Last Updated: February 28th, 2026

Prepared for:
Great Plains Telehealth Resource & Assistance Center

Telehealth Billing and Reimbursement Guide– Wisconsin

Brought to you by:

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Great Plains Telehealth Resource & Assistance Center

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This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number G22RH30357. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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TELEHEALTH

Definition:

There are two types of telehealth services:

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

CPT/HCPCS Codes:

Synchronous Audio/Video CPT Codes:

- **98000:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
- **98001:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98002:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
- **98003:** Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded
- **98004:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded
- **98005:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
- **98006:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98007:** Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded

Other CPT/HCPCS are often eligible to be reported via synchronous audio/video telehealth (refer to payor guidelines section for specific code sets)

Synchronous Audio-Only CPT Codes:

- **98008:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded
- **98009:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98010:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded
- **98011:** Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of

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medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded

- **98012:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded
- **98013:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded
- **98014:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded
- **98015:** Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded

Place of Service Codes

POS 02: Telehealth Provided Other than in Patient's Home

- The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.

POS 10: Telehealth Provider in Patient's Home

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

Modifiers

Synchronous Telehealth Modifiers:

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

Asynchronous Telehealth Modifier:

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

Reporting Criteria:

- Must be initiated by the patient
- Communication must be a direct interaction between the patient and the healthcare professional
- HIPAA compliant platform must be utilized

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, and the length of the call. Obtain 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.

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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**: Nonphysician qualified healthcare professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- **G2062/98971**: Nonphysician qualified healthcare professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
- **G2063/98972**: Nonphysician qualified healthcare professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

Reporting Criteria:

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

Documentation Requirements:

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

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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:

- **98016**: Brief communication technology-based service (eg, 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 evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion
- **G2010**: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
- **G2250**: Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.
- **G2251**: Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion.
- **G2252**: Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
- **G0071**: Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only

Reporting Criteria:

- The patient must be established
- Communication must be a direct interaction between the patient and the practitioner. Not billable if performed by clinical staff.
- If the virtual check-in originates from a related E/M provided within the previous 7 days, then the service is considered bundled into that previous E/M 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.

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Definition:

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

CPT/HCPCS Codes:

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

Reporting Criteria:

- Call must be initiated by the patient
- 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
- The patient must be established

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 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.

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PAYOR MATRIX

PAYOR	E-VISIT	TELEHEALTH-AUDIO/VIDEO	TELEHEALTH-AUDIO ONLY	VIRTUAL CHECK-IN
AETNA	CONDITIONAL Check Contracted Fee Schedule	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: GT, 95, FR	ALLOWABLE Allowable Codes: Audio Only Telehealth Eligible Code POS: 02 or 10 Modifier: 93, FQ	CONDITIONAL Check Contracted Fee Schedule
ANTHEM BCBS	CONDITIONAL Check Contracted Fee Schedule	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: 95, GT	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: 93, FQ	CONDITIONAL Check Contracted Fee Schedule
CIGNA	NOT ALLOWABLE	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 Modifier: 95, GT	ALLOWABLE Allowable Codes: CPT 98008-98015 POS: 02 Modifier: Not Required	ALLOWABLE 98016
MEDICA	ALLOWABLE 99421-99423 98970 -98972 G2061-G2063	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: GT, 95	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: 93, FQ	ALLOWABLE G2010 98016
MEDICARE	ALLOWABLE 99421-99423 G2061-G2063	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: Hospital Based Provider-95 Method II: Modifier GT RHC: G2025	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: 93 Method II: Modifier GT RHC: G2025	ALLOWABLE 98016 G2010 G2250-G2252
WI MEDICAID	ALLOWABLE 99421-99423 98970 -98972	ALLOWABLE Allowable Codes: Code on provider's fee schedule. POS: 02 or 10 Modifier: GT	ALLOWABLE Allowable Codes: Code on provider's fee schedule. POS: 02 or 10 Modifier: 93, FQ	ALLOWABLE 98016 G2010 G2250-G2252
UHC COMMERCIAL	ALLOWABLE 99421-99423 98970 -98972	ALLOWABLE Allowable Codes: Telehealth Eligible Code POS: 02 or 10 Modifier: 95 or GT	ALLOWABLE Allowable Codes: Audio Only Telehealth Eligible Code POS: 02 or 10 Modifier: 93	ALLOWABLE 98016 G2010 G2250-G2252

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Payor Specific Key Points

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: Check Contracted Fee Schedule
- **Virtual Check-Ins**: Check Contracted Fee Schedule

Remote Patient Monitoring:

Allowable Codes:

- 98975, 98976, 98977, 98978, 98980, 98981, 99453, 99454, 99445, 99470, 99457, 99458

Interprofessional Codes:

Allowable Codes:

- 99446-99449, 99451, 99452, G9037, G0546-G0551

Modifier:

- No telehealth modifier required

Telehealth:

Allowable Services:
See table below for allowable code set

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

Modifiers/POS:

- **POS** 02 or 10
- **Modifiers**
  - **Audio-Visual:** GT, 95, FR
  - **Audio-Only**: 93, FQ (only for codes that explicitly allow them)
  - **Asynchronous:** GQ
  - **Tele-Stroke**: G0

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

Reimbursement:
Refer to contracted fee schedule

Not Reimbursable:.

- Care Plan Oversight (Except if authorized by Patient Management)
- Concierge Medicine (boutique medicine)
- Missed appointments

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

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AETNA ELIGIBLE TELEHEALTH CODES													
Telehealth Allowable Codes													
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845	90846	90847
90849	90853	90863	90951	90952	90954	90955	90957	90958	90960	90961	90963	90964	90965
90966	90967	90968	90969	90970	92227	92228	92507	92508	92521	92522	92523	92524	92526
92601	92602	92603	92604	93228	93229	93268	93270	93271	93272	94664	96041	96105	96110
96112	96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138	96139
96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171	97110	97112	97116
97129	97130	97151	97153	97155	97156	97157	97161	97162	97163	97164	97165	97166	97167
97168	97530	97535	97750	97755	97760	97761	97802	97803	97804	98960	98961	98962	99202
99203	99204	99205	99211	99212	99213	99214	99215	99231	99232	99233	99252	99253	99254
99255	99307	99308	99309	99310	99406	99407	99408	99409	99417	99418	99446	99447	99448
99449	99451	99452	99483	99495	99496	99497	99498	C7900	C7901	C7902	G0108	G0109	G0270
G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0425	G0426	G0427	G0438
G0439	G0442	G0443	G0444	G0445	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087
G2088	G2212	G3002	G3003	H0015	H0035	H0038	H2012	H2036	S9443	S9480	97152	97154	97158
97542	98000	98001	98002	98003	98004	98005	98006	98007					
Cells Highlighted in Yellow do **NOT** Require a Modifier Codes in Blue are Allowable via an audio-only connection													

Reference:

- Telemedicine and Direct Patient Contact Payment Policy available on Availity

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Payor Specific Key Points

E-Visits/Virtual Check Ins:

Allowable Codes:

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

Remote Patient Monitoring:

- Place of service appropriate to the location of the billing provider
- The appropriate CPT/HCPCS code by definition

Telehealth:

Allowable Services:

Anthem allows virtual visits rendered at the distant site by professional providers. Allowable codes are outlined as follows:

- Audio Visual: The appropriate CPT/HCPCS code in CPT Appendix P or Anthem Administrative Policy: Allowed Virtual Services*
- Audio Only: The appropriate CPT/HCPCS code in CPT Appendix T or Anthem Administrative Policy: Allowed Virtual Services*
- Asynchronous: The appropriate CPT/HCPCS code by definition or Anthem Administrative Policy: Allowed Virtual Services*
- Facility Services: Anthem allows virtual visits rendered at the distant site by facility providers for Behavioral Health services only

*The Anthem Administrative Policy titled Allowed Virtual Services is no longer available on Anthem's website, despite still being referenced in the Virtual Visit Policy. As a result, the contracted fee schedule should be used to determine the list of allowable codes.

Audio Only Services:

Audio-only services are allowable when billed with the appropriate modifier

- Utilize the appropriate CPT/HCPCS code in CPT Appendix T or Anthem Administrative Policy: Allowed Virtual Services

Non-Reimbursable:

- Non-direct member services other than Remote Patient Monitoring
- Services that require equipment and/or direct physical hands-on care that cannot be provided remotely
- Services rendered virtually that are not eligible for reimbursement when rendered in-person
- PT/OT/ST services provided without live audio/visual communication
- Facility virtual visits via live audio-video for services that are not Behavioral Health
- Facility virtual visits via audio only

Modifiers/POS:

- **POS** 02 or 10
  - **Store and Forward (Provider to Provider Communication):** Place of service appropriate to the location of the billing provider
- **Modifier**
  - **Audio-Visual:** 95 or GT
  - **Audio Only:** 93 or FQ
  - **Asynchronous**: GQ
- **Facility (UB) Claims**:
  - **Audio Visual**: Appropriate revenue code for the service rendered with 95 or GT

Reimbursement:

Virtual visits billed by a professional provider are eligible for non-office place of service reimbursement

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Transmission & Originating Site Fees:
Originating site fee (Q3014) is allowable for originating site facilities. Utilize the appropriate place of service code for the provider rendering in-person services to the member. Transmission fees are not allowed

Reference:

- Anthem Commercial Virtual Visits - Professional and Facility- Reimbursement Policy

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E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits:** Not Allowable
- **Virtual Check-Ins:** 98016

Interprofessional Consultations:

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
- **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.

Remote Patient Monitoring:

Cigna recognizes remote patient monitoring, which is the use of digital technologies to monitor and capture medical data from patients and electronically transmit this information to healthcare providers for assessment:

- **Allowable codes:** 99091, 99453, 99454, 99457, 99458, G0322
- Coverage Policy 0563- Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM)

Telehealth Medical:

Allowable Services:

See below table for allowable medical telehealth codes

Audio Only:

An audiovisual connection is required, except for audio-only telehealth E/M CPT 98008-98015

All of the following must also be met:

- Services must be interactive and use both audio and video internet-based technologies, and would be reimbursed if the service was provided face-to-face
  - Exception for CPT 98008-98015
- The patient or 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 is maintained as part of the record as if the service were provided as an in-office visit
- The permanent record must include documentation which identifies the virtual service delivery method. i.e.: audio/video or telephone only
- All services provided are medically appropriate and necessary
- The evaluation and management services (E/M) provided virtually must meet E/M criteria
- The patient's clinical condition is of low to moderate complexity, and while it may be an urgent encounter, it should not be an emergent clinical condition
- Virtual care services must be provided by a health care professional who is licensed, registered, or otherwise acting within the scope of his/her licensure.

Excluded Services:

- The virtual care service occurs on the same day as a face to face visit, when performed by the same provider and for the same condition.
- Transmission of digitalized data is considered integral to the procedure performed and is not separately reimbursable.

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- Virtual care services billed within the post-operative period of a previously surgical procedure will be considered part of the global payment for the procedure.
- Services were performed via asynchronous communications systems (e.g., fax).
- Store and forward telecommunication, whether an appropriate virtual care modifier is appended to the procedure code or not.
- Patient communications are incidental to E/M services, counseling, or medical services, including, but not limited to reporting of test results and provision of educational materials.
- Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.
- No reimbursement will be made for any equipment used for virtual care communications.

Telehealth Behavioral Health:

Allowable Services:
See below table for allowable medical telehealth codes.

All of the following must also be met:

- Services must be interactive and use audio and/or video internet-based technologies (synchronous communication), and would be reimbursed as if the service was provided face-to- face
- The patient and/or actively involved caregiver must be present on the receiving end
- 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 care and follow- up is maintained as part of the 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
- While some aspects of care in an acute setting may be rendered virtually, exclusively virtual services should be limited to situations when the clinical condition is low to moderate complexity and not the primary intervention for an emergent clinical condition.
- Virtual care services must be provided by a health care professional who is licensed, registered, or otherwise acting within the scope of his/her licensure.

Excluded Services:

- The virtual care service occurs on the same day as a face to face visit, when performed by the same provider and for the same condition.
- Transmission of digitalized data is considered integral to the procedure performed and is not separately reimbursable.
- Patient communications are incidental to E/M services, counseling, or medical services, including, but not limited to reporting of test results and provision of educational materials
- Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.
- No reimbursement will be made for the originating site of service fee or facility fee, unless otherwise mandated by state or federal law
- No reimbursement will be made for any equipment used for virtual care communications.

Modifiers/POS:

- **POS** 02
    - Do not bill POS 10 until further notice
- **Modifier**
    - **Audio-Visual**: GT, 95
    - **Audio-Only**: 93
    - **Asynchronous**: GQ

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Provider Type:
Providers who are licensed, registered, or acting within the scope of their licensure may provide telehealth services

Reimbursement:
Refer to contracted fee schedule

Transmission & Originating Site Fees:
Cigna will not reimburse an originating site of service fee/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 MEDICAL ELIGIBLE VIRTUAL CODES												
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962	90963
90964	90965	90966	90967	90968	90969	90970	92507	92508	92521	92522	92523	92524
92601	92602	92603	92604	96041	96112	96113	96116	96156	96158	96159	96160	96161
96164	96165	96167	96168	97110	97112	97161	97162	97163	97164	97165	97166	97167
97168	97530	97755	97760	97761	97802	97803	97804	99202	99203	99204	99205	99211
99212	99213	99214	99215	99406	99407	99408	99409	99404	99411	99412	99495	99496
99497	99498	G0108	G0151	G0152	G0153	G0155	G0157	G0158	G0270	G0296	G0299	G0300
G0396	G0397	G0438	G0439	G0442	G0443	G0444	G0445	G0446	G0447	G0493	G0513	G0514
98016	S9123	S9128	S9129	S9131	S9152	99446	99447	99448	99449	99451	99452	99381
99382	99383	99384	99385	99386	99387	99391	99392	99393	99394	99395	99396	99397
99401	99402	99403	98000	98001	98002	98003	98004	98005	98006	98007	98008	98009
98010	98011	98012	98018	98014	98015							

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

CIGNA BEHAVIORAL HEALTH ELIGIBLE VIRTUAL CODES												
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845	90846
90847	90849	90853	90863	90875	90876	90880	96110	96127	96156	96158	96159	96164
96165	96167	96168	96170	96171	97151	97152	97153	97154	97155	97156	97157	97158
99058	99078	99202	99203	99204	99205	99211	99212	99213	99214	99215	99217	99218
99219	99220	99221	99222	99223	99224	99225	99226	99231	99232	99233	99234	99235
99236	99238	99239	99281	99282	99283	99284	99285	99304	99305	99306	99307	99308
99309	99310	99315	99316	99318	99324	99325	99326	99327	99328	99334	99335	99336
99337	99354	99335	99336	99337	99354	99355	99356	99357	99404	99408	99409	99415
99416	99417	H2011	S0201	S9480	99446	99447	99448	99449	99456	99484	99495	99496
0591T	0592T	G0410	H0015	H0035	H0038							

References:

- Reimbursement Policy- Virtual Care and Remote Patient Monitoring

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Payor Specific Key Points:

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 99421-99423, 98970-98972, G2061-G2063
- **Virtual Check-In:** G2010, 98016

Telehealth:

Telehealth Allowable Codes:

Interactive audio and video communications that permit real-time communication between the distant site physician or practitioner and the member. The services must be of sufficient audio and visual fidelity with clarity and function equivalent to a face-to-face encounter

See table below for specific codes.

- **Wellness Visits:** Medica will temporarily allow preventive care services, CPT 99381-99387 and 99391-99397, to be provided via telehealth services. Providers may perform all, or portions of, a preventive medicine visit that can be done so appropriately via telehealth services. Services that require face-to-face interaction may be provided later, however, providers may only bill one preventive medicine code to cover both the portion done via telehealth and any necessary face-to-face interaction associated with the preventive care service.

- **Behavioral Health:**
  - For more information regarding telemental health refer to the Telemental Health Services - Commercial

Store and Forward Telehealth:

Medica allows asynchronous (store and forward) telehealth. Utilize modifier GQ. Medical information may include without limitation: video clips, still images, X-rays, MRIs, EKGs, laboratory results, audio clips and text. The physician at the distant site reviews the case without the member being present. Store and Forward substitutes for an interactive encounter with the member present (i.e., the member is not present in real-time).

Audio Only:

Audio only allowable codes defined in the below *Medica Eligible Telehealth Code list*

Modifiers/POS:

- **POS** 02 or 10
- **Modifier**
  - **Audio-Visual:** GT, 95
  - **Audio-Only**: 93, FQ
  - **Asynchronous:** GQ
  - **Tele-Stroke**: G0

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:

Refer to contracted fee schedule

Originating Sites:

The following are examples of originating sites: Community mental health center, Critical-access hospital (CAH), End stage renal disease (ESRD) facilities, Home, Hospital (inpatient or outpatient), Hospital or CAH-based renal dialysis

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center (including satellites), Office of physician or practitioner, Other eligible medical facilities, Other locations as required by applicable state law, Residential substance abuse treatment facility, Rural health clinic (RHC) and federally qualified health center (FQHC), Skilled nursing facility (SNF)

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

Coverage Limitations:
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, educational materials, brief follow-up of a medical procedure 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 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 provider and a patient that consists solely of an e-mail or facsimile

References:

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

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

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Payor Specific Key Points:

E-Visits/ Virtual Check Ins:

Allowable Codes:

- **E-Visits:** 99421-99423, G2061-G2063
- **Virtual Check-In**: G2010, 98016, G2250-G2252

Modifiers: None

Telehealth:

Consolidated Appropriations Act, 2026

Extends certain telehealth flexibilities for Medicare patients through December 31st, 2027

- **Medicare Beneficiary Location**: Patients can receive Medicare telehealth services, regardless of patient location in the United States
- **Medicare Telehealth Practitioners Type**: An extended range of practitioners may bill for telehealth services, including physical therapists, occupational therapists, speech-language pathologists, and audiologists
- **Hospital-Based Outpatient Therapy, Diabetes Self-Management Training, and Medical Nutrition Therapy:** Hospitals may bill for certain outpatient therapy services, diabetes self-management training, and medical nutrition therapy services furnished remotely by hospital staff
- **In-Person Mental Health Visit Requirements:** Delayed in-person visit requirements for behavioral health services provided via telehealth
- **RHC & FQHC Distant Site:** RHCs and FQHCs may continue to bill for non-behavioral health services furnished through interactive telehealth

Allowable Codes:

See table below for codes allowable via telehealth

- Effective January 1st, 2026, CMS permanently removed the application of telehealth frequency limits on subsequent inpatient and nursing facility visits and critical care consultations

Audio Only:

Beneficiaries may continue to receive audio-only telehealth services in their homes through December 31, 2027

- Audio-only can be used for both new and established patients
- Utilized when the patient is not capable of or does not consent to using audio-video communication technology
- Provider must be technically capable of using audio-video communication technology
- Beneficiaries who are receiving remote mental health services, as defined in the CY 2023 and 2024 OPPS Final Rules, furnished by hospital-employed staff in their homes may also receive these services via audio-only communication technology
- Starting January 1, 2028, providers may only use audio-only communication technology for behavioral health services furnished to a patient in their home

Consent:

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

***Hospital Based Providers*:**

Hospitals and other providers of PT, OT, SLP, diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services can continue to bill for telehealth services through December 31st, 2027

- For outpatient hospitals, patients' homes no longer need to be registered as provider-based entities to allow for hospitals to bill for these services

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- The 95 modifier is required on claims from all providers, except for Critical Access Hospitals (CAHs) electing Method II (which utilize a GT modifier)

Medicare Shared Savings Program Accountable Care Organizations (ACOs)

- The Bipartisan Budget Act of 2018 allows clinicians participating in certain Medicare Shared Savings Program (MSSP) ACOs to provide and receive payment for covered telehealth services without geographic restrictions, including services furnished in the beneficiary's home
    - These flexibilities apply only to applicable ACOs with prospective beneficiary assignment in the ENHANCED track or BASIC track Levels C–E, and services must be billed under the ACO participant's TIN for assigned beneficiaries
    - ACOs using retrospective assignment and non-risk ACOs do not qualify and must follow standard Medicare fee-for-service telehealth rules

Modifiers/POS:

- **POS:**
    - 02 or 10
- **Modifier:**
    - Modifier 95
        - Required when the clinician is in the hospital, and the patient is in the home, as well as for outpatient therapy services provided via telehealth by qualified PTs, OTs, or SLPs through December 31st, 2027
    - Modifier GT for CAH Method II (UB) Claims

Patient Location:

Through December 31st, 2027, there is no originating site or geographic restriction

Mental Health Place of Service:

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

- The provider (or another provider in the same practice and subspecialty) has conducted an in-person (non-telehealth) visit within 6 months
- After the initial tele-mental health visit, the provider must conduct an in-person visit at least once every 12 months
    - However, this visit is not required if the patient and provider consider the risks of an in-person visit and agree that the risks outweigh the benefits
    - Provider should document the decision in the patient's medical record
- Through December 31st, 2027, the initial 6 month visit requirement and the in person visit every 12 month requirement, is waived

Provider Type:

Allowable telehealth providers are physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, marriage and family therapists, mental health counselors, and nutrition professionals

- Through December 31st, 2027, physical therapists, occupational therapists, speech-language pathologists, and audiologists to provide Medicare telehealth services

Provider Location:

Practitioners who furnish telehealth services from their homes but have a physical practice location are not required to report their home address on their Medicare enrollment application. Practitioners can enroll and bill from their physical practice location as if they furnished the telehealth service in person. Virtual-only telehealth practitioners whose only physical practice location is their home address will need to enroll their home address as a practice location.

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Reimbursement:
When telehealth services are provided to people in their homes (POS 10), the service will be reimbursed at the non-facility rate. If the telehealth service is provided when the patient is not in their home, and POS 02 is utilized, then the service will be reimbursed at the facility rate.

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

Supervision:
Effective January 1, 2026, the presence of the physician (or other practitioner) required for direct supervision may include virtual presence through audio/video real-time communications technology (excluding audio-only) for services without a 010 or 090 global surgery indicator

- Applies to services where direct supervision is required which do not have a 010 or 090 global surgery indicator
    - Includes most incident-to services under § 410.26, many diagnostic tests under § 410.32, pulmonary rehabilitation services under § 410.47, cardiac rehabilitation and intensive cardiac rehabilitation services under § 410.49, and certain hospital outpatient services as provided under § 410.27(a)(1)(iv)

Teaching Physicians:
CMS will allow teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service was furnished virtually, on a permanent basis

Transmission/ Originating Site Fees:

Medicare will reimburse an originating site fee (HCPCS Q3014) if the patient is present at a healthcare facility. Medicare does not reimburse for transmission fees.

- Modifier 95 not required when billing Q3014

MEDICARE ELIGIBLE TELEHEALTH CODES											
2026 Telehealth Codes											
0362T	0373T	0591T	0592T	0593T	77427	90785	90791	90792	90832	90833	90834
90836	90837	90838	90839	90840	90845	90846	90847	90853	90875	90901	90951
90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962	90963
90964	90965	90966	90967	90968	90969	90970	92002	92004	92012	92014	92507
92508	92521	92522	92523	92524	92526	92550	92552	92553	92555	92556	92557
92563	92565	92567	92568	92570	92587	92588	92601	92602	92603	92604	92607
92608	92609	92610	92625	92626	92627	93750	93797	93798	94002	94003	94004
94005	94625	94626	94664	95970	95971	95972	95983	95984	96105	96110	96112
96113	96116	96121	96125	96127	96130	96131	96132	96133	96136	96137	96138
96139	96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171
97110	97112	97116	97129	97130	97150	97151	97152	97153	97154	97155	97156
97157	97158	97161	97162	97163	97164	97165	97166	97167	97168	97530	97535
97537	97542	97750	97755	97760	97761	97763	97802	97803	97804	98960	98961
98962	98966	98967	98968	99202	99203	99204	99205	99211	99212	99213	99214
99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238	99239
99281	99282	99283	99284	99285	99291	99292	99304	99305	99306	99307	99308
99309	99310	99315	99316	99341	99342	99344	99345	99347	99348	99349	99350
99406	99407	97550	97551	97552	99468	99469	99471	99472	99473	99475	99476
99477	99478	99479	99480	99483	99495	99496	99497	99498	G0108	G0109	G0136

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G0270	G0296	G0316	G0317	G0318	G0396	G0397	G0406	G0407	G0408	G0410	G0420
G0421	G0422	G0423	G0425	G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445
G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514	G2086	G2087	G2088	G2211
G2212	G3002	G3003	G9685	96202	96203	G0011	G0013	G0539	G0540	G0541	G0542
G0543	G0560	90849	92622	92623	G0473	G0545					

Reference:

MLN Matters-Telehealth Services
SE22001 Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers
CMS Telehealth FAQ 2026
Consolidated Appropriations Act, 2026
CMS Telehealth Services List

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Payor Specific Key Points

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 99421-99423, 98970-98972
- **Virtual Check-In**: 98016, G2010, G2250-G2252

Interprofessional Consultations:

Allowable Codes:

Consulting Providers:

- CPT 99446-99449 and 9951
- Services are not covered if the consultation leads to a transfer of care or other face-to-face service within the next 14 days or next available date of the consultant. Additionally, if the sole purpose of the consultation is to arrange a transfer of care or other face-to-face service, these procedure codes should not be submitted.
- Consulting services are covered once in a seven-day period

Treating Providers:

- CPT 99452
- Treating providers may bill CPT procedure code 99452 as a covered service once in a 14-day period

Providers are expected to follow CPT guidelines including that the CPT procedure codes should not be submitted if the consulting provider saw the member in a face-to-face encounter within the previous 14 days

Documentation:

The following is required to be documented in the patient's medical record:

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

Provider Requirements:

Consulting Providers:

- Consulting providers must be physicians enrolled in Wisconsin Medicaid as an eligible rendering provider

Treating Providers:

- Treating providers may be a physician, nurse practitioner, physician assistant, or podiatrist enrolled in Wisconsin Medicaid as an eligible rendering provider.

Remote Physiologic Monitoring:

Allowable Codes:

CPT 95250, 99453, 99454, 99473, 99474, 99457

- Services are not separately reimbursable if the services are bundled or covered by other procedure codes (for example, continuous glucose monitoring is covered under CPT procedure code 95250 and should not be submitted under CPT procedure codes 99453–99454)
- CPT procedure codes 99453 and 99454 can be used for blood pressure remote physiologic monitoring if the device used to measure blood pressure meets remote physiologic monitoring requirements. If the member self-reports blood pressure readings, the provider must instead submit self-measured blood pressure monitoring CPT procedure codes 99473–99474
- CPT procedure code 99457 should be used when the physician, nurse practitioner, or physician assistant uses medical decision making based on interpreted data received from a remote physiologic monitoring device to

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assess the member's clinical stability, communicate the results to the member, and oversee the management and/or coordination of services as needed

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

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

Eligible Devices:
The device used to capture a member's physiologic data must meet the Food and Drug Administration definition of a medical device. To submit claims for CPT 99453–99458, the members' physiologic data must be wirelessly synced so it can be evaluated by the physician, nurse practitioner, or physician assistant. Transmission can be synchronous or asynchronous (data does not have to be transmitted in real time as long as it is automatically updated on an ongoing basis for the provider to review)

Provider Requirements:
Only physicians, nurse practitioners, and physician assistants enrolled in WI Medicaid are eligible to render and submit claims for remote physiologic services

Telehealth

Allowable Services:
Both synchronous (two-way, real-time, interactive communications) and asynchronous (information stored and forwarded to a provider for later review) services identified under permanent policy may be reimbursed when provided via telehealth.

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

WI Medicaid allows the following procedure codes to be reimbursable for telemedicine E&M services:

- Synchronous Audio-Video E/M: 98000-98007
- Synchronous Audio- Only E/M: 98008-98015

Telehealth Policy Requirements:
Telehealth is the use of telecommunications technology by a Medicaid-enrolled provider to deliver functionally equivalent health care services, including assessment, diagnosis, consultation, treatment, and transfer of medically relevant data. It may include real-time interactive audio-only communication, but does not include communication consisting solely of email, text, or fax. Functionally equivalent means the telehealth service must provide the same level of care as an in-person visit, with clear and understandable transmission of voice, images, data, or video.
Requirements:

- Both the member and provider must agree to telehealth; if either decline, the service must be provided in person.
- Members may refuse telehealth at any time without affecting future care or program benefits.
- Providers must be willing to refer members to another provider if telehealth is not appropriate or is declined.
- Providers must ensure language access for individuals with limited English proficiency under Title VI of the Civil Rights Act of 1964.
- Providers must ensure full and equal access for individuals with disabilities under the Americans with Disabilities Act.

Services Not Appropriate Via Telehealth:

- Services that are not covered when provided in-person
- Services that do not meet applicable laws, regulations, licensure requirements, or procedure code definitions if delivered via telehealth
- Services where a provider is required to physically touch or examine the recipient and delegation is not appropriate

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- Services the provider declines to deliver via telehealth
- Services the recipient declines to receive via telehealth
- Transportation services
- Services provided by personal care workers, home health aides, private duty nurses, or school-based service care attendants

Audio Only Services:

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

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

Documentation:

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

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

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

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

Documentation for originating sites must verify the member's presence to bill the originating site fee. If additional services are provided and billed, the medical record must clearly distinguish those services from the originating site fee.

Consent

On at least an annual basis, providers should supply and document that:

- The member expressed an understanding of their right to decline services provided via telehealth.
- Providers should develop and implement their own methods of informed consent to verify that a member agrees to receive services via telehealth. These methods must comply with all federal and state regulations and guidelines.
- Providers have flexibility in determining the most appropriate method to capture member consent for telehealth services. Examples of allowable methods include educating the member and obtaining verbal consent prior to the start of treatment or telehealth consent and privacy considerations as part of the notice of privacy practices.

Modifiers/POS:

- **POS** 02 or 10
- **Modifier**
  - **Audio Visual**: GT
  - **Audio-Only**: FQ, 93
  - **Asynchronous**: GQ
  - **Behavioral Treatment**: FQ, FR, GQ, or GT

Noncovered services:

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

The following cannot be billed to the member:

- Telehealth equipment like tablets or smart devices
- Charges for mailing or delivery of telehealth equipment
- Charges for shipping and handling of:

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- Diagnostic tools
- Equipment to allow the provider to assess, diagnose, repair, or set up medical supplies online such as hearing aids, cochlear implants, power wheelchairs or other equipment

Provider Type:
There are no limitations on what provider types may be reimbursed for telehealth services.

Originating Site & Transmission Fees:
The originating site is where the member is located during a telehealth visit. Only the provider at the originating site can bill for an originating site fee for hosting the member. An eligible originating site can bill an originating site fee (HCPCS Q3014), telehealth modifiers should not be included on the claim, since services are provided in-person. Utilize the place of service code that represents where the member is located during the service. WI Medicaid does not provide guidance on transmission fees.

- Outpatient hospitals, including emergency departments, must bill HCPCS procedure code Q3014 on an institutional claim form as a separate line item with revenue code 0780. WI Medicaid will reimburse hospitals for the fee based on the standard hospital reimbursement methodology.

The following locations are eligible for the originating site fee under permanent telehealth policy:

- Office or clinic: Medical, Dental, Therapies (physical therapy, occupational therapy, speech and language pathology)
- Behavioral and mental health agencies
- Hospital
- Skilled nursing facility
- Community mental health center
- Intermediate care facility for individuals with intellectual disabilities
- Pharmacy
- Day treatment facility
- Residential substance use disorder treatment facility

To receive reimbursement, the originating site must:

- Use an interactive audiovisual telecommunications system that permits real-time communication between the provider at the distant site and the member at the originating site
- Be in a physical location that ensures privacy
- Provide access to broadband internet with sufficient bandwidth to transmit audio and video data.
- Provide access to support staff to assist with technical components of the telehealth visit
- Be compliant with Health Insurance Portability and Accountability Act of 1996 standards

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

Privacy & Security:
Providers are required to follow federal laws to ensure member privacy and security

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

Pediatric and Health Professional Shortage Area-Eligible Services
Claims for services provided via telehealth by distant site providers may additionally qualify for pediatric (services for members 18 years of age and under) or HPSA-enhanced reimbursement. Pediatric and HPSA-eligible providers are

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required to indicate POS code 02 or 10, along with modifier GQ, GT, FQ, or 93 and the applicable pediatric or HPSA modifier, when submitting claims that qualify for enhanced reimbursement.

Reference:
Covered and Noncovered Telehealth Services-Topic 22737

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Payor Specific Key Points:

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 98970-98972, 99421-99423
- **Virtual Check-In**: 98016, G2010, G2250-G2252

POS/Modifier:

POS utilized if visit would have in person and no modifier

Remote Patient Monitoring Codes:

Allowable Codes:

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

POS/Modifier:

POS utilized if visit would have in person and no modifier

Interprofessional Assessment Codes:

Allowable Codes:

- 99446-99449, 99451-99454, G0546-G0551

POS/Modifier:

POS utilized if visit would have in person and no modifier

Telehealth:

Allowable Codes:

UHC will allow any services on the below lists:

- Services recognized by the Centers for Medicare and Medicaid Services (CMS)
- Services recognized by the American Medical Association (AMA) included in Appendix P of the CPT code set
- Additional services identified by UnitedHealthcare that can be effectively performed via Telehealth
    - See Telehealth Allowable Codes table below for UHC specified codes
- Consistent with CMS, UHC will not recognize CPT 98000-98015, as they are assigned to status code “I” on the NPFS Relative Value File, indicating another code (replacement code) is used to report the procedure or service and that replacement code has an assigned RVU

Physical Health, Occupational, and Speech Therapy:

UHC will reimburse certain physical, occupational, and speech therapy (PT/OT/ST) Telehealth services provided by QHPs rendered via interactive audio and video technology.

Services submitted on a CMS 1500 form should include:

- Code(s) from the list of specific physical, occupational and speech therapy Telehealth services (see the PT/OT/ST Telehealth Eligible Services Code List in the Attachments section)
- The appropriate place of service code 02 or 10 in Box 24B

All PT/OT/ST Telehealth visits must be performed using live, interactive video conferencing that involves the presence of both parties at the same time and a communication link between them that allows a real-time audio and visual interaction to take place. E-mailing “stored” exercise videos and discussing or reviewing by phone is not reimbursable.

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Modifiers/POS:

- **POS** 02 or 10
- **Modifiers**
    - **Audio Visual:** 95, GT, GQ, and G0 are not required to identify telehealth services but are accepted as informational if reported on claims
    - **Audio-Only**: 93

Provider Type:

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

Patient Location:

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

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

Reimbursement:

Refer to contracted fee schedule

Transmission & Originating Site Fees:

Claims for Originating Site services may be reported using HCPCS code Q3014 (Telehealth Originating Site facility fee) on either a professional (CMS-1500) or a facility (UB-04) claim when a Telepresenter is present at an Originating Site location other than the patient's home. Q3014 is not reimbursable when the Distant Site claim is reported with a POS 10 indicating the patient is located at home and not receiving any Originating Site services from a Telepresenter. T1014 is not eligible for payment, UHC considers these services as incidental to the charges associated with the E/M.

Audio Only Component:

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

- UHC will align with the AMA and will consider for reimbursement the services included in Appendix T of the CPT code set, which are appropriate for reporting real-time, interactive audio-only telehealth, when appended with modifier 93, and reported with POS 02 or 10.

UHC ELIGIBLE TELEHEALTH CODES											
0362T	0373T	0591T	0592T	0593T	77427	90785	90791	90792	90832	90833	90834
90836	90837	90838	90839	90840	90845	90846	90847	90853	90863	90875	90901
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962
90963	90964	90965	90966	90967	90968	90969	90970	92002	92004	92012	92014
92227	92228	92507	92508	92521	92522	92523	92524	92526	92550	92552	92553
92555	92556	92557	92563	92565	92567	92568	92570	92587	92588	92601	92602
92603	92604	92607	92608	92609	92610	92625	92626	92627	93228	93229	93268
93270	93271	93272	93750	93797	93798	94002	94003	94004	94005	94625	94626
94664	95970	95971	95972	95983	95984	96105	96110	96112	96113	96116	96121
96125	96127	96130	96131	96132	96133	96136	96137	96138	96139	96156	96158
96159	96160	96161	96164	96165	96167	96168	96170	96171	96202	96203	97110
97112	97129	97130	97150	97151	97152	97153	97154	97155	97156	97157	97158

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97161	97162	97163	97164	97165	97166	97167	97168	97530	97535	97537	97542
97550	97551	97552	97750	97755	97760	97761	97763	97802	97803	97804	98960
98961	98962	98966	98967	98968	99202	99203	99204	99205	99211	99212	99213
99214	99215	99221	99222	99223	99231	99232	99233	99234	99235	99236	99238
99239	99281	99282	99283	99284	99285	99291	99292	99304	99305	99306	99307
99308	99309	99310	99315	99316	99341	99342	99344	99345	99347	99348	99349
99350	99406	99407	99408	99409	99417	99418	99468	99469	99471	99472	99473
99475	99476	99477	99478	99479	99480	99483	99495	99496	99497	99498	G0011
G0013	G0108	G0109	G0136	G0270	G0296	G0316	G0317	G0318	G0396	G0397	G0406
G0407	G0408	G0410	G0420	G0421	G0422	G0423	G0425	G0426	G0427	G0438	G0439
G0442	G0443	G0444	G0445	G0446	G0447	G0459	G0506	G0508	G0509	G0513	G0514
G0539	G0540	G0541	G0542	G0543	G0560	G2086	G2087	G2088	G2211	G2212	G3002
G3003	G9685	90482	90483	90484	90849	92622	92623	96041	97116	99497	99498
G0473	G0545										

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

AUDIO ONLY CODES											
90785	90791	90792	90832	90833	90834	90836	90837	90838	90839	90840	90845
90846	90847	92507	92508	92521	92522	92523	92524	96041	96110	96116	96121
96156	96158	96159	96160	96161	96164	96165	96167	96168	96170	96171	97802
97803	97804	99406	99407	99408	99409	99497	99498	90482	90483	90484	90853
96130	96131	96132	96133	96136	96137	96138	96139	96202	96203		

Reference:

- Reimbursement Policy-Telehealth/Virtual Health Policy, Professional

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Payor Specific Key Points:

Virtual Communication Services:

Effective Jan 1, 2026, RHCs are required to report the individual remote evaluation service codes previously billed under G0071 (G0071 is no longer reportable)

Allowable Codes:

Virtual Check-In: G2010, 98016, G2250

Care Coordination Services

Starting Jan 1, 2025, CMS required RHCs & FQHCs to report the individual CPT/HCPCS care coordination codes instead of G0511; CMS allowed billing G0511 during a transition period, but G0511 was no longer billable after Sept 30, 2025

Telehealth:

RHC/FQHC Distant Site Provider Extension:

RHCs and FQHCs may continue to bill for non-behavioral health services furnished through interactive telehealth through December 31st, 2027, utilizing G2025

Allowable Codes:

RHCs and FQHCs may furnish allowable RHC/FQHC services via telehealth utilizing G2025 for medical telehealth claims and the appropriate behavioral health CPT/HCPCS for behavioral health claims.

Audio Only:

Beneficiaries may continue to receive audio-only telehealth services in their homes through December 31, 2027

- Audio-only can be used for both new and established patients
- Utilized when the patient is not capable of or does not consent to using audio-video communication technology
- Provider must be technically capable of using audio-video communication technology
- Beneficiaries who are receiving remote mental health services, as defined in the CY 2023 and 2024 OPPS Final Rules, furnished by hospital-employed staff in their homes may also receive these services via audio-only communication technology
- Starting January 1, 2028, providers may only use audio-only communication technology for behavioral health services furnished to a patient in their home

Billing:

- **Medical Claims**
  - **HCPCS**: G2025
  - **UB**: 52X revenue code
  - **Modifier:**
    - **Audio/Video:** None Required
    - **Audio Only:** FQ
- **Mental Health Claims**:
  - **CPT/HCPCS**: Appropriate Behavioral Health CPT/HCPCS
  - **UB**: 900 revenue code
  - **Modifier:**
    - **Audio/Video:** CG & 95
    - **Audio Only:** FQ

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Mental Health Services:

- CMS will permanently allow mental health telehealth services performed by an RHC/FQHC
- The service must be either audio visual OR
- Audio-only if the following are present:
    - The patient is incapable of, or fails to consent to, the use of video technology for the service
    - The provider has conducted an in-person visit within the last 6 months of the initial tele-mental service
    - The services are medically necessary
    - After the initial telehealth visit, the provider conducts an in-person visit at least once every 12 months of each tele-mental visit.
        - However, if the patient and provider consider the risks of an in person service and agree that these risks outweigh the benefits, then the annual visit may be skipped.
        - Providers must document the decision
    - Until December 31st, 2027, the initial 6 month visit and the in person visit every 12 month requirement is waived

Provider Type:

Physicians, Nurse practitioners (NPs), Physician assistants (PAs), Certified nurse-midwives (CNMs), Clinical psychologists (CPs), Clinical social workers (CSWs), Marriage and family therapists (MFTs), Mental health counselors ((MHCs)

Reimbursement:

Medical:

- The RHC/FQHC telehealth payment rate is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS. For 2026 the rate is $97.53

Mental Health:

- RHC AIR rate or FQHC PPS rate

Supervision:

CMS permanently adopted a definition of direct supervision, for RHC and FQHC services, that allows the physician or supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only)

Transmission/ Originating Site Fees:

Medicare will reimburse an originating site fee (HCPCS Q3014) if the patient is present at a healthcare facility. Medicare does not reimburse for transmission fees.

References:

MLN Matters-Telehealth Services
SE22001 Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers
CMS Telehealth FAQ 2026
Consolidated Appropriations Act, 2026
CMS Telehealth Services List

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Payor Specific Key Points

E-Visits/Virtual Check Ins:

Allowable Codes:

- **E-Visits**: 99421-99423, 98970-98972
- **Virtual Check-In**: 98016, G2010, G2250-G2252

Interprofessional Consultations:

Allowable Codes:

Consulting Providers:

- CPT 99446-99449 and 9951
- Services are not covered if the consultation leads to a transfer of care or other face-to-face service within the next 14 days or next available date of the consultant. Additionally, if the sole purpose of the consultation is to arrange a transfer of care or other face-to-face service, these procedure codes should not be submitted.
- Consulting services are covered once in a seven-day period

Treating Providers:

- CPT 99452
- Treating providers may bill CPT procedure code 99452 as a covered service once in a 14-day period

Providers are expected to follow CPT guidelines including that the CPT procedure codes should not be submitted if the consulting provider saw the member in a face-to-face encounter within the previous 14 days

Documentation:

The following is required to be documented in the patient's medical record:

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

Provider Requirements:

Consulting Providers:

- Consulting providers must be physicians enrolled in Wisconsin Medicaid as an eligible rendering provider

Treating Providers:

- Treating providers may be a physician, nurse practitioner, physician assistant, or podiatrist enrolled in Wisconsin Medicaid as an eligible rendering provider.

Remote Physiologic Monitoring:

Allowable Codes:

CPT 95250, 99453, 99454, 99473, 99474, 99457

- Services are not separately reimbursable if the services are bundled or covered by other procedure codes (for example, continuous glucose monitoring is covered under CPT procedure code 95250 and should not be submitted under CPT procedure codes 99453–99454)
- CPT procedure codes 99453 and 99454 can be used for blood pressure remote physiologic monitoring if the device used to measure blood pressure meets remote physiologic monitoring requirements. If the member self-reports blood pressure readings, the provider must instead submit self-measured blood pressure monitoring CPT procedure codes 99473–99474
- CPT procedure code 99457 should be used when the physician, nurse practitioner, or physician assistant uses medical decision making based on interpreted data received from a remote physiologic monitoring device to assess the member's clinical stability, communicate the results to the member, and oversee the management and/or coordination of services as needed

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

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

Eligible Devices:
The device used to capture a member's physiologic data must meet the Food and Drug Administration definition of a medical device. To submit claims for CPT 99453–99458, the members' physiologic data must be wirelessly synced so it can be evaluated by the physician, nurse practitioner, or physician assistant. Transmission can be synchronous or asynchronous (data does not have to be transmitted in real time as long as it is automatically updated on an ongoing basis for the provider to review)

Provider Requirements:
Only physicians, nurse practitioners, and physician assistants enrolled in WI Medicaid are eligible to render and submit claims for remote physiologic services

Telehealth

Allowable Services:
FQHCs and RHCs (rural health clinics) may serve as originating sites and distant site providers for telehealth services.. FQHCs and RHCs may report services provided via telehealth on the cost settlement report when the FQHC or RHC served as the distant site and the member is an established patient of the FQHC or RHC at the time of the telehealth service. For currently covered services, services that are considered direct when provided in-person will be considered direct when provided via telehealth for FQHCs

Telehealth Policy Requirements:
Telehealth is the use of telecommunications technology by a Medicaid-enrolled provider to deliver functionally equivalent health care services, including assessment, diagnosis, consultation, treatment, and transfer of medically relevant data. It may include real-time interactive audio-only communication, but does not include communication consisting solely of email, text, or fax. Functionally equivalent means the telehealth service must provide the same level of care as an in-person visit, with clear and understandable transmission of voice, images, data, or video.
Requirements:

- Both the member and provider must agree to telehealth; if either decline, the service must be provided in person.
- Members may refuse telehealth at any time without affecting future care or program benefits.
- Providers must be willing to refer members to another provider if telehealth is not appropriate or is declined.
- Providers must ensure language access for individuals with limited English proficiency under Title VI of the Civil Rights Act of 1964.
- Providers must ensure full and equal access for individuals with disabilities under the Americans with Disabilities Act.

Services Not Appropriate Via Telehealth:

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

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

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

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

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

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

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

Documentation for originating sites must verify the member's presence to bill the originating site fee. If additional services are provided and billed, the medical record must clearly distinguish those services from the originating site fee.

Consent
On at least an annual basis, providers should supply and document that:

- The member expressed an understanding of their right to decline services provided via telehealth.
- Providers should develop and implement their own methods of informed consent to verify that a member agrees to receive services via telehealth. These methods must comply with all federal and state regulations and guidelines.
- Providers have flexibility in determining the most appropriate method to capture member consent for telehealth services. Examples of allowable methods include educating the member and obtaining verbal consent prior to the start of treatment or telehealth consent and privacy considerations as part of the notice of privacy practices.

Modifiers/POS:

- **POS** 02 or 10
- **HCPCS:** T1015
- **Modifier**
  - **Audio Visual**: GT
  - **Audio-Only**: FQ, 93
  - **Asynchronous**: GQ
  - **Behavioral Treatment**: FQ, FR, GQ, or GT

Noncovered services:
Services that are not covered when delivered in person are not covered as telehealth services. In addition, services that are not functionally equivalent to the in-person service when provided via telehealth are not covered.
The following cannot be billed to the member:

- Telehealth equipment like tablets or smart devices
- Charges for mailing or delivery of telehealth equipment
- Charges for shipping and handling of:
  - Diagnostic tools
  - Equipment to allow the provider to assess, diagnose, repair, or set up medical supplies online such as hearing aids, cochlear implants, power wheelchairs or other equipment

Provider Type:

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There are no limitations on what provider types may be reimbursed for telehealth services.

Originating Site & Transmission Fees:
The originating site fee is not a FQHC or RHC reportable encounter on the cost report. Any reimbursement for the originating site fee must be reported as a deductive value on the cost report

Reimbursement:
FQHCs and RHCs may report services provided via telehealth on the cost settlement report

Services billed with modifier GQ, GT, FQ, or 93 will be considered under the PPS reimbursement method for non-tribal FQHCs. Billing HCPCS procedure code T1015 (Clinic visit/encounter, all-inclusive) with a telehealth procedure code will result in a PPS rate for fee-for-service encounters. Fee-for-service claims must include HCPCS procedure code T1015 when services are provided via telehealth in order for proper reimbursement.

Privacy & Security:
Providers are required to follow federal laws to ensure member privacy and security

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

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

Reference:
Covered and Noncovered Telehealth Services-Topic 22737

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