459	90836	96116	96164	99406
G9685	92601	97116	97167	99225	99292	99335	99469	G0397	G0270	90837	96121	96165	99407
H0015	92602	97150	97168	99226	99304	99336	99471	G0406	G0506	90838	96127	96167	G0436

H0035	92603	97151	97530	99231	99305	99337	99472	G0407	G0513	90839	96130	96168	G0437
H2012	92604	97152	97542	99232	99306	99341	99475	G0408	G0514	90840	96131	97535	99441
H2036	94002	97153	97750	99233	99307	99342	99476	G0420	G2010	90845	96132	97802	99442
Q3014	94003	97154	97755	99234	99308	99343	99477	G0421	G2012	90846	96133	97803	99443
S9152	94004	97155	97760	99235	99309	99344	99478	G0425	G2086	90847	96136	97804	99446
77427	94005	97156	97761	99236	99310	99345	99479	G0426	G2087	90853	96137	G0270	99447
90875	94664	97157	98970	99238	99315	99347	99480	G0427	G2088	90863	96138	98966	99448
90953	96110	97158	98971	99239	99316	99348	99483	60442	90785	92507	96139	98967	99449
99451	99452	99497	99498	G0438	G0439	G0422	G0423	G0424	G0422	G0423	G0424	99221	99222
92012	93750	93797	93798	95970	95971	95972	95983	95984					

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

Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes**:
  - **E-Visits**: 99421-99423, 98970-98972
  - **Telephone**: Conditional, check your fee schedule
  - **Virtual Check-Ins**: Conditional, check your fee schedule
- **Effective Date**:
  - **E-Visits**: March 13th, 2020-Further Notice
  - **Telephone & Virtual Check**-In: NA
- **Modifier**: None
- **Patient Type**: Established

Telehealth:

- **Allowable Codes**: Blue Cross Blue Shield of NE has waived the originating site requirement and opened up their telehealth code set to allow for any E&M codes, therapy codes, or telehealth codes on the provider's fee schedule to be billed.
  - **Telemedicine Codes:** BCBS NE defines telemedicine as a: "*Two-way video communication between two or more providers with or without the patient present"*. Telemedicine allowable codes are (99201-99215), (90791,90792), (90832-90839), and (90863 or pharmacologic E&M). Both providers must be BlueCard participating providers.
- **Effective Date**: March 13th, 2020-Further Notice
- **HIPAA Compliant Platform**: Non-HIPAA compliant, non-public facing, software can be utilized for telehealth visits, such as Skype & FaceTime. However, BCBS NE has stated they prefer providers use a HIPPA secure platform.
- **Modifiers/POS:**
  - **Professional:** Modifier 95 and place of service 02
  - **Facility:**
    - **March 13th, 2020-October 31st, 2020**: Modifier 95
    - **November 1st, 2020-Forward**: Institutional claims will no longer be reimbursable for telehealth services, except for PT/OT/ST services. PT/OT/ST services billed on a UB will still be eligible for reimbursement.
- **Non-Covered Services:**
  - Services that occur the same day as a face to face visit, when performed by the same provider and for the same condition.
  - Triage to assess the appropriate place of service and/or appropriate provider type.
  - Patient communications incidental to E/M, counseling, or medical services covered by this policy, including, but not limited to:
    - Reporting of test results;
    - Provision of educational materials.
  - Administrative matters, including but not limited to; scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.
  - Medical interpretation or translation services
  - There will be no additional reimbursement for equipment, technicians or other technology or personnel utilized in the performance of the telemedicine service.
  - Inpatient services
  - Costs associated with enabling or maintaining contracted providers' telemedicine technologies
  - Interprofessional telephone or internet consultations
- **Provider Type**:

- **Effective March 13th-June 30th, 2020**-BCBS NE will accept telehealth billed codes from any credentialed provider.
- **Effective July 1st, 2020-Forward**, BCBS will only allow Medical Doctors (MD), Doctors of Osteopathy (DO), Physician Assistants (PA), Nurse Practitioners (APRN), Behavioral Health Providers, Occupational Therapists, Physical Therapists, Speech Therapists to perform and bill for telehealth services.
    - Providers performing and billing telehealth must be eligible to independently perform and bill the equivalent face-to-face service.

- **Patient Type**: Per written communication from a BCBS representative, all E&M, therapy, and telehealth codes are allowable for either new or established patients.
- **Reimbursement:** BCBS will cover all codes at 100% of the provider's existing fee schedule.
- **Transmission & Originating Site Fees**: BCBS NE will not allow for an originating site or transmission fee to be billed.
- **Video Component**: BCBS has waived the video component requirement for telehealth services.

Cost Share Waiver:

- Effective March 13th, 2020-June 30th BCBS will waive the member's cost share for all telehealth visits (regardless of diagnosis) and COVID-19 related diagnostic testing.
- Effective July 1st, 2020-January 20th, 2021, BCBS will waive member cost sharing for telehealth services related to a COVID-19 diagnosis within the below listed code set:

COST SHARE WAIVER BCBS NE TELEHEALTH CODES												
90785	90837	90951	90957	90966	92526	96164	92507	99204	99009	97530	G0397	G0443
90791	90838	90954	90958	90967	95992	96165	97116	99211	99310	92609	G0406	G0444
90792	90839	97163	90960	90968	97166	96169	92523	99212	99354	97168	G0407	G0445
90832	90840	97112	90961	90969	96156	96168	97542	99213	99355	97165	G0408	G0446
90833	90845	97161	90963	90970	96159	97802	99201	99214	99406	G0270	G0436	G0447
90834	90846	92522	90964	96116	96160	97803	99202	99307	99407	G0296	G0437	G2086
90836	90847	90955	90965	99451	96161	97804	99203	99308	90785	G0396	G0442	G2087
G2088	G2025	97110	97162	96158								

Payor Specific Key Points

Effective January 1st, 2021

E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes**:
  - **E-Visits**: Not Allowable
  - **Telephone**: 99441-99443
  - **Virtual Check-Ins**: G2012-reimbursable only through January 21st, 2021.
- **Effective Date**: Effective January 1st,2021 Cigna implemented a permanent Virtual Care Policy.
- **Modifier**: None
- **Patient Type**: Established

Telehealth:

- **Allowable Codes**: See below table for allowable telehealth codes.
  - Cigna will reimburse telehealth when ALL of the following are met:
    - Services must be provided over an interactive audiovisual connection.
      - Services rendered via telephone only are considered interactive and will be reimbursed when the appropriate telephone only code is billed.
    - Service would be reimbursable if the service were provided face-to face.
    - The patient and/or actively involved caregiver must be present on the receiving end and the service must occur in real time.
    - All technology used must be secure and meet or exceed federal and state privacy requirements.
    - A permanent record of online communications relevant to the ongoing medical care and follow up of the customer is maintained as part of the customer's medical record as if the service were provided as an in-office visit.
    - The permanent record must include documentation which identifies the virtual service delivery method. I.e.: audio/video or telephone only.
    - All services provided are medically appropriate and necessary.
    - The evaluation and management services (E/M) provided virtually must meet E/M criteria as defined in the 1997 Centers for Medicare and Medicaid Services (CMS) Documentation guidelines for codes outside of the 99202 through 99215 range and the 2021 CPT E/M documentation guidelines outlined by the American Medical Association for codes within the range 99202 through 99215.
    - The patient's clinical condition is of low to moderate complexity, and while it may be an urgent encounter, it should not be an emergent clinical condition.
    - Services must be provided by a health care professional who is licensed, registered, or otherwise acting within the scope of his/her licensure.
    - Services must be billed on a 1500 form or electronic equivalent.
- **Effective Date**: Effective January 1st,2021 Cigna implemented a permanent Virtual Care Policy.
- **Excluded Services**:
  - Service occurs on the same day as a face to face visit, when performed by the same provider and for the same condition.
  - Services billed within the post-operative period of a previously completed major or minor surgical procedure will be considered part of the global payment for the procedure and not reimbursed separately.
  - Services performed via asynchronous communications systems (e.g., fax).
  - Store and forward telecommunication [transferring data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation] whether an appropriate virtual care modifier is appended to the procedure code or not.
  - Communications are incidental to E/M services, counseling, or medical services included in this policy, including, but not limited to reporting of test results and provision of educational materials.

- Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.
- Urgent Care centers will not be reimbursed for virtual care under the Cigna's virtual care policy.

- **HIPAA Compliant Platform:** All technology used must be secure and meet or exceed federal and state privacy requirements**.**
- **Modifiers/POS**:
  - **Professional/1500 Claims**: POS that would have been used if the service were performed in person (e.g. POS 11) and modifier 95 or GT.
    - Modifier 95 (Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunication system)
    - Modifier GT (Via interactive audio and video telecommunications systems) should be reported with the applicable procedure code when performing a service virtually to indicate the type of technology used and to differentiate a virtual care encounter from an encounter when the physician and patient are at the same site.
  - **Facility/UB Claims**: Services billed on a UB-04 claim will not be reimbursed under Cigna's virtual care policy.
- **Patient Type:** New or established patients.
- **Provider Type:** Providers who are licensed, registered, or otherwise acting within the scope of their licensure may provide telehealth services.
- **Reimbursement:** Reimbursement will be at the same rate as in-person face-to-face visits, refer to your Cigna contract for allowable rates.
- **Video Component:** An audiovisual connection is required except for telephone codes.
- **Transmission & Originating Site Fees**: Cigna will not reimburse an originating site of service fee or facility fee for telehealth visits (HCPCS Q3014). Cigna will also not reimburse transmission fees; transmission of digitalized data is considered integral to the procedure performed and is not separately reimbursable.

CIGNA ELIGIBLE TELEHEALTH CODES												
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962	90963
90964	90965	90966	90967	90968	90969	90970	92507	92508	92521	92522	92523	952524
92601	92602	92603	92604	96040	96116	96156	96158	96159	96160	96161	96164	96165
96167	96168	97110	97112	97161	97162	97163	97164	97165	97166	97167	97168	97530
97755	97760	97761	97802	97803	97804	99202	99203	99204	99205	99211	99212	99213
99214	99215	99406	99407	99408	99409	99441	99442	99443	G0108	G0270	G0296	G0396
G0397	G0438	G0439	G0442	G0443	G0444	G0445	G0446	G0447	G0513	G0514	S9152	

Cost Share Waiver:

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

Effective January 21st, 2021, cost-share and out-of-pocket costs will be the same as if they received the services in-person from that same provider.

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

E-Visits/Telephone/Virtual Check Ins:

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

E-Consults:

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

- **Allowable Codes**: 99446-99452
- **Effective Date**: March 2nd, 2020-January 21st, 2021
- **Modifier & POS**: No modifier, unless COVID-19 related, then utilize modifier CS. POS used if visit was performed in person.
- **Patient Type**: New or Established
- **Non-Billable**:
  - If the consultation to a transfer of care or other face-to-face service (e.g., a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes should not be billed.
  - If the consultation lasted less than 5 minutes.
  - If the consultation was for the sole purpose to arrange transfer of care or a face to face visit.

Telehealth:

- **Allowable Codes**: Cigna will allow any existing face-to-face service on a provider's fee schedule to be performed and billed via telehealth.
  - **Level Four & Five Codes**: Cigna has encouraged providers to bill the appropriate E/M code that was performed; however providers should be cognizant when billing level four and five codes for virtual services. Cigna will reimburse these services consistent with face-to-face rates but will monitor the use of level 4 and 5 codes and audit as necessary.
  - **Inappropriate Virtual Services**: Cigna will closely monitor and audit claims for inappropriate services that should not be performed virtually (including but not limited to: acupuncture, all surgical codes, anesthesia, radiology services, laboratory testing, administration of drugs and biologics, infusions or vaccines, and EEG or EKG testing).
  - **Urgent Care Centers**: Virtual care services are covered, including S9083 for services that require a more complex telephone call. Cigna will reimburse the full face to face rate of insured and NON-ERISA ASO providers where telehealth parity laws exist. For all other providers, Cigna will reimburse urgent care centers a flat rate of $88.00 per visit.
- **Effective Date**: March 2nd, 2020-December 31st, 2020.
- **HIPAA Compliant Platform:** Telehealth visits can be performed via non-compliant HIPAA platforms, such as FaceTime, Facebook Messenger, Skype, and Google Hangouts.
- **Modifiers/POS**:
  - **Professional/1500 Claims**: Modifiers GT or 95 with POS that would have been used if service had been provided in-person. DO NOT use POS 02 for virtual visits, as that will result in reduced payment or denied claims.
  - **Facility/UB Claims**: Appropriate revenue code and modifiers GT or 95

- **COVID-19 Related Telehealth Care**:
  - Suspected or Likely COVID-19 Exposure: ICD-10 Z03.818 or Z20.828, CS modifier, and GT or 95 modifier.
  - Confirmed COVID-19 Case: ICD-10 U07.1
- **DX Code Placement**:
  - Cigna does not require any specific placement for COVID-19 DX codes, however they recommend providers place the COVID-19 DX code for confirmed or suspected cases in the first position when the primary reason for the visit is to determine if the patient has COVID-19.
  - For services where COVID-19 is not the reason for visit (ex.-labor/delivery), but the patient is also tested for COVID-19, the provider should bill the DX code specific to the primary reason for visit in the first position, and the COVID-19 DX code in any position after the first.

- **Patient Type:** New or established patients.
- **Provider Type:** If the provider can deliver the service in a clinic/facility setting, then they can also provide the service virtually. Providers should bill virtual visits on the same form they usually do (UB/1500) for in-person visits.
- **Reimbursement:** Reimbursement will be allowed at 100% of the provider's contracted rate, refer to your Cigna contract for allowable rates.
- **Video Component:** Telehealth codes can be performed over an audiovisual or audio only connection.
- **Transmission & Originating Site Fees**: Cigna will not reimburse an originating site of service fee or facility fee for telehealth visits (HCPCS Q3014). Cigna will also not reimburse for transmission fees.

Cost Share Waiver:

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

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

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

Telehealth:

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

        - **Commercial**: POS 02 with modifier GT for CMS recognized CPTs or modifier 95 for AMA Appendix P CPTs.
        - **Medicare Advantage** POS that would have been used if the visit were performed in person with modifier 95.
    - **Facility (UB) Claims**: Utilize modifier GT or 95.
    - **COVID-19 Related**: For services relating to the order for or administration of a COVID-19 diagnostic test or for services related to the evaluation of an individual for purposes of determining the need for diagnostic testing, append modifier CS.
- **Patient Type:** Not Specified.
- **Provider Type:** Audiologist, Certified Genetic Counselor, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist, Licensed Drug & Alcohol Counselor, Dentist, Nurse Midwife, Nurse Practitioner, Occupational Therapist, Physical Therapist, Physician, Physician Assistant, podiatrist, Registered Dietitian or Nutrition Professional, and Speech Therapist.
- **Reimbursement**: Reimbursement will be at the same rate as in-person face-to-face visits, refer to your Medica contract for allowable rates.
- **Store and Forward Telehealth:** Medica allows both synchronous (interactive audiovisual communication) and asynchronous (store and forward).
- **Originating Sites:**
    - Allowable originating sites:
        - Office of physician or practitioner; hospital (inpatient or outpatient); home; critical-access hospital (CAH); rural health clinic (RHC) and federally qualified health center (FQHC); hospital-based or CAH-based renal dialysis center (including satellites); skilled nursing facility (SNF); end-stage renal disease (ESRD) facilities; community mental health center; Residential Substance Abuse Treatment Facility; and other eligible medical facilities.
- **Transmission & Originating Site Fees**: Transmission fees (HCPCS T1014) are not eligible for payment, however Medica will allow an originating site fee (HCPCS Q3014) to be billed by an originating site facility.
- **Telehealth Coverage Limitations**: The following are not covered under telemedicine:
- Provider initiated e-mail, refilling or renewing existing prescriptions, scheduling a diagnostic test or appointment, clarification of simple instructions or issues from a previous visit, reporting test results, reminders of scheduled office visits, requests for a referral, non-clinical communication (i.e. Updating patient information), providing educational materials, Brief follow-up of a medical procedure to confirm stability of the patient's condition without indication of complication or new condition including, but not limited to, routine global surgical follow-up, brief discussion to confirm stability of the patient's chronic condition without change in current treatment, when information is exchanged and the patient is subsequently asked to come in for an office visit, a service that would similarly not be charged for in a regular office visit, consultative message exchanges with an individual who is seen in the provider's office immediately afterward, communication between two licensed health care providers that consists solely of a telephone conversation, email or facsimile, communications between a licensed health care provider and a patient that consists solely of an e-mail or facsimile.
- **Video Component:** See below matrix for codes that can be performed over an audio only connection.

Cost Share Waiver:

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

MEDICA ALLOWABLE TELEHEALTH CODES										
77427	90957	93268	96168	99201	99234	99305	99354	99498	G0459	G2010
87633	90958	93270	97110	99202	99235	99306	99355	G0108	G0506	G2012
90785	90959	93271	97112	99203	99236	99307	99356	G0109	G0459	G2061
90791	90960	93272	97116	99204	99238	99308	99357	G0270	G0506	G2062
90792	90961	93298	97161	99205	99239	99309	99406	G0296	G0508	G2063

90832	90962	96040	97162	99211	99241	99310	99407	G0396	G0509	99381
90833	90963	96116	97163	99212	99242	99315	99408	G0397	G0513	99382
90834	90964	96130	97164	99213	99243	99316	99409	G0406	G0514	99383
90836	90965	96131	97165	99214	99244	99327	99468	G0407	G2086	99384
90837	90966	96132	97166	99215	99245	99328	99469	G0408	G2088	99385
90838	90967	96133	97167	99217	99251	99334	99471	G0420	Q3014	99386
90839	90968	96136	97168	99218	99252	99335	99472	G0421	98966	99387
90840	90969	96137	97535	99219	99253	99336	99473	G0425	98967	99391
90845	90970	96138	97750	99220	99254	99337	99475	G0426	98968	99392
90846	92227	96139	97755	99221	99255	99341	99476	G0427	98970	99393
90847	92228	96156	97760	99222	99281	99342	99477	G0438	98971	99394
90853	92507	96158	97761	99223	99282	99343	99478	G0439	98972	99395
90863	92521	96159	97802	99224	99283	99344	99479	G0442	99421	99396
90951	92522	96160	97803	99225	99284	99345	99480	G0443	99422	99397
90952	92523	96161	97804	99226	99285	99347	99483	G0444	99423	0373T
90953	92524	96164	98960	99231	99291	99348	99495	G0445	99441	0362T
90954	93228	96165	98961	99232	99292	99349	99496	G0446	99442	90875
90955	93229	96167	98962	99233	99304	99350	99497	G0447	99443	90956
92002	92004	92014	92508	92601	92602	92603	92604	93750	93797	93798
94002	94003	94004	94005	94664	95970	95971	95972	95983	95984	96110
96113	96121	96127	96170	96171	97150	97151	97152	97153	97153	97154
97155	97156	97157	97158	97530	97542	99324	99325	99326	99381	99382
99383	99384	99385	99386	99387	99391	99392	99393	99384	99385	99386
99397	G0410	G0422	G0423	G0424	G0466	G0467	G0468	G0469	G0470	G2087
G9685	S9152	G0071								

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

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes**:
  - **E-Visits**: 99421-99423, G2061-G2063
  - **Telephone**: 99441-99443, 98966-98968
  - **Virtual Check-In**: G2010, G2012, G2250-G2251, G2252
- **Effective Date**:
  - **E-Visits & Virtual Check-Ins**: Permanently Allowed
  - **Telephone**: March 6th, 2020-End of PHE
- **Modifier**:
  - **E-Visits & Virtual Check-Ins**: None
  - **Telephone**: Modifier 95
- **Patient Type**: New & Established (New patients allowable only for COVID-19 PHE)
- **Provider Type**:
  - **E-Visits (99421-99423), Telephone (99441-99443), Virtual Check-In (G2010, G2012, G2252)**: Qualified Healthcare Professional.
  - **E-Visits (G2061-G2063) Virtual Check-In (G2250 & G2251**): Effective January 1st, 2021 Medicare clarified that licensed clinical social workers, clinical psychologists, physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) can furnish E-visits (G2061-G2063) and Virtual Check-Ins. Medicare created two new HCPCS codes, G2250 & G2251, for virtual check-ins for these provider types.
- **Telephone Services Reporting:** When providers are providing an E/M service that would otherwise be reported as an in-person or telehealth visit, using audio-only technology, providers should utilize the appropriate telephone E/M code (99441-99443), not the in person or telehealth visit code.
- **Telephone Reimbursement Change**: Effective March 1st, 2020, CMS has increased payments for telephone visits to match payments for similar office and outpatient visits.

Telehealth:

- **Allowable Codes**: See table below for all codes allowable via telehealth.
  - Note- Telehealth rules do not apply when the beneficiary and the practitioner are in the same location and are utilizing telehealth to reduce exposure risks, even if audio/video technology assists in furnishing a service.
- **Effective Date**: Effective March 6th, 2020-End of COVID-19 PHE.
  - CMS implemented an 1135 blanket waiver for Medicare telehealth services. This waiver allows for additional flexibilities in Medicare telehealth services. Specifically, Medicare will pay for office, hospital, and other visits furnished via telehealth across the country, whether urban or rural, and in all settings, including in patients' homes. Prior to this waiver, Medicare required telehealth to originate from a healthcare facility within a rural area.
- **HIPAA Compliant Platform**: Effective March 17th, 2020-End of COVID-19 PHE, the HHS Office for Civil Rights (OCR) will waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime.
- **Hospitals-CAH & PPS**: See "Hospital" section for details on Medicare telehealth hospital regulations.
- **Modifiers/POS**:
  - **Professional (1500) Claims**: POS that would have been used if the visit were provided in person with modifier 95.
  - **CAH Method II (UB) Claims**: Modifier GT
  - **CAH & PPS PT/OT/Speech UB Claims**: Modifier 95
  - **PPS Facility (UB) Claims**: PN or PO modifier with condition code DR. Appropriate use of the PN and PO modifier is dependent on your specific services and locations. See the "hospital" section for details.
  - **COVID-19 Related:** If COVID-19 Part B related services were performed also append a CS modifier to applicable line items.

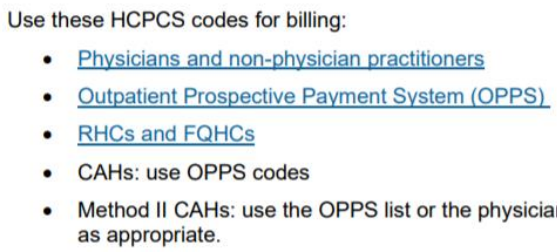
    - **DR Condition Code & CR Modifier**: For all services relating to a COVID-19 waiver, except telehealth services, append the "DR" condition code (UB claims) or "CR" modifier (1500 claims).
- **Patient Type**: As part of the CARES Act, practitioners can provide telehealth services to both new and established patients.
- **Provider Type**: All health care practitioners who are authorized to bill Medicare for their professional services may also furnish and bill for telehealth services. This allows health care professionals who were not previously authorized under the statute to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.
    - There are no payment restrictions on distant site providers furnishing Medicare telehealth services from their home during the PHE. Report the place of service code that would have been reported had the service been furnished in person.
    - Direct supervision may be provided using real-time, interactive audio and video technology through the later of the end of the calendar year in which the PHE ends or December 31, 2021.
- **Reimbursement**: Reimbursement will be at the same rate as in-person face-to-face visits, refer to the Medicare fee schedule for allowable rates.
    - **Site of Service Differential**: Prior to CMS-1744-IFC, services that had a site differential (facility versus office), were paid on the facility payment rate when services were furnished via telehealth. Effective March 1st, 2020, CMS now allows physicians' offices to be paid at the office rate.
        - Providers should report the POS code that would have been reported had the service been furnished in person with modifier 95.
        - CMS is maintaining the facility payment rate for services billed using the POS code 02 if providers choose to not change their current billing practices.
- **Removal of Frequency Limitations on Medicare Telehealth**: Per CMS, the following services no longer have limitations on the number of times they can be provided by telehealth:
    - A subsequent inpatient visit can be furnished via telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233).
    - A subsequent skilled nursing facility visit can be furnished via telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310).
        - Effective January 1st, 2021 Medicare has permanently changed the frequency limitation of subsequent skilled nursing visits to one visit every 14 days.
    - Critical care consult codes may be furnished by telehealth beyond the once per day limitation (CPT codes G0508-G0509).
- **Rural Health Clinics & Federally Qualified Health Centers:** See the RHC and FQHC section for specific billing regulations.
- **Transmission/ Originating Site Fees:** Medicare does not reimburse for transmission fees. If applicable, Medicare will reimburse an originating site fee (HCPCS Q3014).
    - Effective April 30th, 2020, Hospitals may bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home.
- **Video Component**: See the "Medicare Telehealth Allowable Codes" below for codes that can be performed via an audio only connection during the COVID-19 PHE only.
    - Effective January 1st, 2021-Medicare is creating a new permanent HCPCS G-code (G2252) describing 11-20 minutes of medical discussion to determine the necessity of an in-person visit. This HCPCS G-Code will take place of audio only allowable telehealth services once the COVID-19 PHE is over.

Cost Share Waiver:

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

emergency department services, nursing facility services, domiciliary, rest home, or custodial care services, home services, online digital evaluation, and management services.

- **Specific List Applicable HCPCS codes**: Visit https://www.cms.gov/files/document/se20011.pdf, view page 11, and click on the hyperlink as shown below.


Use these HCPCS codes for billing:

- Physicians and non-physician practitioners
- Outpatient Prospective Payment System (OPPS)
- RHCs and FQHCs
- CAHs: use OPPS codes
- Method II CAHs: use the OPPS list or the physician and non-physician practitioner list, as appropriate.

- Cost-sharing does not apply to the above medical visit services for which payment is made to:
  - Hospital Outpatient Departments paid under the Outpatient Prospective Payment System, Physicians and other professionals under the Physician Fee Schedule, Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs).
- Providers who bill for Medicare Part B services should use CS modifier on applicable claim lines.
- Providers should NOT charge Medicare patients any co-insurance and/or deductible amounts for these services.

2020 MEDICARE ELEGIBLE TELEHEALTH CODES										
2020 Standard Telehealth Codes										
90785	90840	90961	96156	97804	99215	99356	G0109	G0425	G0445	G2087
90791	90845	90963	96159	99201	99231	99357	G0270	G0426	G0446	G2088
90792	90846	90964	96160	99202	99232	99406	G0296	G0427	G0447	
90832	90847	90965	96161	99203	99233	99407	G0396	G0436	G0459	
90833	90951	90966	96164	99204	99307	99495	G0397	G0437	G0506	
90834	90954	90967	96165	99205	99308	99496	G0406	G0438	G0508	
90836	90955	90968	96167	99211	99309	99497	G0407	G0439	G0509	
90837	90957	90969	96168	99212	99310	99498	G0408	G0442	G0513	
90838	90958	90970	97802	99213	99354	90785	G0420	G0443	G0514	
90839	90960	96116	97803	99214	99355	G0108	G0421	G0444	G2086	
Temporarily Added Telehealth Codes for the COVID-19 Pandemic- Effective March 1st 2020										
77427	92508	94664	96139	97156	97542	99225	99292	99336	99443	0373T
90853	92521	96110	96158	97157	97750	99226	99304	99337	99468	S9152
90875	92522	96112	96170	97158	97755	99234	99305	99341	99469	0362T
90952	92523	96113	96171	97161	97760	99235	99306	99342	99471	G0410
90953	92524	96121	97110	97162	97761	99236	99315	9943	99472	G6985
90956	92601	96127	97112	97163	99217	99238	99316	99344	99473	93797
90959	92602	96130	97116	97164	99218	99239	99324	99345	99475	93798
90962	92603	96131	97150	97165	99219	99281	99325	99347	99476	93750
92002	92604	96132	97151	97166	99220	99282	99326	99348	99477	95971
92004	94002	96133	97152	97167	99221	99283	99327	99349	99478	95972
92012	94003	96136	97153	97168	99222	99284	99328	99350	99479	95983
92014	94004	96137	97154	97530	99223	99285	99334	99441	99480	95984
92507	94005	96138	97155	97535	99224	99291	99335	99442	99483	G0422
G0423	G0424									

Codes Highlighted in Blue -Require an Audiovisual Connection
Codes Highlighted in Green-Can Be Performed via an Audio only (Telephone) or Audiovisual Connection
Codes Highlighted in Yellow-Have a Medicare Payment Limitation (See Table Below)

2021 MEDICARE ELEGIBLE TELEHEALTH CODES										
2021 Standard Telehealth Codes										
90785	90840	90961	96156	97804	99215	99356	G0109	G0425	G0445	G2087
90791	90845	90963	96159	99201	99231	99357	G0270	G0426	G0446	G2088
90792	90846	90964	96160	99202	99232	99406	G0296	G0427	G0447	90853
90832	90847	90965	96161	99203	99233	99407	G0396	G0436	G0459	96121
90833	90951	90966	96164	99204	99307	99495	G0397	G0437	G0506	99347
90834	90954	90967	96165	99205	99308	99496	G0406	G0438	G0508	99348
90836	90955	90968	96167	99211	99309	99497	G0407	G0439	G0509	99483
90837	90957	90969	96168	99212	99310	99498	G0408	G0442	G0513	99334
90838	90958	90970	97802	99213	99354	90785	G0420	G0443	G0514	99335
90839	90960	96116	97803	99214	99355	G0108	G0421	G0444	G2086	G2211
G2121										
Codes Available up Through the Year in Which the PHE Ends										
90952	90953	90956	90959	90962	92507	92521	92522	92523	92524	96130
96131	96132	96133	96136	96137	96138	96139	97110	97161	97162	97163
97164	97165	97166	97167	97168	97535	97750	97755	97760	97761	99217
99224	99225	99226	99238	99239	99281	99282	99283	99284	99285	99291
99292	99315	99316	99336	99337	99349	99350	99469	99472	99476	99478
99479	99480									
Codes Available for the COVID-19 PHE Only										
77427	90875	92002	92004	92012	92014	92508	92601	92602	92603	92604
93797	93798	93750	94002	94003	94004	94005	94664	95970	95971	95972
95983	95984	96110	96112	96113	96127	96158	96170	96171	97112	97116
97150	97151	97152	97153	97154	97155	97156	97157	97158	97530	97542
99218	99219	99220	99221	99222	99223	99234	99235	99236	99304	99305
99306	99324	99325	99326	99327	99328	99341	99342	99343	99344	99345
99441	99442	99443	99468	99471	99473	99475	99477	0373T	S9152	0362T
G0410	G0422	G0423	G0424	G9685						

Codes Highlighted in Blue -Require an Audiovisual Connection
Codes Highlighted in Green-Can Be Performed via an Audio only (Telephone) or Audiovisual Connection during the COVID-19 PHE ONLY
Codes Highlighted in Yellow-Have a Medicare Payment Limitation (See Table Below)

Medicare Telehealth Codes Payment Limitations	
CPT/HCPCS	**Medicare Payment Limitation**
90875	Non-covered service
94005	Bundled code
96112	Non-covered service
96170	Non-covered service
96171	Non-covered service
S9152	Not valid for Medicare purposes
G0410	Statutory exclusion

Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes**:
  - **E-Visits**: Not Allowable
  - **Telephone**:
    - 99441-9944: For patients requiring routine, uncomplicated follow-up for chronic disease or routine primary care, and are not experiencing symptoms of COVID-19.
      - Billing provider: MD, DO, PA, APRN
    - 98966-98968: For patients requiring a behavioral health assessment
      - Billing provider: psychologist, provisional psychologist, LIMHP, LMHP, PLMHP, LADC, PLADC
  - **Virtual Check-In**:
    - G2012: For patients actively experiencing mild symptoms of COVID-19 (fever, cough, shortness of breath)
- **Effective Date**:
  - **E-Visits**: Not Allowable
  - **Telephone & Virtual Check-Ins**: March 1st, 2020-End of PHE
- **Modifier**: None
- **Patient Type**: Established
- **Reimbursement:**

MEDICAID TELEPHONE SERVICES			
CPT	**Allowable**	**CPT**	**Allowable**
99441	$14.47	98966	$11.75
99442	$29.26	98967	$20.67
99443	$47.28	98968	$32.42
G2012	$14.08	G0071	$46.40

Telehealth:

- **Allowable Codes**: Providers can perform and bill appropriate CPT/HCPCs codes on their fee schedule if it meets the below requirements:
  - All treatments or services submitted for reimbursement must be delivered in accordance with existing service definitions.
  - All treatments and services are expected to be rendered in a clinically appropriate manner and be directly related to the beneficiary's treatment needs or treatment plan.
  - Providers must document the rationale for delivery of treatment or services through teletherapy in addition to existing documentation requirements.
  - **PT/OT/ST**: Although there were some PT/OT/ST services that were previously allowable prior to the COVID-19 PHE, NE Medicaid has issued a specific list of temporary allowable telehealth codes, which are provided in the below matrix
  - **Behavioral Health Services**: Although there were some behavioral services that were previously allowable prior to the COVID-19 PHE, NE Medicaid has issued a specific list of temporary allowable telehealth codes, which are provided in the below matrix
- **Documentation Requirements:** Along with standard documentation requirements, Medicaid also requires documentation of which site initiated the call, the telecommunication technology utilized, and the time the telehealth service began and ended, and rationale for delivery of treatment or services through telehealth.
- **Effective Date**:
  - **PT/OT/ST & Behavioral Health Services Specific Codes**: March 1st, 2020-End of federal PHE
- **HIPAA Compliant Platform**: Per communication with a Nebraska Medicaid representative, NE Medicaid has NOT waived their HIPAA complaint platform requirement.
- **Modifiers/POS**:

    - **Professional:** POS 02 and modifier GT
    - **Facility:** Modifier GT
- **Medicaid Informed Consent**:
    - During the COVID-19 PHE, the written consent requirement for telehealth, found in the Nebraska DHHS Medicaid Program Manual, section 1-006.05, is waived.
        - Therefore, written consent is not required prior to providing a service via telehealth, although providers should obtain a written consent when possible. The provider must document the reason the written consent was unable to be obtained. Even though written consent is not required, the patient must receive the following information verbally:
            - Patient has the option to refuse telehealth without affecting patient's right to future care
            - Provider must inform the patient all existing confidentiality protections shall apply to service being provided by telehealth
            - Sharing of any patient identifiable images or information from the telehealth visit to researchers or other individuals will not occur without the consent of the patient
        - If a patient does not want to receive treatment through telehealth the provider will need to assist the patient in finding alternative care.
    - **Safety Plan:**
        - For each adult client or for a client who is a child but who is NOT receiving telehealth behavioral health services, a safety plan must be developed, should it be needed at any time during or after the provision of telehealth. This plan shall document the actions the client and the health care practitioner will take in an emergency or urgent situation that arises during or after the telehealth consultation.
    - (There are additional consent and safety plan requirements for a child receiving telehealth behavioral health services that can be found in the Nebraska DHHS Medicaid Program Manual, section 1-006.05).
- **Non-Covered Services**: Includes inpatient services, crisis stabilization, mental health and substance use disorder residential services, mental health respite, social detoxification, hospital diversion, and day treatment.
- **Patient Type**: New & Established
- **Patient Location**: Patient can be located at home, an originating site, or any other location.
- **Provider Type**: Under Nebraska statutes, including but not limited to N.R.S. § 38-1,143, currently authorize "any credential holder under the Uniform Credentialing Act" to use telehealth in establishing a provider-patient relationship, except those holding credentials under the following:
    - Cosmetology, Electrology, Esthetics, Nail Technology, and Body Art Practice Act; Dialysis Patient Care Technician Registration Act; Environmental Health Specialists Practice Act; Funeral Directing and Embalming Practice Act; Massage Therapy Practice Act; Medical Radiography Practice Act; Nursing Home Administrator Practice Act; Perfusion Practice Act; Surgical First Assistant Practice Act; Veterinary Medicine and Surgery Practice Act; and Water Well Standards and Contractors' Practice Act.
- **Reimbursement**: Reimbursement rates are the same as the comparable in-person rates published in the Medicaid 2020 Physician Fee Schedule.
- **Transmission Fees & Originating Site Fee:** NE Medicaid will reimburse practitioners for transmission costs (HCPCS T1014) if services were NOT provided by an internet service provider. Transmission costs can be billed in minutes with HCPCS code T1014. NE Medicaid will also reimburse originating site facilities an originating site fee (HCPCS Q3014).
- **Video Component**: In instances where it is documented that the beneficiary does not have access to an audiovisual device, NE Medicaid will allow audio only services if it is clinically appropriate and the treatment or service can meet the standard service expectations.

Cost Share Waiver:

- Effective March 1st, 2020-April 30th, 2020-NE Medicaid and MCOs will waive copays for COVID-19 related services.
- Effective May 1st, 2020-End of Federal PHE-NE Medicaid and MCOs have suspended copays for all services.

ADDITIONAL MEDICAID TELEHEALTH ELIGIBLE CODES										
PT/OT/ST										
97161	97162	97163	97164	97110	97112	97116	97530	97165	97166	97167
97168	92507	92508	92521	92522	92523	92526				
Behavioral Health Services										
90791	H0031, HO	90792	90832	90832, HF	90832, U3/HF	90832, U4/HF	90832, U5/HF	90832, U6/HF	90833	90833, U4
90833, U5	90834	90834, HF	90834, U3/HF	90834, U4/HF	90834, U5/HF	90834, U6/HF	90836	90836, U4	90836, U5	90837
90837, HF	90837, U3/HF	90837, U4/HF	90837, U5HF	90837, U6/HF	90838	90838, U4	90838, U5	90839	90840	90846
90846, HF	90846, U3/HF	90846, U4/HF	90846, U5/HF	90847, U7	90846, HA/HF	90846 U6/HF	90847	90847, HF	90847, ET/HF	90847, HA/HF
90847, U3/HF	90847, U4/HF	90847, U5/HF	90847, U6/HF	90847, U8	90853	90853, HF	90853, U3/HF	90853, U4/HF	90853, U6/HF	90832, U9
90834, U9	90837, U9	90847, U9	90887	90887, HF	90887, U5/HF	99211	92212	99213	99214	92215
99241	99242	99243	99244	99245	99307	99308	99309	99310	H1011	H0001
H0001, 52	H0031, AH	H0031, 52H0036	H2033	H0040, 52	H2015, HK	H2014	H2027	H2015, HE	H2000, SK	H2000, HA
97151	97152	97153	97154	97155	97156	97158	H0038, HE	H0038, HF	H0038, HE/HQ	H0038 HF/HQ
H2017	H2018									

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

Payor Specific Key Points:

E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes**:
  - **E-Visits**: 99421-99423, G2061-G2063
  - **Telephone**: 99441-99443, 98966-98968
  - **Virtual Check-In**: G2010, G2012
- **Effective Date**:
  - **E-Visits**: Previously Allowable
  - **Virtual Check-In & Telephone:**
    - **In-Network**:
      - In-Network Telehealth: March 18th, 2020 through December 31st, 2020
        - From January 1st. 2021 going forward, UHC will cover in-network telehealth visits as outlined in current CMS guidelines.
    - **Out of Network:**
      - **COVID-19 Visits**:
        - Out-of-Network Telehealth for COVID-19 **Testing**: March 18th, 2020-End of PHE
        - Out-of-Network Telehealth for COVID-19 **Treatment**: March 18th, 2020-October 22nd, 2020.
          - As of October 23rd, 2020, telehealth services will be covered according to the member's benefit plan and UHC's standard telehealth reimbursement policy.
      - **Non-COVID-19 Visits**:
        - Out-of-Network Telehealth: March 18th, 2020-July 24th, 2020.
          - As of July 25th, 2020, telehealth services are covered according to the member's benefit plan and UHC's standard telehealth reimbursement policy.
- **Modifier**: None
- **Patient Type**:
  - **E-Visits**: Established Only
  - **Virtual Check-Ins & Telephone:** New & Established

Telehealth:

- **Allowable Codes:** UHC will allow any code on the Medicare covered telehealth code list to be billed. Any code on UHC's telehealth eligible code list can still also be used. See table below for allowable code set.
- **Effective Date:** UHC has waived the originating site requirement (allowing the patient to be at home) and has waived the telehealth video requirement with effective and term dates as listed below.
  - **In-Network**:
    - In-Network Telehealth: March 18th, 2020 through December 31st, 2020
      - From January 1st. 2021 going forward, UHC will cover in-network telehealth visits as outlined in current CMS guidelines.
  - **Out of Network:**
    - **COVID-19 Visits**:
      - Out-of-Network Telehealth for COVID-19 **Testing**: March 18th, 2020-End of PHE
      - Out-of-Network Telehealth for COVID-19 **Treatment**: March 18th, 2020-October 22nd, 2020.
        - As of October 23rd, 2020, telehealth services will be covered according to the member's benefit plan and UHC's standard telehealth reimbursement policy.
    - **Non-COVID-19 Visits**:
      - Out-of-Network Telehealth: March 18th, 2020-July 24th, 2020.
        - As of July 25th, 2020, telehealth services are covered according to the member's benefit plan and UHC's standard telehealth reimbursement policy.

- **HIPAA Compliant Platform:** Telehealth visits can be performed via non-compliant HIPAA platforms, such as FaceTime, Facebook Messenger, Skype, Google Hangouts and WhatsApp.
- **Modifiers/POS**:
    - **Professional (1500) claims**:
        - **Commercial**: Utilize modifier GT for CMS recognized CPTs, modifier 95 for AMA Appendix P CPTs, and modifier G0 for telehealth services for diagnosis, evaluation, or treatment, of an acute stroke with POS that would have been used if visit were furnished in person.
        - **Medicare Advantage**: Utilize modifier 95 and POS that would have been used if visit were furnished in person.
    - **Facility (UB) claims:** Utilize revenue code 780.
- **Provider Type:** UHC follows CMS' policies on the types of care providers eligible to deliver telehealth services. These include physician, nurse practitioner, physician assistant, nurse-midwife, clinical nurse specialist, registered dietitian or nutrition professional, clinical psychologist, clinical social worker, certified registered nurse anesthetists. UHC will also allow physical therapists, occupational therapists, speech therapists, and chiropractic providers to provide limited services via telehealth.
- **Reimbursement:** Reimbursement will be at the same rate as in-person face-to-face visits, refer to your UHC contract for allowable rates.
- **Transmission & Originating Site Fees**: T1014 and Q3014 are not eligible for payment, UHC considers these services as incidental to the charges associated with the E/M.
- **Video Component:** The video component requirement for telehealth services has been waived, except in cases where UHC has specifically stated audiovisual is required, which includes PT/OT/ST, chiropractic therapy, home health, and hospice.
    - Medicare Advantage plans, including DSNP plans, still require an audiovisual connection, except for CMS indicated audio only codes.

Cost Share Waiver:

Commercial:

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

Medicare Advantage:

- **Non COVID-19 Telehealth**:
    - March 31st, 2020 -September 30th, 2020, UHC waived member cost sharing for all in-network telehealth visits for medical, outpatient behavioral, PT/OT/ST, chiropractic therapy, home health and hospice, and remote patient monitoring services, regardless of DX.
    - October 1st, 2020-December 31st 20, 2020, UHC will waive the cost share for in-network and covered out-of-network primary care telehealth services only.
        - Effective October 1st, 2020 UHC will adjudicate in accordance with the member's benefit plan for non-primary care telehealth services.
- **COVID-19 Testing Related Telehealth:**
    - **In & Out of Network:** February 4th, 2020-End of PHE
- **COVID-19 Treatment Related Telehealth**:
    - **In& Out of Network:** February 4th, 2020-December 31st, 2020

UHC ELEGIBLE TELEHEALTH CODES											
Codes Recognized with Modifier GT or GQ											
90785	90840	90960	96040	99201	99231	99406	G0109	G0425	G0447	99356	G9978
90791	90845	90961	96116	99202	99232	99407	G0270	G0426	G0459	G9481	G9979

90792	90846	90963	96160	99203	99233	99408	G0296	G0427	G0506	G9482	G9980
90832	90847	90964	96161	99204	99307	99409	G0396	G0438	G0508	G9483	G9981
90833	90951	90965	97802	99205	99308	99495	G0397	G0439	G0509	G9484	G9982
90834	90952	90966	97803	99211	99309	99496	G0406	G0442	G0513	G9485	G9983
90836	90954	90967	97804	99212	99310	99497	G0407	G0443	G0514	G9486	G9984
90837	90955	90968	98960	99213	99354	99498	G0408	G0444	G2086	G9487	G9985
90838	90957	90969	98961	99214	99355	99499	G0420	G0445	G2087	G9488	G9986
90839	90958	90970	98962	99215	99357	G0108	G0421	G0446	G2088	G9489	
Codes Recognized with Modifier 95											
90791	90836	90847	90955	92227	93270	96116	98961	99204	99215	99308	99406
90792	90837	90863	90957	92228	93271	97802	98962	99205	99231	99309	99407
90832	90838	90951	90958	93228	93272	97803	99201	99212	99232	99310	99408
90833	90845	90952	90960	93229	93298	97804	99202	99213	99233	99354	99409
90834	90846	90954	90961	93268	96040	98960	99203	99214	99307	99355	99495/96
Chiropractic											
99201	99203	99204	99205	99211	99212	99213	97110	97116	97530	97112	97535
97112	97535	97750	97755	97760	97761						
PT/OT/ST											
97161	97162	97163	97164	97110	97116	97530	97112	97535	97750	97755	97760
97761	97165	97166	97167	97168	92507	92521	92522	92523	92524	92526	96105
97129	97130										
Preventive Medicine and Applied Behavior Analysis											
99381	99382	99383	99384	99385	99396	99387	99391	99392	99393	99394	99395
99395	99396	99397	H0031	H0032	H2012	H2014	H2019	H2021	H2027		

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

Payor	Cost Sharing Guidelines
Aetna	**Commercial**: • Effective March 6th, 2020 through June 4th, 2020, Aetna waived member cost sharing for in-network telemedicine visits, regardless of diagnosis. • Effective June 5th, 2020 through January 31st, 2021, Aetna will waive member cost sharing for in-network telemedicine visits for behavioral health services only. **Medicare Advantage**: • Effective March 6th, 2020 through May 13th, 2020, Aetna will waive member cost sharing for in-network telemedicine visits, regardless of diagnosis. • Effective May 13th, 2020 through January 31st, 2021, Aetna will waive member out-of-pocket costs for all in-network primary care and specialist visits, whether done in-office or via telehealth, for any reason.
BCBS NE	• **Effective March 13th, 2020-June 30th, 2020**: BCBS will waive the member's cost share for all telehealth visits (regardless of diagnosis). • **Effective July 1st, 2020-January 20th, 2021**, BCBS will waive member cost sharing for services related to a COVID-19 diagnosis within a specific code set.
Cigna	• **Effective March 30th, 2020 through December 31st, 2020**, Cigna will waive member cost sharing for all COVID-19 related treatment. • **Effective March 13th, 2020 through January 21st, 2021**, Cigna will waive member cost sharing for diagnostic testing and office visits/telehealth visits related to assessment and administration of diagnostic testing. Cigna will also waive member cost sharing for all virtual screening telephone consults (regardless of DX). • **Effective January 21st, 2021**, cost-share and out-of-pocket costs will be the same as if they received the services in-person from that same provider.
Medica	• **Effective March 1st, 2020 through January 31st, 2021:** Medica will waive cost-sharing for in-network telehealth visits when related to administration of a COVID-19 test.
Medicare	• **Effective March 18th, 2020-End of PHE**: Medicare will waive COVID-19 testing-related services, which are medical visits that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in a specified set of HCPCS E/M codes
NE Medicaid	• **Effective March 1st, 2020-April 30th, 2020**-NE Medicaid and MCOs will waive copays for COVID-19 related services. • **Effective May 1st, 2020-End of Federal PHE**-NE Medicaid and MCOs have suspended copays for all services.

UHC Commercial and Medicare Advantage	**Commercial**:
	• **Non COVID-19 Telehealth**: March 31st, 2020 -September 30th, 2020, UHC waived member cost sharing for all in-network telehealth visits for medical, outpatient behavioral, PT/OT/ST, chiropractic therapy, home health and hospice, and remote patient monitoring services, regardless of DX.
	• **COVID-19 Testing Related Telehealth:**
	  ○ **In & Out of Network:** February 4th, 2020-End of PHE
	• **COVID-19 Treatment Related Telehealth**:
	  ○ **In-Network:** February 4th, 2020-December 31st, 2020
	  ○ **Out of Network:** February 4th, 2020-October 22nd, 2020
	Medicare Advantage:
	• **Non COVID-19 Telehealth**: March 31st, 2020 -September 30th, 2020, UHC waived member cost sharing for all in-network telehealth visits for medical, outpatient behavioral, PT/OT/ST, chiropractic therapy, home health and hospice, and remote patient monitoring services, regardless of DX.
	• **COVID-19 Testing Related Telehealth:**
	  ○ **In & Out of Network:** February 4th, 2020-End of PHE
	• **COVID-19 Treatment Related Telehealth**:
	  ○ **In & Out of Network:** February 4th, 2020-December 31st, 2020

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

- **Allowable Telehealth Codes**: During the COVID-19 PHE, providers can provide any telehealth service that is approved as a Medicare telehealth service under the Medicare Professional Fee Schedule (PFS) (see the Medicare Allowable Telehealth Code Table in the Medicare section).
- **Billing**:
    - **Telehealth Services Provided January 27, 2020- June 30, 2020:** RHCs must report HCPCS code G2025 on their claims with the CG modifier. Modifier "95" may also be appended but is not required.
        - Claims will be paid at the RHC's all-inclusive rate (AIR).
        - Claims will automatically reprocess in July when the Medicare claims processing system is updated with the new payment rate.
            - RHCs do not need to resubmit these claims for the payment adjustment.
    - **Telehealth Services Provided July 1, 2020 and Forward:** RHCs will no longer need to append the CG modifier on claims with HCPCS code G2025. Modifier "95" may be appended but is not required.
    - **COIVD-19 Related Care**: Append modifier CS

RHC Claims for Telehealth Services from January 27, 2020 through June 30, 2020		
Revenue Code	HCPCS Code	Modifiers
052X	G2025	CG (required) 95 (optional)
RHC Claims for Telehealth Services starting July 1, 2020		
Revenue Code	HCPCS Code	Modifiers
052X	G2025	95 (optional)

- **Cost Report**: Costs for furnishing distant site telehealth services will not be used to determine the RHC AIR rate but must be reported on the appropriate cost report form. RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled "Cost Other Than RHC Services."
- **Cost Share Waiver**: Effective March 18th-the end of the COVID-19 PHE, Medicare is waiving cost sharing for specified categories of E/M services if they result in an order for or an administration of a COVID-19 test and relate to the furnishing or administration of such test or to the evaluation of an individual for purposes of determining the need for such test.
    - RHCs must waive collection of co-insurance from beneficiaries.
    - Apply CS modifier to the service item.
    - Claims with CS modifier will automatically reprocess July 1st, 2020.
- **Preventative Services**: If an RHC performs a preventive service via telehealth that is traditionally subject to a cost share waiver, then the RHC should apply a CS modifier to HCPCS G2025, even though the service is unrelated to COVID-19.
- **Reimbursement:** The RHC telehealth payment rate is set at $92.03 per visit, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS. This rate will apply to telehealth visits performed by independent or provider based RHCs.
- **Telephone Services**: Effective March 1st, 2020 RHCs can perform audio only telephone E/M services utilizing CPT codes 99441, 99442, and 99443.
    - RHCs can furnish and bill for these services using HCPCS code G2025.
    - At least 5 minutes of telephone E/M by physician or other qualified health care professional who may report E/M services must be provided to an established patient, parent, or guardian.

- Cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

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

NEBRASKA MEDICAID

Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes**:
  - RHCs can bill G0071 for virtual communication services when at least 5 minutes of communication technology-based or remote evaluation services is furnished by an RHC practitioner to a patient who has had an FQHC or RHC billable visit within the previous year, and both of the following requirements are met:
    - The medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous 7 days, and
    - The medical discussion or remote evaluation does not lead to an RHC visit within the next 24 hours or at the soonest available appointment.
- **Effective Date**: March 1st, 2020-End of PHE
- **Modifier**: None
- **Patient Type**: Established
- **Reimbursement:** $46.40

Telehealth:

- **Allowable Codes**: Providers can perform and bill appropriate CPT/HCPCs codes on their fee schedule if it meets the below requirements:
    - All treatments or services submitted for reimbursement must be delivered in accordance with existing service definitions.
    - All treatments and services are expected to be rendered in a clinically appropriate manner and be directly related to the beneficiary's treatment needs or treatment plan.
    - Providers must document the rationale for delivery of treatment or services through teletherapy in addition to existing documentation requirements.
  - **PT/OT/ST**: Although there were some PT/OT/ST services that were previously allowable prior to the COVID-19 PHE, NE Medicaid has issued a specific list of temporary allowable telehealth codes, which are provided in the below matrix
  - **Behavioral Health Services**: Although there were some behavioral services that were previously allowable prior to the COVID-19 PHE, NE Medicaid has issued a specific list of temporary allowable telehealth codes, which are provided in the below matrix

- **Documentation Requirements:** Along with standard documentation requirements, Medicaid also requires documentation of which site initiated the call, the telecommunication technology utilized, and the time the telehealth service began and ended, and rationale for delivery of treatment or services through telehealth.
- **Effective Date**:
    - **PT/OT/ST & Behavioral Health Services Specific Codes**: March 1st, 2020-End of federal PHE
- **HIPAA Compliant Platform**: Per communication with a Nebraska Medicaid representative, NE Medicaid has NOT waived their HIPAA complaint platform requirement.
- **Modifiers/POS**: NE Medicaid has not released specific guidance around RHC telehealth billing. An NE Medicaid Public Information Officer, stated the following through an inquiry:
    - "FQHC and RHC's are allowed to bill their normal encounter services as they would have prior to COVID, with the GT Modifier, as long as they are fulfilling the service definition of what they are billing for. If they are performing a service outside of what would be paid under a typical encounter rate, they would need to bill that separately and get paid on a fee-for-service basis."
- **Medicaid Informed Consent**:
    - During the COVID-19 PHE, the written consent requirement for telehealth, found in the Nebraska DHHS Medicaid Program Manual, section 1-006.05, is waived.
        - Therefore, written consent is not required prior to providing a service via telehealth, although providers should obtain a written consent when possible. The provider must document the reason the written consent was unable to be obtained. Even though written consent is not required, the patient must receive the following information verbally:
            - Patient has the option to refuse telehealth without affecting patient's right to future care
            - Provider must inform the patient all existing confidentiality protections shall apply to service being provided by telehealth
            - Sharing of any patient identifiable images or information from the telehealth visit to researchers or other individuals will not occur without the consent of the patient
        - If a patient does not want to receive treatment through telehealth the provider will need to assist the patient in finding alternative care.
    - **Safety Plan:**
        - For each adult client or for a client who is a child but who is NOT receiving telehealth behavioral health services, a safety plan must be developed, should it be needed at any time during or after the provision of telehealth. This plan shall document the actions the client and the health care practitioner will take in an emergency or urgent situation that arises during or after the telehealth consultation.
    - (There are additional consent and safety plan requirements for a child receiving telehealth behavioral health services that can be found in the Nebraska DHHS Medicaid Program Manual, section 1-006.05).
- **Non-Covered Services**: Includes inpatient services, crisis stabilization, mental health and substance use disorder residential services, mental health respite, social detoxification, hospital diversion, and day treatment.
- **Patient Type**: New & Established
- **Patient Location**: Patient can be located at home, an originating site, or any other location.
- **Provider Type**: Under Nebraska statutes, including but not limited to N.R.S. § 38-1,143, currently authorize "any credential holder under the Uniform Credentialing Act" to use telehealth in establishing a provider-patient relationship, except those holding credentials under the following:
    - Cosmetology, Electrology, Esthetics, Nail Technology, and Body Art Practice Act; Dialysis Patient Care Technician Registration Act; Environmental Health Specialists Practice Act; Funeral Directing and Embalming Practice Act; Massage Therapy Practice Act; Medical Radiography Practice Act; Nursing Home Administrator Practice Act; Perfusion Practice Act; Surgical First Assistant Practice Act; Veterinary Medicine and Surgery Practice Act; and Water Well Standards and Contractors' Practice Act.
- **Reimbursement**: NE Medicaid has not released specific guidance around RHC telehealth reimbursement. An NE Medicaid Public Information Officer, stated the following through an inquiry:
    - "FQHC and RHC's can bill their normal encounter services as they would have prior to COVID, with the GT Modifier, as long as they are fulfilling the service definition of what they are billing for. If they are performing a service outside of what would be paid under a typical encounter rate, they would need to bill that separately and get paid on a fee-for-service basis."

- **Transmission Fees & Originating Site Fee:** NE Medicaid will reimburse practitioners for transmission costs (HCPCS T1014) if services were NOT provided by an internet service provider. Transmission costs can be billed in minutes with HCPCS code T1014. NE Medicaid will also reimburse originating site facilities an originating site fee (HCPCS Q3014).
- **Video Component**: In instances where it is documented that the beneficiary does not have access to an audiovisual device, NE Medicaid will allow audio only services if it is clinically appropriate and the treatment or service can meet the standard service expectations.

Cost Share Waiver:

- Effective March 1st, 2020-April 30th, 2020-NE Medicaid and MCOs will waive copays for COVID-19 related services.
- Effective May 1st, 2020-End of Federal PHE-NE Medicaid and MCOs have suspended copays for all services.

ADDITIONAL MEDICAID TELEHEALTH ELIGIBLE CODES										
PT/OT/ST										
97161	97162	97163	97164	97110	97112	97116	97530	97165	97166	97167
97168	92507	92508	92521	92522	92523	92526				
Behavioral Health Services										
90791	H0031, HO	90792	90832	90832, HF	90832, U3/HF	90832, U4/HF	90832, U5/HF	90832, U6/HF	90833	90833, U4
90833, U5	90834	90834, HF	90834, U3/HF	90834, U4/HF	90834, U5/HF	90834, U6/HF	90836	90836, U4	90836, U5	90837
90837, HF	90837, U3/HF	90837, U4/HF	90837, U5HF	90837, U6/HF	90838	90838, U4	90838, U5	90839	90840	90846
90846, HF	90846, U3/HF	90846, U4/HF	90846, U5/HF	90847, U7	90846, HA/HF	90846 U6/HF	90847	90847, HF	90847, ET/HF	90847, HA/HF
90847, U3/HF	90847, U4/HF	90847, U5/HF	90847, U6/HF	90847, U8	90853	90853, HF	90853, U3/HF	90853, U4/HF	90853, U6/HF	90832, U9
90834, U9	90837, U9	90847, U9	90887	90887, HF	90887, U5/HF	99211	92212	99213	99214	92215
99241	99242	99243	99244	99245	99307	99308	99309	99310	H1011	H0001
H0001, 52	H0031, AH	H0031, 52H0036	H2033	H0040, 52	H2015, HK	H2014	H2027	H2015, HE	H2000, SK	H2000, HA
97151	97152	97153	97154	97155	97156	97158	H0038, HE	H0038, HF	H0038, HE/HQ	H0038 HF/HQ
H2017	H2018									
Codes Highlighted in Blue -Require an Audiovisual Connection **Codes Highlighted in Green-Can Be Performed via an Audio only (Telephone) or Audiovisual Connection**										

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

MEDICARE

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

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

- **Billing**:
  - **Telehealth Services Furnished January 27, 2020- June 30, 2020:** FQHCs should report 3 HCPCS/CPT codes: the FQHC Prospective Payment System (PPS) specific payment code (GO466, G0467, G0468, G0469, or G0470); the HCPCS/CPT code that describes the services furnished via telehealth with modifier 95; and G2025 with modifier 95.
    - Must be an FQHC qualifying visit.
    - These claims will be paid at the FQHC PPS rate until June 30th, 2020.
    - Claims will be automatically reprocessed beginning July 1st, 2020 at the $92.03 rate.
    - FQHCs do not need to resubmit these claims for payment adjustment.
    - Telehealth Services Furnished for Non-Qualifying FQHC Visits**:** FQHCs would need to hold these visits until July 1st, 2020 and then bill with HCPCS code G2025.
  - **Telehealth Services Furnished July 1, 2020 and Forward:** FQHCs will only need to submit HCPCS code G2025. Modifier "95" may be appended but is not required.
  - **COIVD-19 Related Care**: Append modifier CS

FQHC Claims for Telehealth Services January 27, 2020 through June 30, 2020		
Revenue Code	HCPCS Code	Modifiers
052X	FQHC Specific Payment Code- G0466, G0467, G0468, G0469, G0470	None
052X	FQHC PPS Qualifying Payment Code	95
052X	G2025	95
FQHC Claims for Telehealth Services Starting July 1, 2020		
Revenue Code	HCPCS Code	Modifiers
052X	G2025	95 (optional)

- **Cost Report**: Costs for furnishing distant site telehealth services will not be used to determine the FQHC PPS rate but must be reported on the appropriate cost report form. FQHCs must report both originating and distant site telehealth costs on Form CMS-224-14, the Federally Qualified Health Center Cost Report, on line 66 of the Worksheet A, in the section titled "Other FQHC Services".
- **Cost Share Insurance Waiver**: Effective March 18th-the end of the COVID-19 PHE, Medicare is waiving cost sharing for specified categories of E/M services if the service results in an order for or an administration of a COVID-19 test and relate to the furnishing or administration of such test or to the evaluation of an individual for purposes of determining the need for such test.
  - FQHCs must waive collection of co-insurance from beneficiaries.
  - Apply CS modifier to the service item.
  - Claims with CS modifier will automatically reprocess July 1st, 2020.
- **Preventative Services**: If an FQHC performs a preventive service via telehealth that is traditionally subject to a cost share waiver, then the FQHC should apply a CS modifier to HCPCS G2025, even though the service is unrelated to COVID-19.
- **Reimbursement:** The FQHC telehealth payment rate is set at $92.03 per visit, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS.
- **Telephone Services**: Effective March 1st, 2020 FQHCs can perform audio only telephone E/M services utilizing CPT codes 99441, 99442, and 99443.
  - FQHCS can furnish and bill for these services using HCPCS code G2025.
  - At least 5 minutes of telephone E/M by physician or other qualified health care professional who may report E/M services must be provided to an established patient, parent, or guardian.
  - Cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

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

NEBRASKA MEDICAID

Payor Specific Key Points

E-Visits/Telephone/Virtual Check Ins:

- **Allowable Codes**:
    - FQHCs can bill G0071 for virtual communication services when at least 5 minutes of communication technology-based or remote evaluation services is furnished by an FQHC practitioner to a patient who has had an FQHC or RHC billable visit within the previous year, and both of the following requirements are met:
        - The medical discussion or remote evaluation is for a condition not related to an FQHC service provided within the previous 7 days, and
        - The medical discussion or remote evaluation does not lead to an FQHC visit within the next 24 hours or at the soonest available appointment.
- **Effective Date**: March 1st, 2020-End of PHE
- **Modifier**: None
- **Patient Type**: Established
- **Reimbursement:** $46.40

Telehealth:

- **Allowable Codes**: Providers can perform and bill appropriate CPT/HCPCs codes on their fee schedule if it meets the below requirements:
        - All treatments or services submitted for reimbursement must be delivered in accordance with existing service definitions.
        - All treatments and services are expected to be rendered in a clinically appropriate manner and be directly related to the beneficiary's treatment needs or treatment plan.
        - Providers must document the rationale for delivery of treatment or services through teletherapy in addition to existing documentation requirements.
    - **PT/OT/ST**: Although there were some PT/OT/ST services that were previously allowable prior to the COVID-19 PHE, NE Medicaid has issued a specific list of temporary allowable telehealth codes, which are provided in the below matrix
    - **Behavioral Health Services**: Although there were some behavioral services that were previously allowable prior to the COVID-19 PHE, NE Medicaid has issued a specific list of temporary allowable telehealth codes, which are provided in the below matrix
- **Documentation Requirements:** Along with standard documentation requirements, Medicaid also requires documentation of which site initiated the call, the telecommunication technology utilized, and the time the telehealth service began and ended, and rationale for delivery of treatment or services through telehealth.
- **Effective Date**:
    - **PT/OT/ST & Behavioral Health Services Specific Codes**: March 1st, 2020-End of federal PHE

- **HIPAA Compliant Platform**: Per communication with a Nebraska Medicaid representative, NE Medicaid has NOT waived their HIPAA complaint platform requirement.
- **Modifiers/POS**: NE Medicaid has not released specific guidance around FQHC telehealth billing. An NE Medicaid Public Information Officer, stated the following through an inquiry:
    - "FQHC and RHC's are allowed to bill their normal encounter services as they would have prior to COVID, with the GT Modifier, as long as they are fulfilling the service definition of what they are billing for. If they are performing a service outside of what would be paid under a typical encounter rate, they would need to bill that separately and get paid on a fee-for-service basis."
- **Medicaid Informed Consent**:
    - During the COVID-19 PHE, the written consent requirement for telehealth, found in the Nebraska DHHS Medicaid Program Manual, section 1-006.05, is waived.
        - Therefore, written consent is not required prior to providing a service via telehealth, although providers should obtain a written consent when possible. The provider must document the reason the written consent was unable to be obtained. Even though written consent is not required, the patient must receive the following information verbally:
            - Patient has the option to refuse telehealth without affecting patient's right to future care
            - Provider must inform the patient all existing confidentiality protections shall apply to service being provided by telehealth
            - Sharing of any patient identifiable images or information from the telehealth visit to researchers or other individuals will not occur without the consent of the patient
        - If a patient does not want to receive treatment through telehealth the provider will need to assist the patient in finding alternative care.
    - **Safety Plan:**
        - For each adult client or for a client who is a child but who is NOT receiving telehealth behavioral health services, a safety plan must be developed, should it be needed at any time during or after the provision of telehealth. This plan shall document the actions the client and the health care practitioner will take in an emergency or urgent situation that arises during or after the telehealth consultation.
    - (There are additional consent and safety plan requirements for a child receiving telehealth behavioral health services that can be found in the Nebraska DHHS Medicaid Program Manual, section 1-006.05).
- **Non-Covered Services**: Includes inpatient services, crisis stabilization, mental health and substance use disorder residential services, mental health respite, social detoxification, hospital diversion, and day treatment.
- **Patient Type**: New & Established
- **Patient Location**: Patient can be located at home, an originating site, or any other location.
- **Provider Type**: Under Nebraska statutes, including but not limited to N.R.S. § 38-1,143, currently authorize "any credential holder under the Uniform Credentialing Act" to use telehealth in establishing a provider-patient relationship, except those holding credentials under the following:
    - Cosmetology, Electrology, Esthetics, Nail Technology, and Body Art Practice Act; Dialysis Patient Care Technician Registration Act; Environmental Health Specialists Practice Act; Funeral Directing and Embalming Practice Act; Massage Therapy Practice Act; Medical Radiography Practice Act; Nursing Home Administrator Practice Act; Perfusion Practice Act; Surgical First Assistant Practice Act; Veterinary Medicine and Surgery Practice Act; and Water Well Standards and Contractors' Practice Act.
- **Reimbursement**: NE Medicaid has not released specific guidance around FQHC telehealth reimbursement. An NE Medicaid Public Information Officer, stated the following through an inquiry:
    - "FQHC and RHC's can bill their normal encounter services as they would have prior to COVID, with the GT Modifier, as long as they are fulfilling the service definition of what they are billing for. If they are performing a service outside of what would be paid under a typical encounter rate, they would need to bill that separately and get paid on a fee-for-service basis."
- **Transmission Fees & Originating Site Fee:** NE Medicaid will reimburse practitioners for transmission costs (HCPCS T1014) if services were NOT provided by an internet service provider. Transmission costs can be billed in minutes with HCPCS code T1014. NE Medicaid will also reimburse originating site facilities an originating site fee (HCPCS Q3014).

- **Video Component**: In instances where it is documented that the beneficiary does not have access to an audiovisual device, NE Medicaid will allow audio only services if it is clinically appropriate and the treatment or service can meet the standard service expectations.

Cost Share Waiver:

- Effective March 1st, 2020-April 30th, 2020-NE Medicaid and MCOs will waive copays for COVID-19 related services.
- Effective May 1st, 2020-End of Federal PHE-NE Medicaid and MCOs have suspended copays for all services.

ADDITIONAL MEDICAID TELEHEALTH ELIGIBLE CODES										
PT/OT/ST										
97161	97162	97163	97164	97110	97112	97116	97530	97165	97166	97167
97168	92507	92508	92521	92522	92523	92526				
Behavioral Health Services										
90791	H0031, HO	90792	90832	90832, HF	90832, U3/HF	90832, U4/HF	90832, U5/HF	90832, U6/HF	90833	90833, U4
90833, U5	90834	90834, HF	90834, U3/HF	90834, U4/HF	90834, U5/HF	90834, U6/HF	90836	90836, U4	90836, U5	90837
90837, HF	90837, U3/HF	90837, U4/HF	90837, U5HF	90837, U6/HF	90838	90838, U4	90838, U5	90839	90840	90846
90846, HF	90846, U3/HF	90846, U4/HF	90846, U5/HF	90847, U7	90846, HA/HF	90846 U6/HF	90847	90847, HF	90847, ET/HF	90847, HA/HF
90847, U3/HF	90847, U4/HF	90847, U5/HF	90847, U6/HF	90847, U8	90853	90853, HF	90853, U3/HF	90853, U4/HF	90853, U6/HF	90832, U9
90834, U9	90837, U9	90847, U9	90887	90887, HF	90887, U5/HF	99211	92212	99213	99214	92215
99241	99242	99243	99244	99245	99307	99308	99309	99310	H1011	H0001
H0001, 52	H0031, AH	H0031, 52H0036	H2033	H0040, 52	H2015, HK	H2014	H2027	H2015, HE	H2000, SK	H2000, HA
97151	97152	97153	97154	97155	97156	97158	H0038, HE	H0038, HF	H0038, HE/HQ	H0038 HF/HQ
H2017	H2018									
Codes Highlighted in Blue -Require an Audiovisual Connection **Codes Highlighted in Green-Can Be Performed via an Audio only (Telephone) or Audiovisual Connection**										

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

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

Commercial Billing:

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

Medicare Billing:

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

- **Facility (UB Form):** CMS-5531-IFC specifically outlines appropriate billing for hospitals during the COVID-19 pandemic.
    - **CAHs:** The extraordinary circumstances policy in CMS-5531-IFC only applies to PPS hospitals and to services paid on OPPS. **It does not apply to CAHs**.
        - **CAH PT/OT/ST:** Append modifier 95 if therapy services are provided via telehealth.

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

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

            - **Medicare FAQ:**
              Question: *When hospital clinical staff furnish a service using telecommunication technology*
              to the patient who is a registered outpatient of the hospital and the hospital makes the patient's home provider-based to the hospital as a temporary expansion site, should the hospital bill using the telehealth modifier (modifier 95)?
              Answer: *No. In this situation the hospital is furnishing an outpatient hospital service, not a telehealth service, to a patient in a temporarily relocated department of the hospital as discussed at 85 FR 27560. Accordingly, the hospital would bill as it ordinarily would bill and would include the DR condition code or CR condition code (as applicable) on the*

claim. If the situation involves a relocation of an on-campus or excepted off-campus provider-based department to an off-campus hospital location, the hospital would bill using the PO modifier (service provided at an excepted off-campus provider-based department) only if the hospital requests an extraordinary circumstances relocation request within 120 days of the date the temporary expansion site is made provider-based to the hospital; otherwise, the hospital would append the PN modifier (service provided at a non-excepted off-campus
https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

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

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

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

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

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

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

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

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

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

Payor	Telehealth Codes	E-Visits
Aetna	**ALLOWABLE** • Allowable PT/OT/ST code set is available in the "Aetna" section of this guide. • PT/OT/STs are considered providers eligible to bill for telehealth services. • 1500 Form: Utilize modifier GT or 95 and 02 POS. UB Form: Utilize GT or 95 modifier.	**1500 FORM-ALLOWABLE** Individually enrolled therapists can bill CPT 98970 -98972 or G2061-G2063 for E-visits. **UB FORM-UNCLEAR** No guidance for hospital-based therapists.
BCBS NE	**ALLOWABLE** • PT/OT/STs can provide therapy services on their fee schedule, if appropriate to be provided via telehealth. • PT/OT/STs are considered providers eligible to bill for telehealth services. • 1500 Form: Utilize POS 02 and modifier 95. UB Form: Seeking clarification if hospital-based PT/OT/STs can provide telehealth services.	**1500 FORM-ALLOWABLE** Individually enrolled therapists can bill CPT 98970 -98972 for E-visits. **UB FORM-UNCLEAR** No guidance for hospital-based therapists.
Cigna	**ALLOWABLE** • PT/OT/STs can provide therapy services on their fee schedule, if appropriate to be provided via telehealth PT/OT/STs are considered providers eligible to bill for telehealth services. • 1500 Form: Utilize modifier GT or 95 and in person POS. UB Form: Not Allowable as of January 1st, 2021	**NOT ALLOWABLE**
Medica	**ALLOWABLE** • Allowable PT/OT/ST code set is available in the "Medica" section of this guide. • PT/OT/STs are considered providers eligible to bill for telehealth services. • 1500 Form: Utilize modifier GT or 95 and POS 02. UB Form: Utilize GT or 95 modifier. •	**1500 FORM-ALLOWABLE** Individually enrolled therapists can bill CPT 98970 -98972 or G2061-G2063 for E-visits. **UB FORM-UNCLEAR** No guidance for hospital-based therapists.
Medicare	**ALLOWABLE** • Allowable PT/OT/ST code set is available in the "Medicare" section of this guide. • PT/OT/STs are considered providers eligible to bill for telehealth services. • PT/OT/ST services can be furnished to a beneficiary in their home by a hospital-based therapist when the beneficiary is registered as an outpatient of the hospital and the hospital considers the beneficiary's home to be a provider-based department of the hospital. 1500 Form: Utilize POS for in person visit and 95 modifier. UB Form: Utilize 95 modifier.	**1500 FORM-ALLOWABLE** Individually enrolled therapists can bill G2061-G2063 for E-visits. **UB FORM-UNCLEAR** No guidance for hospital-based therapists, however these codes are marked with a non-payable status indicator in the OPPS fee schedule, therefore they are most likely not reimbursable on a UB.
NE Medicaid & MCOs	**ALLOWABLE** • Allowable PT/OT/ST code set is available in the "NE Medicaid" section of this guide.	**NOT ALLOWABLE** E-visit codes G2061-G2063 are not listed as allowable on the NE Medicaid fee schedule.

	• PT/OT/STs are considered providers eligible to bill for telehealth services. • 1500 Form: POS 02 and modifier GT. UB Form: Modifier GT.	
UHC	**ALLOWABLE** • Allowable PT/OT/ST code set is available in the "UHC" section of this guide. 1500 Form: Utilize modifier 95 and in person POS. UB Form: Utilize 95 modifier and revenue code 780.	**1500 FORM-ALLOWABLE** Individually enrolled therapists can bill G2061-G2063 for E-visits. **UB FORM-UNCLEAR** No guidance for hospital-based therapists.

HIPAA COMPLIANT SOFTWARE

The Office of Civil Rights (OCR) has issued the below statement, and therefore Medicare and most other payors are allowing non-HIPAA compliant software to be used for virtual visits. However, some payors have still not waived this as requirement for payment. Refer to the HIPAA compliant statement within each payor section, or if the payor is not listed within this guide, reach out to the payor to verify their telehealth platform requirements.

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

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, to protect the privacy and security of protected health information, namely the HIPAA Privacy, Security and Breach Notification Rules (the HIPAA Rules).

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

https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

REFERENCES & RESOURCES

Aetna:

https://navinet.navimedix.com/

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

BCBS NE:

https://www.nebraskablue.com/en/Providers/COVID-19

Navinet COVID-19 Provider FAQ

https://www.nebraskablue.com/Providers/Policies-and-Procedures

HHS

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

Cigna:

https://static.cigna.com/assets/chcp/resourceLibrary/medicalResourcesList/medicalDoingBusinessWithCigna/medicalDbwcCOVID-19.html

https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/Notifications/R31_Virtual_Care.pdf

CMS:

https://www.cms.gov/newsroom/press-releases/president-trump-expands-telehealth-benefits-medicare-beneficiaries-during-covid-19-outbreak

https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

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

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

https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf
https://www.cms.gov/index.php/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers
https://www.cms.gov/files/document/covid-final-ifc.pdf
https://www.cms.gov/files/document/se20016.pdf
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se
https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf
https://www.cms.gov/files/document/se20011.pdf
https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1#:~:text=In%20the%20CY%202021%20PFS%20proposed%20rule%2C%20CMS%20proposed%20to,ends%20or%20December%2031%2C%202021.

Medica:

https://www.medica.com/providers
https://www.medica.com/-/media/documents/provider/emergency-telemedicine-policy-excluding-mhcp.pdf?la=en&hash=D154D75363E094EB8C24010607883665
https://www.medica.com/-/media/documents/provider/covid-19-preparedness-provider-faq.pdf?la=en&hash=71B81851C5046B016DD910711E6D18F4

Nebraska Department of Health & Human Services:

http://dhhs.ne.gov/Pages/Medicaid-Provider-Bulletins.aspx
https://www.nebraska.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-01.pdf
http://dhhs.ne.gov/Medicaid%20Provider%20Bulletins/Provider%20Bulletin%2020-12.pdf
http://dhhs.ne.gov/Medicaid%20Provider%20Bulletins/Provider%20Bulletin%2020-06.pdf
http://dhhs.ne.gov/Medicaid%20Provider%20Bulletins/Provider%20Bulletin%2020-13.pdf
http://dhhs.ne.gov/Medicaid%20Provider%20Bulletins/Provider%20Bulletin%2020-10.pdf
http://dhhs.ne.gov/Medicaid%20Provider%20Bulletins/Provider%20Bulletin%2020-09.pdf

Nebraska Total Care:

https://www.nebraskatotalcare.com/newsroom/covid-19-testing-billing-guidance.html
https://www.nebraskatotalcare.com/providers/resources/covid-19.html
https://www.nebraskatotalcare.com/content/dam/centene/Nebraska/PDFs/ProviderRelations/NTC-Telehealth-Resource-060718_508.pdf

NARHC:

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

UHC:

https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19.html
https://www.uhc.com/health-and-wellness/health-topics/covid-19
https://www.uhcprovider.com/en/resource-library/news/provider-telehealth-policies.html
https://www.uhcprovider.com/content/provider/en/viewer.html?file=https%3A%2F%2Fwww.uhcprovider.com%2Fcontent%2Fdam%2Fprovider%2Fdocs%2Fpublic%2Fpolicies%2Fcomm-reimbursement%2FCOMM-Telehealth-and-Telemedicine-Policy.pdf

Other:

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

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