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Reimbursement Policy

Effective Date.....01/01/2021
Reimbursement Policy Number R31

Virtual Care

Table of Contents

Related Policies

HCPCS - Health Care Procedure Coding System, National level II Medicare Codes
MRG - Modifier Reference Guide
R30 - Evaluation and Management Services
R12 - Facility Routine Services, Supplies and Equipment

INSTRUCTIONS FOR USE
*Reimbursement policies are intended to supplement certain **standard** benefit plans. Please note, the terms of an individual's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which a reimbursement policy is based. For example, an individual's benefit plan document may contain specific language which contradicts the guidance outlined in a reimbursement policy. In the event of a conflict, an individual's benefit plan document **always supersedes** the information in a reimbursement policy. Reimbursement terms in agreements with participating health care providers may also supersede the information in a reimbursement policy Proprietary information of Cigna. Copyright ©2021 Cigna*

Overview

This policy outlines reimbursement for virtual care services which occur when the physician or other health care professional and the patient are not at the same site. Virtual care is also known as telemedicine and telehealth.

This policy applies to professional claims submitted on a CMS1500 claim form or its electronic equivalents.

This policy does not apply to Cigna Medicare and Medicaid health benefit plans or Cigna Behavioral Health administered benefit plans.

Reimbursement Policy

Cigna will reimburse virtual care services when all of the following are met:

1. **Modifier 95 or GQ or GT is appended to the appropriate Current Procedural Terminology (CPT®) and/or HCPCS procedure code(s);**
2. **Services must be interactive and use both audio and video internet-based technologies (synchronous communication), and would be reimbursed if the service was provided face-to-face (Note: services rendered via telephone only are considered interactive and will be reimbursed when the appropriate telephone only code is billed);**
3. **The customer and/or actively involved caregiver must be present on the receiving end and the service must occur in real time;**
4. **All technology used must be secure and meet or exceed federal and state privacy requirements;**

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5. **A permanent record of online communications relevant to the ongoing medical care and follow-up of the customer is maintained as part of the customer's medical record as if the service were provided as an in-office visit;**
6. **The permanent record must include documentation which identifies the virtual service delivery method. I.e.: audio/video or telephone only;**
7. **All services provided are medically appropriate and necessary;**
8. **The evaluation and management services (E/M) provided virtually must meet E/M criteria as defined in the 1997 Centers for Medicare and Medicaid Services (CMS) Documentation guidelines for codes outside of the 99202 through 99215 range and the 2021 CPT E/M documentation guidelines outlined by the American Medical Association for codes within the range 99202 through 99215;**
9. **The customer's clinical condition is considered to be of low to moderate complexity, and while it may be an urgent encounter, it should not be an emergent clinical condition;**
10. **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**.

Cigna will not reimburse virtual care services when any of the above is not met or any of the following:

1. **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.**
2. **Transmission of digitalized data is considered integral to the procedure performed and is not separately reimbursable.**
3. **Virtual care services billed within the post-operative period of a previously completed major or minor surgical procedure will be considered part of the global payment for the procedure and not reimbursed separately.**
4. **Services were performed via asynchronous communications systems (e.g., fax).**
5. **Store and forward telecommunication [transferring data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation] whether an appropriate virtual care modifier is appended to the procedure code or not.**
6. **Customer communications are incidental to E/M services, counseling, or medical services included in this policy, including, but not limited to reporting of test results and provision of educational materials.**
7. **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.**
8. **Any CPT or HCPCS code that is not listed in the eligible code section of this policy if billed with modifier 95, GQ or GT.**
9. **No reimbursement will be made for the originating site of service fee or facility fee.**
10. **No reimbursement will be made for any equipment used for virtual care communications.**

Note: This policy does not apply to virtual care when accessed through an intermediary vendor or when there is an applicable superseding state mandate.

General Background

Virtual care is the use of medical information exchanged from one site to another via electronic communications to improve a customer's clinical health status. Virtual care includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications.

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Virtual care can provide important benefits to patients, including: increased access to health care, and expanded utilization of specialty expertise.

The terms “virtual care”, "telemedicine" and "telehealth" are often used interchangeably although virtual care may be used to include a broader range of services such as videoconferencing, remote monitoring, online medical evaluations, and transmission of still images. For the purposes of this policy, virtual care refers the delivery of clinical services via synchronous, secure interactive audio and video internet-based systems, or telephone only communications.

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

The CPT and Healthcare Common Procedure Coding System (HCPCS) codes that describe a virtual care service (a physician to customer or physician to physician encounter from one site to another) are generally the same codes that describe an encounter if the service was provided as a face-to-face office visit.

Virtual Care Modifiers:

The following modifiers are billed to describe the technology used to facilitate a virtual care encounter:

- Modifier 95 (Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunication system)
- Modifier G0 is used to report telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke. This modifier became effective 01/01/2019 however it is does not impact reimbursement and is not required by Cigna for virtual care reimbursement.
- Modifier GQ is used to report virtual care services via an asynchronous telecommunications system.
- Modifier GT (Via interactive audio and video telecommunications systems) should be reported with the applicable procedure code when performing a service virtually to indicate the type of technology used and to differentiate a virtual care encounter from an encounter when the physician and patient are at the same site.

There has been interest on behalf of patients and providers to use electronic means to manage common medical conditions in lieu of a formal office visit. Online medical evaluations are non-face-to-face evaluation and management (E/M) services by a physician or other non-physician qualified health care professional, typically in response to a customer’s online inquiry, and are used to address non-urgent ongoing or new symptoms.

It should be noted that while virtual care visits are available there are times it will not be the preferred method of delivering care. Face to face visits would be the preferred method of delivering care for patients who have an emergent condition or whose condition would otherwise warrant an in-person office visit.

Coding/Billing Information

Note: Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Eligible for reimbursement under the Virtual Care Reimbursement Policy when the service is billed as indicated in this Policy:

Notification for effective date of policy 01/01/2021. For Virtual Care Billing guidance prior to 01/01/21 and/or extended during the Public Health Emergency (PHE) period, please review the COVID-19 Interim Billing Guidelines Reimbursement Policy on CignaforHCP.com.

Codes	Description
90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90952	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90953	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90954	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90955	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90956	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90957	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90958	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90959	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents

Notification for effective date of policy 01/01/2021. For Virtual Care Billing guidance prior to 01/01/21 and/or extended during the Public Health Emergency (PHE) period, please review the COVID-19 Interim Billing Guidelines Reimbursement Policy on CignaforHCP.com.

Codes	Description
90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older
90967	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age
90968	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age
90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92521	Evaluation of speech fluency (eg, stuttering, cluttering)
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming
96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes

Notification for effective date of policy 01/01/2021. For Virtual Care Billing guidance prior to 01/01/21 and/or extended during the Public Health Emergency (PHE) period, please review the COVID-19 Interim Billing Guidelines Reimbursement Policy on CignaforHCP.com.

Codes	Description
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable

Notification for effective date of policy 01/01/2021. For Virtual Care Billing guidance prior to 01/01/21 and/or extended during the Public Health Emergency (PHE) period, please review the COVID-19 Interim Billing Guidelines Reimbursement Policy on CignaforHCP.com.

Codes	Description
	completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes

Notification for effective date of policy 01/01/2021. For Virtual Care Billing guidance prior to 01/01/21 and/or extended during the Public Health Emergency (PHE) period, please review the COVID-19 Interim Billing Guidelines Reimbursement Policy on CignaforHCP.com.

Codes	Description
99202	Office or other outpatient 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 time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99212	Office or other outpatient 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 time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established

Notification for effective date of policy 01/01/2021. For Virtual Care Billing guidance prior to 01/01/21 and/or extended during the Public Health Emergency (PHE) period, please review the COVID-19 Interim Billing Guidelines Reimbursement Policy on CignaforHCP.com.

Codes	Description
	patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge
99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

HCPCS Codes	Description
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
G0296	Counseling visit to discuss need for lung cancer screening using low dose ct scan (LDCT) (service is for eligibility determination and shared decision making)
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, DAST), and brief intervention 15 to 30 minutes
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, DAST), and intervention, greater than 30 minutes
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit
G0442	Annual alcohol misuse screening, 15 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
G0444	Annual depression screening, 15 minutes
G0445	Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes
G0447	Face-to-face behavioral counseling for obesity, 15 minutes

Notification for effective date of policy 01/01/2021. For Virtual Care Billing guidance prior to 01/01/21 and/or extended during the Public Health Emergency (PHE) period, please review the COVID-19 Interim Billing Guidelines Reimbursement Policy on CignaforHCP.com.

G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
G0513	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)
G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service)
S9152	Speech therapy, re-evaluation

Modifiers	**Description**
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunication system
GQ	Via asynchronous telecommunications system
GT	Via interactive audio and video telecommunications systems

References

1. Current Procedural Terminology (CPT®) Professional Edition (Chicago, IL: American Medical Association: ©2020).

2. Health Care Procedure Coding Systems (HCPCS®) ©2020 Practice Management Information Corporation: Los Angeles, California

3. Centers for Medicare and Medicaid Services (CMS). Accessed 10/25/2017 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

4. Centers for Medicare and Medicaid Services (CMS). https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf?utm_campaign=2a178f351b-EMAIL_CAMPAIGN_2019_04_19_08_59&utm_term=0_ae00b0e89a-2a178f351b-353229765&utm_content=90024811&utm_medium=social&utm_source=linkedin&hss_channel=lcp-3619444. Accessed 09/16/2019

5. Optum 360º, *Understanding Modifiers 2020* (West Valley City, UT: Optum 360, ©2020), 132,133.

6. American Telemedicine Association. What is Telemedicine? http://www.americantelemed.org/main/about/about-telemedicine/telemedicine-benefits. Accessed 11/01/2017

7. American Medical Association. Delivering care. https://www.ama-assn.org/delivering-care/telemedicine-mobile-apps accesses 11/01/2017

Notification for effective date of policy 01/01/2021. For Virtual Care Billing guidance prior to 01/01/21 and/or extended during the Public Health Emergency (PHE) period, please review the COVID-19 Interim Billing Guidelines Reimbursement Policy on CignaforHCP.com.

8. Centers for Medicare and Medicaid Services (CMS) COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. Accessed 09/09/2020: https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

9. American Medical Association: Telemedicine During the COVID-19 Public Health Emergency Frequently Asked Questions. Accessed 09/09/2020: https://www.ama-assn.org/system/files/2020-05/telemedicine-during-phe-faqs.pdf

Policy History/Update

Date	Change/Update
01/07/2021	Added CPT 99495, 99496, 99497, 99498 to list of codes eligible for reimbursement when billed per the policy, effective beginning 01/17/2021.
11/24/2020	Clarified intent of E/M documentation requirements for 1997 guidelines vs. 2021 documentation guidelines, including corresponding E/M code ranges.
10/01/2020	Notification for policy effective date of 01/01/2021
03/15/2020	Policy pulled from notification posting
03/12/2020	Notification for policy effective date of 06/15/2020