Telehealth Toolkit

Last Updated: 12/31/20

DELAWARE VALLEY ACO
an accountable care organization

Telehealth Toolkit

COVID-19 Public Health Emergency: CMS Telehealth Services

On March 17, 2020, CMS stated that it will immediately expand coverage for telemedicine nationwide. Under Section 1135 of the Social Security Act, CMS temporarily waives certain Medicare, Medicaid, SCHIP, HIPAA requirements. The waiver temporarily eliminates the requirement that the originating site must be a physician's office or other authorized healthcare facility and allows Medicare to pay for telehealth services for patients that are in their homes or any setting of care. The waiver is expected to expire when the underlying emergency/disaster declaration terminates.

What Practices Need to Know

Items that are <u>temporarily waived/suspended</u> through the blanket waiver

- Prior authorization requirements for fee-for-service programs
- Requirements that out-of-state providers be licensed in the state where they are providing services when they are licensed in another state (this applies to Medicare and Medicaid)
- Certain provider enrollment and revalidation requirements to increase access to care
- Requirements for certain pre-admission and annual screenings for nursing home residents

Telehealth Services Provided Under the Current Emergency Declaration

Telehealth services are paid under the Physician Fee Schedule (PFS) at the same amount as in-person services. As of 3/30/20, the claim for these non-traditional telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency, providers should bill with the Place of Service code equal to what it would have been in the absence of the public health emergency, along with a modifier 95, indicating that the service was performed via telehealth. Medicare coinsurance and deductibles still apply for these services; however, the Health and Human Services (HHS) Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Update 12/18/20: 2021 Physician Fee Schedule Final Rule

CMS made additional changes for telehealth services that were finalized in the 2021 Physician Fee Schedule Final Rule which was released 12/3/20. These changes included adding additional codes to the list of codes that can be provided via telemedicine and virtual check-in codes and modifications to e-visit codes. These changes will become effective 1/1/21. CMS did not finalize changes to remove originating site and geographic restrictions for traditional telehealth visits or add telephone E/M codes on a permanent basis. Billing for the expanded Medicare telehealth services as well as for the telephone evaluation and management services, and additional flexibilities for communications technology-based services will only continue through the end of the PHE.

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Medicare Service	What Does the Service Entail?	Modalities Allowed	Billing (HCPCS/CPT Codes) Dates of service starting 3/6/20	Patient Relationship with Provider	Eligible Patients

Telehealth Visits	• A visit/appointment between provider and patient via telecommunication systems
	  ➤ CMS allows for use of telecommunications technology that have audio and video capabilities that are used for two-way, real-time interactive communication
	  ➤ CMS is allowing audio only equipment for certain Telehealth Services
	• Examples:
	  ➤ Evaluation and Management Visits
	  ➤ Mental Health Counseling
	  ➤ Preventive Health Screenings
	  ➤ Prescription Refills
	  ➤ Chronic Care Management
		• **Applications Allowed:**
		  ➤ Apple FaceTime
		  ➤ Facebook Messenger video
		  ➤ Google Hangouts video
		  ➤ Zoom
		  ➤ Skype
		• **Applications <u>Not</u> Allowed:**
		  ➤ Applications that are public facing
		  ➤ Facebook Live
		  ➤ Twitch
		  ➤ TikTok
			Common Codes:
			• 99201-99215 (Office or other Outpatient Visits)
			• G0425-G0427 (Telehealth Consultations, Emergency Department or Initial Inpatient)
			• G0406-G0408 (Follow-up Inpatient Telehealth consultation to patients in hospitals or SNFs)
			• Link to Complete List of Billable Telehealth Codes
			• Medicare coinsurance and deductible apply
				• Physicians
				• Qualified Health Care Professionals who can report evaluation and management services (Examples: Nurse Practitioners, Physician Assistants, etc.)
				• Qualified Non-Physician Health Care Professionals (Examples: Physical Therapists, Occupational Therapists, Speech Language Pathologists, Clinical Psychologists)
					• Established patients
					• New patients

Virtual Check-Ins	• A brief (5-20 minutes) check-in with the provider via telephone or other telecommunication devices, such as video or images to decide whether an office visit or other visit is needed
	• The check-in is not related to a medical visit provided within the previous 7 days nor leading to a visit or procedure within the next 24 hours, or next available appointment
	• As of 3/30/20- Annual consent may be obtained at the same time, and not necessarily before, the time that services are furnished.
		• **Patient Submission:**
		  ➤ Use a device like a phone, integrated audio/video system, or captured video image to communicate with provider
		• **Provider Response:**
		  ➤ Follow- up with the patient can take place via phone call, audio/video communication, secure text messaging, email, or patient portal communication
			• HCPCS Code G2012
			• New 1/1/21: HCPCS Code G2252
			• New 1/1/21: HCPCS Code G2251
			• HCPCS Code G2010
			• New 1/1/21: HCPCS Code G2250
			• Medicare coinsurance and deductible apply
				• Physicians
				• Qualified Health Care Professionals who can report evaluation and management services (Examples: Nurse Practitioners, Physician Assistants, etc.)
				• Practitioners who cannot independently bill for E/M services
					• Established patients
					• New patients

E-Visits	• A communication between a patient and their provider through an online patient portal • The patient must generate the initial inquiry and communications can occur over a 7-day period • The patient must verbally consent to receive this service	• Patient Portal	• 99421 • 99422 • 99423 Update effective 1/1/2021: • 98970 • 98971 • 98972 • Medicare coinsurance and deductible apply	• Physicians • Qualified Health Care Professionals who can report evaluation and management services (Examples: Nurse Practitioners, Physician Assistants, etc.) • Practitioners who cannot independently bill for E/M services	• Established patients
Telephone E/M Visits	• A communication between a patient or caregiver and their provider (between 5-30 minutes of medical discussion) on the telephone • Cannot be related to a medical visit provided within the previous 7 days nor leading to a visit or procedure within the next 24 hours, or next available appointment	• Telephone	• 99441 • 99442 • 99443 • 98966 • 98967 • 98968	• Physicians • Qualified Health Care Professionals who can report evaluation and management services • Qualified Non-Physician Health Care Professionals (Examples: Physical Therapists, Occupational Therapists, Speech Language Pathologists, Clinical Psychologists)	• Established patients

Updated: 12/31/20

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Key Takeaways

1. **Telehealth Visits**
   - Patients in all areas of the country can receive telehealth services, including at their home
   - Telehealth services are not only limited to services related to patients with COVID-19
   - Medicare will make payments effective for services starting 3/6/20, and for the duration of the COVID-19 Public Health Emergency, for any professional services to patients in any healthcare facility and in their homes
   - Visits are considered the same as in-person office visits and are paid the same rate as in-person office visits
   - Can be provided by a non-public facing remote communication product that is available to communicate with patients
   - The HHS will not conduct audits to ensure a prior relationship between patient and provider existed for claims submitted during public health emergencies
   - CMS recommends the patient verbally consent to receive this service
   - Medicare coinsurance and deductible would apply to these services
   - Physicians can now declare patients homebound if they do not leave home because of a medical contraindication or due to suspected or confirmed COVID-19
   - <mark>Updated 12/18/20:</mark> Since the beginning of the PHE, CMS has added a total of 144 additional services that can be delivered through telehealth on a temporary basis
     - In the 2021 PFS Final Rule 9 Codes were added to the list of codes that can be delivered through telehealth on a permanent basis:
       - Group Psychotherapy: CPT code 90853
       - Psychological and Neuropsychological Testing: CPT code 96121
       - Domiciliary, Rest Home, or Custodial Care services, Established patients: CPT codes 99334-99335
       - Home Visits, Established Patient: CPT codes 99347-99348
       - Cognitive Assessment and Care Planning Services: CPT code 99483
       - Visit Complexity Inherent to Certain Office/Outpatient Evaluation and Management (E/M): HCPCS code G2211
       - Prolonged Services: HCPCS code G2212
   - Claims for non-traditional telehealth services with dates of services on or after 3/1/20, and for the duration of the Public Health Emergency, providers should bill with the Place of Service code equal to what it would have been in the absence of the public health emergency, along with a modifier 95, indicating that the service was performed via telehealth
   - Qualified Non-Physician Health Care Professionals (Examples: Physical Therapists, Occupational Therapists, Speech Language Pathologists, Clinical Psychologists) can deliver telehealth services
   - CMS will allow the use of audio-only equipment to more than 80 telehealth services; including Medicare Annual Wellness Visits (AWV)

2. **Virtual Check-Ins**
   - Virtual check-ins can be conducted with a broader range of communication methods, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication
   - This service is not limited to only rural settings or certain locations
   - Medicare coinsurance and deductible would apply to these services
   - Annual consent may be obtained at the same time, and not necessarily before, the time that services are furnished
   - HHS will not conduct audits to ensure a prior relationship between patient and provider existed for claims submitted during public health emergencies
   - Services billed by practice occupational therapist, physical therapist, and speech-language pathologist must include the corresponding GO, GP, or GN therapy modifier on claims
   - Effective 1/1/21: Addition of 3 new virtual check-in codes
     - Two New Brief Communication Technology-Based Service Codes:
       - HCPCS Code G2252: added on an interim basis for the duration of 2021
         - Code is for 11-20 minutes of medical discussion
         - Code must be billed by a physician or other qualified health care professional who can report evaluation and management services
       - HCPCS Code G2251
         - Code is for 5-10 minutes of medical discussion
         - Code can be billed by qualified health care professional who cannot report evaluation and management services
     - One New Remote Evaluation of Pre-Recorded Patient Information Code:
       - HCPCS Code G2250
         - Can be billed by Qualified health care professional who cannot report evaluation and management services

3. **E-Visits**
   - Patients communicate with their providers by using online patient portals
   - Individual services need to be initiated by the patient and communications can occur over a 7-day period. Providers may educate patients on the availability of the service prior to patient initiation
   - This service is not limited to only rural settings or certain locations
   - Services can only be reported when the billing practice has an established relationship with the patient
   - Patients must verbally consent to this service. Providers can educate patients on the availably of the service prior to consent
   - Medicare coinsurance and deductible would apply to these service
   - Effective 1/1/21: HCPCS codes G2061-G2063 were deleted and replaced with updated CPT codes 98970-98972

4. **Telephone E/M Visits**
   - This service is not limited to only rural settings or certain locations

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- Services can only be reported when the billing practice has an established relationship with the patient
- HHS will not conduct review to consider whether those services were furnished to established patients
- Services billed by practice Occupational Therapist, Physical Therapist, and Speech-language Pathologist must include the corresponding GO, GP, or GN therapy modifier on claims
- CMS increased reimbursement for CPT codes 99441-99443 from a range of about $14-$41 to about $46-$110. The payments are retroactive to 3/1/20 for the remainder of the PHE
  - ➤ Medicare Administrative Contractors (MACs) will reprocess claims for those services that they previously denied and/or paid at the lower rate for dates of service on or after 3/1/20
- CMS is paying for Medicare telehealth services provided by Rural Health Clinics and Federally Qualified Health Clinics (FQHCs)

Telehealth Services Updates from Other Payers
*Sources: Letters from Payers and References below

Important: DVACO & MLHPP are providing the information below as a courtesy for reference only. Please consult your assigned representative from each payer to confirm this information or if you have clarifying questions / concerns.

Aetna

1. **Billing Guidance**
   - Telemedicine services can be offered for any reason, not just COVID-19 diagnosis
   - Telemedicine Policy is available to providers on the Availity portal
   - In most cases, providers will be reimbursed for telemedicine at the same rate as in-person visits included behavioral services, with the exception of some telephone-only services in commercial plans
   - Updated 12/14/20: Telephone-only services (99441 – 99443), rendered between 3/5/20 and 9/30/20, were set to equal 99212 – 99214 (e.g. 99441 was set to equate to 99212)
     - ➤ After 9/30/20, telephone-only services (99441 – 99443) resumed to pre-3/5/20 rates
   - Telemedicine will be covered within the capitation agreement, similar to an in-office visit
   - Physicians may provide care from any location if they follow Aetna's telemedicine policy
     - ➤ Physicians should continue to bill using their currently enrolled location and should not use their home address
   - Covering appropriate evaluation and management codes with a wellness diagnosis for those aspects of the visit done via telehealth
     - ➤ Preventative visit codes should be reserved for such time when routine in-office visits resume, and the remaining parts of the well visit can be completed
     - ➤ Both services will be fully reimbursed, and the patient will not incur cost-sharing
   - Commercial Plans:
     - ➤ As of 12/14/20, continuing to cover limited minor acute care evaluation and care management services and some behavioral health services rendered via telephone-only until further notice
     - ➤ As of 12/14/20, Aetna's liberalized coverage of Commercial telemedicine services will now extend until further notice

- o Specific details are outlined on the Telemedicine policy available on Availity
  - ➤ A synchronous audiovisual connection is required for specialty, most general medicine and some behavioral health visits
  - ➤ Non-facility telemedicine claims must use Place of Service (POS) 02 with the GT or 95 modifier
- Medicare Advantage:
  - ➤ Audio-only telemedicine services can be billed for a limited number of codes
    - o For other codes announced by CMS, an audiovisual connection is also still required
  - ➤ Non-facility telemedicine claims must use POS 02 or POS 11, or the POS equal to what it would have been if the service was rendered in-person, along with a modifier 95 indicating that the service rendered was performed via telehealth

2. **Cost-Sharing Waivers**
- Commercial Plans:
  - ➤ As of 12/14/20, extending all member cost-sharing waivers for covered in-network telemedicine visits for outpatient and mental health counseling services through 1/31/21 (Self-insured plans can offer this waiver at their own discretion)
- Medicare Advantage:
  - ➤ As of 12/14/20, waiving cost sharing for in-network primary care and specialist telehealth visits, including outpatient behavioral and mental health counseling services through 1/31/21
  - ➤ As of 12/14/20, waiving member out-of-pocket costs for all in-network primary care visits, whether done in-office and via telehealth, for any reason, and encourages member to continue seeking essential preventive and primary care during the crisis through 1/31/21
- The no-cost telemedicine benefit only applies to real-time virtual care delivered by in-network providers

3. **Diagnostic Testing/COVID-19 Treatment**
- Diagnostic (molecular PCR or antigen) tests to determine the need for member treatment will be covered without cost sharing
  - ➤ This includes to direct-to-consumer/home-based diagnostic or antigen tests
- Serological (antibody) tests that are ordered by a physician or authorized health care professional and are medically necessary will be covered without cost sharing
  - ➤ Serological (antibody) tests that are for purposes of: return to work or school or for general health surveillance or self-surveillance or self-diagnosis, except as required by applicable law
- As of 12/14/20, waiving member cost-sharing for inpatient admissions for treatment of COVID-19 or health complications associated with COVID-19
  - ➤ This applies to all Commercial and Medicare Advantage plans and is effective immediately for any admission through 1/31/21
- As of 12/14/20, covering the cost of the hospital stay for all Medicare Advantage members admitted 3/25/20 through 1/31/21
- As of 12/14/20, covering the full cost of provider in office treatment of COVID-19 for Medicare Advantage members through 1/31/21
- As of 12/9/20, waiving member cost -sharing related to COVID-19 vaccination for Commercial members
  - ➤ For Medicare, CMS has indicated it will cover the full cost of the vaccine for all Medicare beneficiaries, including those in a Medicare Advantage plan, in 2020 and 2021

4. Prescription Coverage
- Waiving early refill limits on most 30-day prescription maintenance medications for all Commercial members with pharmacy benefits administered through CVS Caremark
- Aetna Medicare members may request early refills on 90-day prescription maintenance medications at retail or mail pharmacies if needed
  - ➢ For drugs on a specialty tier, early refill limits for a 30-day supply are waived

Humana

1. Billing Guidance
- Applying the same coverage-related waivers to Original Medicare telehealth services that the CMS has announced in response to the COVID-19 PHE to both MA and commercial plans (except as prohibited under state statute or regulation)
- As of 12/21/20, reimbursing 100% of the contracted rate for a covered telehealth or other virtual service as outlined in the chart below, when rendered by an in-network provider:
  - ➢ This includes any member cost-sharing that would have otherwise applied

Plan type	Dates of service in 2020	Dates of service in 2021
Medicare Advantage	Any allowed *telehealth* or virtual service, provided and reported consistent with this policy	Any allowed *telehealth* or virtual service, provided and reported consistent with this policy, for the following types of service, as defined by Humana: • Primary care • Urgent care • Mental health or substance abuse care
Commercial	Any allowed *telehealth* or virtual service, provided and reported consistent with this policy	Any allowed *telehealth* or virtual service, provided and reported consistent with this policy, when rendered pursuant to a Humana *telehealth* vendor partnership, for dates of service through March 31, 2021

- Requiring a provider to submit a charge for a telehealth service with the place of service (POS) code that would have been reported had the service been furnished in person
- Requiring providers to report a telehealth or other virtual service with modifier 95 to identify that the service was furnished via telecommunications-based technology
- Increasing rates for the Medicare and other fee schedules that are based on current Medicare allowable amounts, for telephone E/M services. Increases will apply to services provided during the PHE, for dates of service beginning 3/1/20
- Some services that are coverable when provided using real-time, interactive audio-video telecommunications are also coverable when video was not used; however, because video is clinically significant to services that normally require face-to-face interaction, such services provided without video are only coverable when it was impossible to use video
  - ➢ Example: Public health emergency exceptions to normal requirements designed to ensure that patients receive critical services in unprecedented times, do not imply when otherwise-applicable standards can be ignored when it is practical to continue to meet them

- As of 12/21/20, Humana Telehealth Policy including list of procedure codes that are reimbursable during the PHE as telehealth or other virtual services: 📎
- As of 12/21/20, COVID related coding policy: 📎

2. **Cost-Sharing Waivers**
   - Member copays, deductibles and coinsurance cost sharing will be waived for covered services for treatment of confirmed cases of COVID-19, regardless of where they take place
     - ➤ This could include telehealth, primary care physician visits, specialty physician visits, facility visits, labs, home health and ambulance services

3. **Diagnostic Testing/COVID-19 Treatment**
   - As of 12/21/20, Humana intends to cover FDA-approved medications when they become available
     - ➤ This includes Veklury® (remdesivir), which has been approved by the FDA for the treatment of patients with COVID-19 requiring hospitalization
     - ➤ If a member is prescribed non-FDA-approved medications for the treatment of COVID-19, he or she will be responsible for any cost sharing required per his or her plan design
       - ○ Non-FDA approved drugs are excluded Part D drugs and ineligible for any Part D coverage
   - As of 12/21/20, covering all FDA-authorized COVID-19 vaccines at no additional cost for Humana members during the public health emergency
     - ➤ Coverage applies no matter where members get the vaccine—including at both in-network and out-of-network providers
     - ➤ Covers instances in which 2 vaccine doses are required

4. **Prescription Coverage**
   - As of 12/21/20, implementing a process to override "refill too soon" edits during the COVID-19 outbreak public health emergency in all U.S. states and territories that all contracted pharmacies can use as needed to ensure Humana members have appropriate access to their medications
   - As of 12/21/20, waiving mail or home delivery restrictions for retail-only pharmacies for a limited time so that members can choose to receive medications from a retail-only pharmacy via mail or home delivery
     - ➤ The waiver will be for claims with dates of service beginning in 3/1/2020 through 1/21/21

5. **Miscellaneous**
   - AWVs can be provided through telehealth services as long as they are consistent with CMS guidelines, state guidance, and Humana's policy
   - Humana will no longer accept PAFs and Member Summary with clinical inference completed during a visit using real-time interactive audio-only technology, but will continue to accept visits conducted using a real-time interactive audio and video telecommunications system
     - ➤ A visit performed using audio-only technology should be billed with telephonic evaluation and management codes (99441-99443), though these will no longer be accepted for the PAFs Member Summary with clinical inference program effective 7/1/2020
   - Telephonic and interactive video/audio consultations can be administered for the following measures:
     - ➤ Medication Reconciliation Post-Discharge

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- ➢ Care for Older Adults- Medication Review, Functional Status Assessment, Pain Screening, and Advance Care Planning
- ➢ Comprehensive Diabetes Care- Medical Attention for Nephropathy, but only if the telehealth visit is with a nephrologist
- ➢ Transitions of Care
- ➢ Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions

- Information can be gathered from patients during a telehealth visit regarding the administration and results of prior care. Submission of medical records with this care documented addresses these measures:
  - ➢ Comprehensive Diabetes Care- Eye Exam and Blood Sugar Controlled
  - ➢ Breast Cancer Screening
  - ➢ Colorectal Cancer Screening
- Risk Adjustment Information Table

COVID-19 telehealth and other virtual services that are eligible for risk adjustment

Technology solution/visit type	Medicare-covered services	Qualifies for risk adjustment	Equivalent to face-to-face visit	Physician location	Submission POS[1]	Common CPT[2] and HCPCS[3] codes
Telehealth with interactive audio and video	✓	✓	✓	Home/office/facility	Use CPT telehealth modifier "95" with any POS	99201 – 99215 (office or outpatient visits) G0425 – G0427 (telehealth consultations, emergency department or initial inpatient)
Telephonic visit (audio only)	✓	✗	✗	Home/office/facility	Any POS	99441 – 99443
Virtual check-in (5 – 10 min. visit)	✓	✗	✗	Home/office/facility	Any POS	G2010 and G2012
E-visit (use of patient portal)	✓	✗	✗	Home/office/facility	Any POS	99421, 99422, 99423, G2061, G2062 and G2063

For a complete list, visit: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Diagnoses resulting from telehealth services can meet the risk adjustment face-to-face requirement when the services are provided using an interactive audio and video telecommunications system that permits real-time interactive communication.

[1] POS = place of service   [2] CPT® = Common Procedural Terminology   [3] HCPCS = Healthcare Common Procedural Coding System

Source: Centers for Medicare & Medicaid Services (CMS), Dept. of Health & Human Services (HHS), April 10, 2020

Important: DVACO & MLHPP are providing the information below as a courtesy for reference only. Please consult your assigned representative from each payer to confirm this information or if you have clarifying questions / concerns.

Payer	Telephone Only	Audio with Video	CPT/HCPCS Codes	Modifier	POS Type	Consent Needed	May be Subject to Copay, etc.	Policy End Date	Miscellaneous
AmeriHealth	Either is allowed		99201-99205 99211-99215 90791-90792 90832-90840 97802-97803	95	2	Yes	Yes (No for PCP)	6/30/2020 or end of PHE	Use Telephonic Visit Template and document as if visit occurred face-to-face.
Auto/Workers Comp	X		99441-5-10 min w/physician or ACP 99442-11-20 min w/physician or ACP 99443-21-30 min w/physician or ACP 98966-5-10 min w/NPP 98967-11-20 min w/NPP 98968-21-30 min w/NPP	N/A	11	Yes	No	End of PHE	99441-99443 billable for established patients only. G2012 billable for new or established patients. Time and consent should be documented. Cannot bill if call results in decision to see patient within 24 hours or call refers to E/M svc reported within previous 7 days.
Auto/Workers Comp		X	99201-99205 99211-99215 90791-90792 90832-90847 97802-97803	95	11	Yes	No	End of PHE	Use Telephonic Visit Template and document as if visit occurred face-to-face. Document time for Codes 90832-90847 and 97802-97803.
Cigna	Either is allowed		99201-99205 99211-99215	95	11	Yes	Yes	12/31/2020	Use Telephonic Visit Template and document as if visit occurred face-to-face. Cost sharing waived if COVID related but plan specific. Plans may opt out of waiving cost sharing.
Cigna Medicare (aka Cigna HealthSpring)	X		99441-5-10 min w/physician or ACP 99442-11-20 min w/physician or ACP 99443-21-30 min w/physician or ACP 98966-5-10 min w/NPP 98967-11-20 min w/NPP 98968-21-30 min w/NPP	N/A	11	Yes	No	End of PHE	99441-99443 billable for established patients only. G2012 billable for new or established patients. Time and consent should be documented. Cannot bill if call results in decision to see patient within 24 hours or call refers to E/M svc reported within previous 7 days.
Cigna Medicare (aka Cigna HealthSpring)		X	99201-99205 99211-99215 90791-90792 90832-90847 97802-97803	95	11	Yes	No	End of PHE	Use Telephonic Visit Template and document as if visit occurred face-to-face. Document time for Codes 90832-90847 and 97802-97803.

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Payer	Telephone Only	Audio with Video	CPT/HCPCS Codes	Modifier	POS Type	Consent Needed	May be Subject to Copay, etc.	Policy End Date	Miscellaneous
Freedom Blue	X		99441-5-10 min w/physician or ACP 99442-11-20 min w/physician or ACP 99443-21-30 min w/physician or ACP 98966-5-10 min w/NPP 98967-11-20 min w/NPP 98968-21-30 min w/ NPP G2012	N/A	11	Yes	No	12/31/2020	99441-99443 billable for established patients only. G2012 billable for new or established patients. Time and consent should be documented. Cannot bill if call results in decision to see patient within 24 hours or call refers to E/M service reported within previous 7 days.
Freedom Blue		X	99201-99205 99211-99215 90791-90792 90832-90847 97802-97803	95	11	Yes	No	12/31/2020	Use Telephonic Visit Template and document as if visit occurred face-to-face. Document time for Codes 90832-90847 and 97802-97803.
Health Partners	Either is allowed		99201-99205 99211-99215	95	11 or 02	Yes	Yes	End of PHE	Time MUST be documented in the medical record. Cannot bill if call results in decision to see patient within 24 hours or call refer to an E/M service reported within previous 7 days.
Highmark-BCBS OOA-BCBS Federal	Either is allowed		99201-99205 99211-99215 90791-90792 90832-90840 97802-97803	95	2	Yes	Yes	12/31/2020	For established patients only. Time and consent should be documented. Cannot bill if call results in decision to see patient within 24 hours or call refers to E/M service reported within previous 7 days. Applies to commercial group, individual and Medicare Advantage products. This will not apply to any self-insured employer group that has opted out of the cost share waiver. Members should contact Member Services (using the number on the back of their card) to see if this applies to their plan.
IBC & IBC Medicare	Either is allowed		99201-99205 99211-99215 90791-90792 90832-90840 97802-97803	95	2	Yes	Yes (No for PCP)	Commercial 12/31/2020 and Medicare until end of PHE	Use Telephonic Visit Template and document as if visit occurred face-to-face. For HMO patients services are capitated. PCP visit will not access copay, but specialist visit will access a copay.
Keystone First/Keystone VIP	X		G2012	N/A	11	Yes	Yes	End of PHE	For established patients only. Cannot bill if call results in decision to see patient within 24 hours or call refers to E/M svc reported within previous 7 days. For HMO patients services are capitated.

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Payer	Telephone Only	Audio with Video	CPT/HCPCS Codes	Modifier	POS Type	Consent Needed	May be Subject to Copay, etc.	Policy End Date	Miscellaneous
Keystone First/Keystone VIP		X	99201-99215	GT	2	Yes	Yes	End of PHE	Use Telephonic Visit Template and document as if visit occurred face-to-face. For HMO patients services are capitated.
Medical Assistance	Either is allowed		99201-99205 99211-99215 90791-90792 90832-90840 97802-97803	N/A	11	Yes	No	End of PHE	
Multiplan	Either is allowed		99201-99205 99211-99215 90791-90792 90832-90840 97802-97803	95	2	Yes	Yes (No for PCP)	End of PHE	Use Telephonic Visit Template and document as if visit occurred face-to-face. For HMO patients services are capitated. PCP visit will not access copay, but specialist visit will access a copay
PA Health & Wellness	Either is allowed		99201-99205 99211-99215 90791-90792 90832-90840 97802-97803	95	11	Yes	No	End of PHE	*Please note: For Health Savings Account (HSA)-Qualified plans, IRS guidance is pending as to deductible application requirements for telehealth/telemedicine related services.
Tricare	X		99441-5-10 min w/physician or ACP 99442-11-20 min w/physician or ACP 99443-21-30 min w/physician or ACP 98966-5-10 min w/NPP 98967-11-20 min w/NPP 98968-21-30 min w/NPP Tricare will NOT pay for audio only	N/A	11	Yes	Yes	End of PHE	Use Telephonic Visit Template and document as if visit occurred face-to-face. Document time for Codes 90832-90847 and 97802-97803. Tricare will NOT pay for audio only. Noticed on 10/12/20 that Tricare will not cover audio only.
Tricare		X	99201-99205 99211-99215 90791-90792 90832-90847 97802-97803	GT	2	Yes	Yes	End of PHE	
United Healthcare (Medicare Advantage, DSNP)	X		99441-5-10 min w/physician or ACP 99442-11-20 min w/physician or ACP 99443-21-30 min w/physician or ACP 98966-5-10 min w/NPP 98967-11-20 min w/NPP 98968-21-30 min w/NPP	N/A	11	Yes	No	End of PHE	
United Healthcare (Medicare Advantage, DSNP)		X	99201-99205 99211-99215 90791-90792 90832-90847 97802-97803	95	11	Yes	No	End of PHE	

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Payer	Telephone Only	Audio with Video	CPT/HCPCS Codes	Modifier	POS Type	Consent Needed	May be Subject to Copay, etc.	Policy End Date	Miscellaneous
United Healthcare (Commercial)	Either is allowed (as of 3/26/20)		99201-99215	95	11	Yes	No	12/31/2020	Self-funded plans can opt out of no cost sharing.
UPMC	X		G2012	95	2	Yes	Yes	End of PHE	For established patients only. Cannot bill if call results in decision to see patient within 24 hours or call refers to E/M svc reported within previous 7 days. For HMO patients services are capitated.
UPMC		X	99201-99215	95	2	Yes	Yes	End of PHE	Use Telephonic Visit Template and document as if visit occurred face-to-face. For HMO patients services are capitated.
Commercial Payers/Other Unspecified	Either is allowed		99201-99205 99211-99215 90791-90792 90832-90840 97802-97803	95	2	Yes	Yes	End of PHE	

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