

Virtual Visit & Reimbursement Guide

Texas

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Partnered with:



Virtual Visit Types

- Telehealth
- E-Visits
- Virtual Check In
- Telephone

Payor Matrix

Payor Guidelines

- Aetna
- BCBS
- Cigna
- Medica
- Medicare
- Texas Medicaid
- United Healthcare

Rural Health Clinics & Federally Qualified Health Clinics

- Medicare
- Medicaid

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 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

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.

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.

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 a 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.

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 within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- **98967:** Telephone assessment and management service 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 within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
- **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 within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion

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.

PAYOR MATRIX

PAYOR	E-VISIT	TELEHEALTH-AUDIO/VIDEO	TELEHEALTH-AUDIO ONLY	VIRTUAL CHECK-IN
AETNA	CONDITIONAL Check Contracted Fee Schedule	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 or 10 <u>Modifier:</u> GT, 95, FR	ALLOWABLE <u>Allowable Codes:</u> Audio Only Telehealth Eligible Code <u>POS:</u> 02 or 10 <u>Modifier:</u> 93, FQ	CONDITIONAL Check Contracted Fee Schedule
BCBS	ALLOWABLE 99421-99423 98970 -98972	ALLOWABLE <u>Allowable Codes:</u> AMA Synchronous Audio/Video Telehealth Code <u>POS:</u> 02 or 10 <u>Modifier:</u> GT, FR, or 95	ALLOWABLE <u>Allowable Codes:</u> AMA Synchronous Audio Only Telehealth Code <u>POS:</u> 02 or 10 <u>Modifier:</u> FQ, 93	ALLOWABLE 98016
CIGNA	NOT ALLOWABLE	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 <u>Modifier:</u> 95, GT	ALLOWABLE <u>Allowable Codes:</u> CPT 98008-98015 <u>POS:</u> 02 <u>Modifier:</u> Not Required	ALLOWABLE 98016
MEDICA	ALLOWABLE 99421-99423 98970 -98972 G2061-G2063	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 or 10 <u>Modifier:</u> GT, 95	NOT ALLOWABLE	ALLOWABLE G2010 98016
MEDICARE	ALLOWABLE 99421-99423 G2061-G2063	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 or 10 <u>Modifier:</u> Hospital Based Provider-95 <u>Method II:</u> Modifier GT <u>RHC:</u> G2025	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 or 10 <u>Modifier:</u> 93 <u>Method II:</u> Modifier GT <u>RHC:</u> G2025	ALLOWABLE 98016 G2010 G2250-G2252
MEDICAID	NOT ALLOWABLE	ALLOWABLE <u>Allowable Codes:</u> Eligible Code In Individual TMPPM Handbooks <u>POS:</u> 02 or 10 <u>Modifier:</u> 95	ALLOWABLE <u>Allowable Codes:</u> Eligible Code In Individual TMPPM Handbooks <u>POS:</u> 02 or 10 <u>Modifier:</u> 93 (Behavioral-FQ)	NOT ALLOWABLE
UHC COMMERCIAL	ALLOWABLE 99421-99423 98970 -98972	ALLOWABLE <u>Allowable Codes:</u> Telehealth Eligible Code <u>POS:</u> 02 or 10 <u>Modifier:</u> 95 or GT	ALLOWABLE <u>Allowable Codes:</u> Audio Only Telehealth Eligible Code <u>POS:</u> 02 or 10 <u>Modifier:</u> 93	ALLOWABLE 98016 G2010 G2250-G2252

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.

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

References:

- Telemedicine and Direct Patient Contact Payment Policy available on [Availity](#)

Payor Specific Key PointsE-Visits/Virtual Check-In:**Allowable Codes:**

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

Telehealth**Allowable Codes:**

See allowable code set below

AMA E/M Telehealth Codes:

The AMA has established new E/M telemedicine services codes (98000-98015). Providers should take notice that the telemedicine symbol “★” has been removed from E/M CPT codes 99202-99205, and 99212- 99215. The telemedicine symbol remains for E/M CPT code 99211. Providers must continue to append an appropriate telehealth modifier if billing services with 99202-99205 and 99212-99215.

- Unless otherwise noted in the code descriptor, the new telemedicine services codes are based on the level of medical decision making (MDM), or the total time for the E/M service rendered on the date of the encounter. Codes listed below may not be reported on the same calendar date as another E/M service. If another E/M service is rendered on the same calendar date, the elements and time of these services are totaled and reported in aggregate. The minimum time for reporting a telemedicine service, if not reached, may count towards the total time spent in an in-person E/M visit on the same date from a separate encounter.
- These telemedicine services codes should not be used to report any routine telecommunications that is related to a previous encounter but may be reported when a follow-up E/M service is required.
- Note, if audio-video connection is lost during an encounter and only audio is restored, providers should report the service that attributed to the majority of the time of the interactive portion of the service. For audio-only services, ten minutes of medical discussion or patient observation must be exceeded.

Delivery Methods:

Delivery methods may include but are not limited to the following:

- Synchronous: 2-way, live interactive audio and video communications, including digital video consultations
- Asynchronous telecommunication - Via image and video not provided in real-time (a service is recorded as video or captured as an image; the provider evaluates it later) in connection with a synchronous audio interaction between the practitioner and the patient in another location
 - **E-Visits-** Allow a member to communicate with a provider using an online patient portal to answer questions or decide if a visit needs to be scheduled.
 - **Mobile Health-** Technology used to allow members to review personal health data via mobile devices from their own home and assists in communicating their health status and any changes.
 - **Store and Forward** - Technology that stores and transmits or grants access to a member's clinical information for review by a health care professional at a different physical location than the person.
 - **Remote Monitoring Services** - Remote monitoring is a service that enables member's health monitoring as well as transfers the health data to an eligible physician or other qualified health care professional. Additional information for remote monitoring services for Intraoperative Neurophysiology Monitoring (IONM) can be found in CPCP032 Intraoperative Neurophysiology Monitoring (IONM) Coding and Reimbursement Policy
 - **Virtual Check-Ins-** Remote evaluations of recorded video or images submitted by a member followed by a brief 5-10 minute check-in with a healthcare professional via telephone or other telecommunications device to decide whether an office visit or other service is needed.
- Other methods allowed by state and federal laws, which can allow members to connect with physicians outside of a traditional provider office setting

Documentation:

- Provider must maintain complete and accurate medical records including but not limited to start and end times of the telemedicine/telehealth or virtual health care service.
- The method of communication must be documented
- Ensure HIPAA compliant and federal and state privacy laws are implemented for member communications, recordings, and member's records

Audio Only Services:

Codes that are appropriate for use with modifier 93 are indicated with the audio symbol throughout the AMA CPT codebook

Modifier/POS:

- **POS 02 or 10**
 - POS 02 does not apply to originating site facilities when billing the facility fee
- **Modifiers**

Only non- telemedicine procedure codes require a telemedicine modifier

 - **Audio Visual:** 95, FR, GT
 - **Audio Only:** 93, FQ
 - **Asynchronous:** GQ
 - **Stroke:** G0
 - Only accepted when modifier GQ, GT, and/or 95 are also appended to the service
 - **Modifier 93** is applicable to certain codes that can be found in AMA, CPT documents. Check current CPT documents for the appendix on CPT Codes that can be used for Synchronous Real-Time Interactive Audio-Only Telemedicine Services. Codes that are appropriate for use with modifier 93 are indicated with the audio symbol throughout the AMA, CPT codebook
 - **Modifier 95** is applicable to certain codes that can be found in AMA, CPT documents. Check current CPT documents for the appendix on CPT Codes that can be used for Synchronous Telemedicine Services. These procedures codes are billed when electronic communication using interactive telecommunications equipment include, at a minimum, audio and video. In addition, codes that are appropriate for use with modifier 95 are indicated with a star (★) throughout the AMA, CPT codebook

Patient Location:

Patient can be located at home or at an allowable originating site facility

Provider Type:

A physician or an individual who is licensed, certified or authorized in the Plan's state to perform a health care service; and is authorized to perform a telemedicine service or is authorized to assist a provider in performing a telemedicine service that is delegated and supervised by the physician or a licensed or certified health care professional acting within the scope of the license or certification who does not perform the telemedicine service.

- Note, eligible providers performing telemedicine services must possess the necessary license to treat members of the Plan's state. Licensed providers must meet the health plans definition of eligible provider

Reimbursement:

Refer to contracted fee schedule

Transmission and Originating Site Fees:

The following is used to determine eligibility for HCPCS Q3014, Telehealth originating site facility fee:

Appropriate billing of Q3014 (To transmit data between unaffiliated providers):

- The provider who is supplying the room and telecommunication equipment with the member physically present, may submit Q3014
- The member visits their PCP's office, and the PCP helps to initiate a telehealth appointment with an outside specialist (not employed/contracted with the PCP or their practice) located in another office location.
 - PCP's office can submit Q3014 for physically hosting the patient (member)
 - The outside specialist located in another office location may not bill code Q3014 since they are not the originating site

Inappropriate billing of Q3014 (Not to be used for virtual type visits or use of equipment for those purposes):

- The member is in their home and initiates telehealth visit with their PCP
 - Since the PCP is not physically hosting the patient (member), they cannot bill Q3014 as the patient (member) is not present at their facility
 - The PCP is acting as a distant site provider to the member who is at home.
- The member visits their PCP’s office and initiates a telehealth or virtual-type visit with their PCP, regardless of whether the PCP is onsite or offsite at the time of the visit.
 - The PCP can bill the CPT/HCPCS code reflecting the service rendered and would append the appropriate telehealth modifier if the PCP was offsite. The PCP cannot also bill Q3014.

References:

- [BCBS of Texas-R9033-Telemedicine and Telehealth/Virtual Services Policy](#)

BCBS TEXAS ELIGIBLE TELEHEALTH CODE LIST											
59425	59426	59430	76140	77263	77336	82962	88321	90785	90791	90792	90832
90833	90834	90836	90837	90838	90839	90840	90845	90846	90847	90849	90853
90863	90875	90876	90882	90887	90899	90901	90935	90937	90940	90945	90951
90952	90953	90954	90955	90956	90957	90958	90959	90960	90961	90962	90963
90964	90965	90966	90967	90968	90969	90970	90989	92002	92004	92012	92014
92060	92065	92066	92083	92132	92136	92227	92228	92250	92260	92285	92504
92507	92508	92520	92521	92522	92523	92524	92526	92542	92551	92597	92601
92602	92603	92604	92605	92606	92607	92608	92609	92610	92611	92618	92626
92630	92633	93000	93005	93010	93041	93224	93225	93227	93228	93229	93241
93242	93244	93248	93261	93268	93270	93271	93272	93294	93295	93296	93297
93298	93750	93784	93788	93790	93793	93797	93798	94002	94003	94004	94005
94010	94014	94060	94375	94618	94660	94664	94690	94726	94729	94760	94761
95249	95250	95251	95700	95800	95803	95806	95816	95836	95851	95852	95957
95970	95971	95972	95983	95984	96041	96105	96110	96112	96113	96116	96121
96125	96127	96130	96131	96132	96133	96136	96137	96138	96139	96146	96156
96158	96159	96160	96161	96164	96165	96167	96168	96170	96171	96202	96203
97014	97032	97110	97112	97113	97116	97124	97129	97130	97139	97150	97151
97152	97153	97154	97155	97156	97157	97158	97161	97162	97163	97164	97165
97166	97167	97168	97530	97533	97535	97537	97542	97750	97755	97760	97761
97763	97799	97802	97803	97804	98000	98001	98002	98003	98004	98005	98006
98007	98008	98009	98010	98011	98012	98013	98014	98015	98016	98960	98961
98962	98966	98967	98968	98970	98971	98972	98975	98976	98977	98978	98980
98981	99024	99050	99051	99053	99058	99078	99091	99173	99199	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	99358	99359	99366	99367	99368	99374	99375	99381	99382	99383
99384	99385	99386	99387	99391	99392	99393	99394	99395	99396	99397	99401
99402	99403	99404	99406	99407	99408	99409	99411	99412	99415	99416	99417
99418	99421	99422	99423	99429	99446	99447	99448	99449	99451	99452	99453
99454	99457	99458	99468	99469	99471	99472	99473	99474	99475	99476	99477
99478	99479	99480	99483	99484	99487	99489	99490	99491	99492	99493	99494
99495	99496	99497	99498	99499	99605	99606	99607	0403T	0488T	0738T	0740T

0764T	0765T	0771T	0772T	0773T	0774T	G0071	G0108	G0109	G0129	G0151	G0152
G0153	G0157	G0158	G0159	G0160	G0161	G0175	G0176	G0177	G0180	G0181	G0182
G0248	G0250	G0270	G0271	G0283	G0296	G0316	G0317	G0318	G0322	G0372	G0396
G0397	G0402	G0406	G0407	G0408	G0410	G0411	G0420	G0422	G0423	G0421	G0425
G0426	G0427	G0438	G0439	G0442	G0443	G0444	G0445	G0446	G0447	G0459	G0463
G0467	G0470	G0473	G0506	G0508	G0509	G0513	G0514	G2010	G2025	G2086	G2087
G2088	G2168	G2169	G2211	G2212	G2214	G2251	G2252	G9001	G9002	G9003	G9004
G9005	G9006	G9007	G9008	G9009	G9010	G9011	G9012	H0001	H0002	H0004	H0005
H0006	H0015	H0020	H0023	H0024	H0025	H0031	H0032	H0035	H0036	H0038	H0046
H0047	H0049	H0050	H1000	H1001	H2000	H2010	H2011	H2012	H2014	H2015	H2016
H2019	H2020	H2021	H2027	H2033	H2040	H2041	Q5001	S0201	S0220	S0221	S0250
S0257	S0265	S0281	S0285	S0315	S0316	S0317	S3005	S5110	S5190	S9083	S9110
S9140	S9141	S9152	S9212	S9213	S9214	S9401	S9441	S9442	S9443	S9449	S9452
S9453	S9460	S9465	S9470	S9473	S9475	S9480	S9484	S9485	T1007	T1013	T1015
T1016	T1017	T1023	T1024	T1025	T1026	T1027	T2024	V5011	V5362	V5363	V5364

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 and is not separately reimbursable.
- 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
- 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 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

Provider Type:

Providers who are licensed, registered, or otherwise 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.

References:

- [Reimbursement Policy- R31- Virtual Care](#)

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	98013	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							

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:** 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 technology was only available through December 31, 2024

Modifiers/POS:

- **POS** 02 or 10
- **Modifier**
 - **Audio-Visual:** GT, 95
 - **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 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 fax, communications between a licensed health care provider and a patient that consists solely of an e-mail or fax

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	90482	90483	90484	90785	90791	90792
90832	90833	90834	90836	90837	90838	90839	90840	90845	90846	90847	90849
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	92622	92623
92625	92626	92627	93228	93229	93268	93270	93271	93272	93750	93797	93798
94002	94003	94004	94005	94625	94626	94664	95970	95971	95972	95983	95984
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	96202	96203	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	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	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	99468
99469	99471	99472	99473	99475	99476	99477	99478	99479	99480	99483	99495
99496	99497	99498	99605	99606	99607	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	G0473	G0506	G0508	G0509	G0513	G0514	G0539	G0540	G0541	G0542
G0543	G0545	G0560	G2086	G2087	G2088	G2211	G2212	G3002	G3003	G9685	Q3014

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 OPPTS 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
- 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:

- **Professional Claims:**
 - **POS:** 02 or 10
- **Institutional Claims:**
 - Modifier 95 is for outpatient therapy services provided via telehealth by a qualified physical therapists, occupational therapists, or speech language pathologists employed by hospitals
 - Modifier GT is required 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.

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
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					

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](#)



E-Visits/Telephone/Virtual Check Ins:**Allowable Codes:**

- **E-Visits:** Not Allowed
- **Virtual Check-In:** Not Allowed

Remote Patient Monitoring:

Home telemonitoring, also known as remote patient monitoring, is a Texas Medicaid benefit that requires scheduled remote monitoring of client health data and transmission of that data from the client's home to a licensed home health agency, hospital, FQHC, or RHC. Data transmission must comply with HIPAA standards.

Home telemonitoring providers must establish a plan of care (POC) with outcome measures based on the physician's or requesting provider's order, and the POC must be reviewed by the client's physician. An RN, NP, CNS, or PA in the licensed home health agency, hospital, FQHC, or RHC is responsible for reporting data to the physician or requesting provider.

Telemonitoring providers must be available 24 hours a day, 7 days a week. Client data must be reported when a measurement falls outside the physician's established parameters or at least monthly when no readings fall outside the established parameters.

Eligible Clients

Home telemonitoring is a benefit for clients diagnosed with:

- Diabetes;
- Hypertension; or
- Both diabetes and hypertension.

It is also a benefit for clients age 20 and younger with one or more of the following:

- End-stage solid organ disease;
- Organ transplant recipient status; or
- Requirement for mechanical ventilation.

The physician or requesting provider must ensure the client has a choice of home telemonitoring providers and may discontinue services at any time. NPs, CNSs, and PAs are considered requesting providers and may request home telemonitoring and sign prior authorization forms. Clients are not required to use home telemonitoring services.

CPT 99091 Requirements:

Collection and interpretation of home telemonitoring data, billed with 99091, is a benefit in the office or hospital setting when performed by a physician or other qualified health care professional. Code 99091 is limited to once per 30-day period for the physician or provider ordering the service and does not require prior authorization.

For clients with dual Medicare and Medicaid eligibility, claims for 99091 must be submitted to Medicare first. Claims for S9110 with any modifier should not be submitted to Medicare, as S9110 is not payable by Medicare.

Facility Services:

The provision and maintenance of home telemonitoring equipment is the responsibility of the home health agency, hospital, FQHC, or RHC.

- **Initial Setup and Installation:** Procedure code S9110-U1 is reimbursed one time to a home health agency or hospital for the initial setup and installation of home telemonitoring equipment in the client's home. A subsequent setup and installation is not reimbursed unless there is a documented new episode of care. Additional monitoring parameters added during the current episode of care are not separately reimbursed.
- **Monthly Home Telemonitoring Services:** Monthly home telemonitoring services are billed with S9110 and the appropriate modifier based on the number of days data is transmitted from the client's home and reviewed by the

home telemonitoring provider during the rolling month. Monthly S9110 services are a benefit when provided by a home health agency or hospital.

- Home health agency and hospital providers must submit revenue code 780 with S9110 and one of the following modifiers:

Modifier	Number of Days Per Month
U2	1–5 days
U3	6–10 days
U4	11–15 days
U7	16–20 days
U8	21–25 days
U9	26–30 days

- Modifiers U2, U3, U4, U7, U8, and U9 are not required on the prior authorization request but must be submitted on the claim based on the number of transmission days.

Prior Authorization

Code S9110, with or without modifier U1, requires prior authorization and may be approved for up to 180 days. Prior authorization for data transmission is limited to no more than once per month during the authorization period.

The initial prior authorization request must be received no more than three business days from the date services begin. Requests received late will be denied for dates of service before the request was received.

Prior authorization requests must include:

- A completed Home Telemonitoring Services Prior Authorization Request Texas Medicaid form;
- The physician or requesting provider's signature dated within 30 days before the start of care;
- The ordered frequency of clinical data transmission;
- The client's qualifying diagnosis or condition and applicable risk factors; and
- Ordered services, including applicable procedure codes or descriptions.

For clients with diabetes or hypertension, approval also requires at least one qualifying risk factor, such as two or more hospitalizations in the prior 12 months, frequent or recurrent emergency department visits, poor medication adherence, risk of falls, or documented care access challenges.

Documentation

The home telemonitoring provider must maintain documentation supporting medical necessity in the client's medical record. Paid services not supported by documentation are subject to recoupment.

Documentation must support:

- Equipment capability to monitor POC data parameters;
- Use of FDA Class II hospital-grade medical equipment;
- Ability to measure and transmit weight, oxygen levels, glucose levels, or blood pressure data;
- Transmission dates, frequency, and clinical data reported to the physician or requesting provider;
- Qualified staff to install equipment and monitor data;
- No duplicate monitoring by another provider;
- Client ability to operate the equipment, or availability of assistance when needed; and

- Written protocols, policies, and procedures addressing user authentication, data origin authentication, system security, unauthorized access prevention, documentation of system use, data storage/maintenance/transmission, and patient profile verification.

Telehealth & Telemedicine:

Not all Medicaid-covered services are authorized by HHSC for telemedicine or telehealth delivery. Providers must confirm the service is allowable for the specific delivery method being used, including synchronous audiovisual, audio-only, store-and-forward, or other asynchronous methods.

Telemedicine and telehealth services may be reimbursed when the service:

- Is designated for reimbursement by HHSC;
- Is determined by HHSC to be clinically effective and cost-effective;
- Is delivered using an HHSC-approved technology method;
- Is clinically appropriate, safe, and agreed to by the client; and
- Meets any service-specific coverage requirements in the applicable TMPPM handbook.

For example, if a service is authorized only for synchronous audiovisual delivery, it may not be provided through audio-only, store-and-forward, or other asynchronous methods.

Reimbursement may not be denied solely because the service was not provided in person, and providers cannot be required to use a specific technology platform to receive reimbursement. However, HHSC encourages face-to-face interaction whenever possible.

More than one medically necessary telemedicine or telehealth service may be reimbursed on the same date and same place of service if billed by providers of different specialties

Intermediate Care Facilities: The use of telemedicine and telehealth services within intermediate care facilities for individuals with intellectual disabilities (ICF-IID) and State Supported Living Centers is subject to the policies established by the Health and Human Services Commission (HHSC)

Texas Medicaid separates Telehealth and Telemedicine by provider/service type, based on Texas Occupations Code definitions

Term	Texas Medicaid Meaning	Key Distinction
Telemedicine Medical Services	Medical services delivered remotely by a Texas-licensed physician or by a health professional acting under physician delegation/supervision.	Generally applies to physician-directed medical services.
Telehealth Services	Health-care services, other than telemedicine medical services or teledentistry, delivered remotely by a licensed, certified, or otherwise authorized health professional.	Generally applies to non-physician or non-medical telehealth services, such as therapy, behavioral health, counseling, nutrition, and similar services.

Telemedicine Service

Texas Medicaid FFS telemedicine services may be delivered using:

- Synchronous audiovisual technology between the distant site provider and client;
- Synchronous audio-only technology between the distant site provider and client; or
- Store-and-forward technology with synchronous audio-only, using clinically relevant images, videos, diagnostic images, or relevant medical records, such as medical history, lab/pathology results, or prescription history.

- **Medicaid MCOs:** are not required to reimburse telemedicine services provided only by text-only email or fax. MCOs may choose whether to reimburse services delivered through asynchronous audio-only technology, such as voicemail; providers should verify coverage with the specific MCO.
 - Texas Medicaid MCOs must reimburse procedure codes G0406, G0407, G0408, G0425, G0426, and G0427 when delivered via telemedicine services.
- **Distant Site Provider:** Telemedicine distant-site providers must be enrolled Texas Medicaid providers and meet applicable Texas licensure, delegation, and supervision requirements. Eligible distant-site providers include physicians, CNSs, NPs, PAs, and CNMs.
 - A valid practitioner-patient relationship must be established, and the provider must obtain informed consent before rendering the telemedicine service. Distant-site providers rendering mental health services must be appropriately licensed or certified in Texas, or be a QMHP-CS.
 - When using electronic communication methods other than telephone or fax, the provider must give the client required notice of privacy practices and must provide guidance on appropriate follow-up care
- **Originating Site:** The patient site is the location where the client is physically located, which may include the client's home. Enrolled Texas Medicaid patient-site providers may only be reimbursed for the originating site fee using Q3014, which is payable to NPs, CNSs, PAs, physicians, and outpatient hospital providers. Other services performed at the patient site may be billed separately. Q3014 is not payable when the patient site is the client's home.
- **Prescriptions:** A distant site provider may issue a valid prescription, including an e-prescription when allowed by law, as part of a telemedicine medical service. The same standards that apply to in-person prescribing also apply to telemedicine, including a valid practitioner-patient relationship, legitimate medical purpose, appropriate Texas licensure, and DEA registration when prescribing controlled substances.
 - Prescriptions must comply with applicable state and federal requirements, including the Texas Controlled Substance Act, Texas Dangerous Drug Act, DEA rules, and Texas Medical Board telemedicine prescribing rules. Chronic pain treatment with scheduled drugs via audio-only is prohibited unless the patient is established, the prescription is identical to the prior visit, and the patient was seen within the last 90 days in person or via audiovisual telemedicine. Acute pain treatment with scheduled drugs through telemedicine is permitted when otherwise compliant.
- **School-Based Telemedicine:** Telemedicine in a primary or secondary school-based setting is a benefit when:
 - The physician is an authorized Texas Medicaid provider;
 - The client is a child receiving the service in a school-based setting; and
 - The parent or legal guardian provides consent before the service

The physician may also delegate the service to an NP, CNS, or PA, as long as the provider is working within their professional scope and delegation agreement.
- **Documentation:** Medical records must be maintained for all telemedicine services and must meet the same standards as comparable in-person services.
 - When the client has a PCP who is not the distant site provider, and the client or parent/legal guardian consents to release of information, the distant site provider must send the PCP a report summarizing the treatment, evaluation, analysis, or diagnosis. Mental health distant site providers are not required to send a PCP treatment summary unless the service is provided to a child in a school-based setting.
 - For school-based telemedicine provided to a child, the telemedicine physician must notify the child's PCP with a summary of the service, exam findings, prescribed or administered medications, and patient instructions. If the child does not have a PCP, the notice must be sent to the parent/legal guardian and include a list of PCPs for selection.

Telehealth Services

Texas Medicaid defines telehealth services as health-care services, other than telemedicine medical services or teledentistry, delivered by a health professional who is licensed, certified, or otherwise authorized to practice in Texas and acting within the scope of their license or certification. Telehealth services are reimbursed in accordance with 1 TAC §355.

Texas Medicaid FFS telehealth services may be delivered using:

- Synchronous audiovisual technology between the distant site provider and client;
- Synchronous audio-only technology between the distant site provider and client; or

- Store-and-forward technology with synchronous audio-only, using clinically relevant images, videos, diagnostic images, or relevant medical records, such as medical history, lab/pathology results, or prescription history.

Texas Medicaid MCOs are not required to reimburse telehealth services provided only by text-only email or fax. MCOs may choose whether to reimburse services delivered through asynchronous audio-only technology, such as voicemail; providers should verify coverage with the specific MCO.

- **Distant Site Provider:** The distant site is the location of the provider rendering the telehealth service. The distant site provider must be appropriately licensed, certified, or otherwise authorized to practice in Texas and must obtain informed consent from the client, parent, or legal guardian before rendering the telehealth service.
 - For mental health services, the distant site provider must be appropriately licensed or certified in Texas, or be a QMHP-CS as defined in 26 TAC §301.303(48). LPAs, PLPs, post-doctoral psychology fellows, and pre-doctoral psychology interns under psychologist supervision may provide telehealth services when all outpatient mental health benefit requirements are met. A distant site provider located outside of Texas while rendering services is considered an out-of-state provider.
- **Originating Site:** The patient site is the location where the client is physically located during the service, which may include the client's home. Enrolled Texas Medicaid patient-site providers may only be reimbursed for the originating site fee using Q3014, and other services performed at the patient site may be billed separately. Q3014 is not payable when the patient site is the client's home.
- **Documentation:** Medical records must be maintained for all telehealth services and must meet the same standards as comparable in-person services.
 - When the client has a PCP and the client or parent/legal guardian consents to release of information, the distant site provider must send the PCP a medical record or report explaining the treatment provided, along with the provider's evaluation, analysis, or diagnosis. Mental health providers and ECI providers are not required to send the PCP a treatment summary.

Allowable Services:

Eligible telemedicine and telehealth procedure codes are identified in the applicable TMPPM benefit handbooks by service type and delivery method. Providers should verify whether the service is approved for synchronous audiovisual, synchronous audio-only, store-and-forward with audio-only, or other allowable delivery methods before billing.

Audio Only:

Behavioral Health Audio-Only Services: May be delivered via synchronous audio-only technology when designated by HHSC and determined to be clinically effective and cost-effective. The provider must obtain informed consent from the client, parent, or legally authorized representative before the service, unless not feasible or doing so could result in death or injury. Verbal consent is allowed and must be documented in the medical record.

Non-Behavioral Health Audio-Only Services: May be delivered via synchronous audio-only technology only when designated by HHSC and determined to be clinically effective and cost-effective. Providers should confirm the service is approved for audio-only delivery in the applicable TMPPM handbook before billing.

Enrollment:

Texas Medicaid providers may provide telemedicine or telehealth services under their existing NPI, with no additional enrollment required.

Home health agency and hospital providers who wish to provide telemonitoring services must notify the Texas Medicaid & Healthcare Partnership (TMHP) as follows:

- Current providers must use the Provider Enrollment and Management System (PEMS) to indicate that they provide telemonitoring services
- Newly enrolling or re-enrolling home health agency or outpatient hospital providers must indicate whether they provide telemonitoring services during the enrollment process.

Guidelines for Medicaid MCOs

Texas Medicaid MCOs may not deny reimbursement for medically necessary, covered services solely because they are delivered via telemedicine or telehealth, or based on the provider's choice of telecommunications platform.

MCOs may consider clinical and cost effectiveness when determining coverage, including whether synchronous audio-only or store-and-forward with audio-only technology is appropriate. Providers should refer to individual MCO policies for specific coverage requirements.

Patient Health Information Security

Telehealth and telemedicine services must be provided using software that allows secure authentication of the distant site provider and the client. Both the client's and provider's physical environments must protect the confidentiality of the client's protected health information (PHI).

For services provided to a child, a parent or legal guardian may be present at either the patient site or distant site

- Any other individual may only be present if the parent or legal guardian provides written or verbal consent to the distant site provider

Adult clients must also provide written or verbal consent before any other individual may be present at either site during the service.

Providers must maintain PHI confidentiality in accordance with applicable federal and state laws

All client health information generated or used during a telehealth or telemedicine service must be stored in the client's health record by the distant site provider. If stored electronically, the provider should use software that complies with HIPAA confidentiality and data encryption requirements, as well as applicable HHS HIPAA rules

Modifiers/POS:

- **POS 02 or 10**
 - The Texas Medicaid Telecommunications Services Handbook does not specify POS 02 or POS 10 billing requirements. TMHP guidance indicates POS 10 is used when the patient is located in their home, and POS 02 is used when the patient is located somewhere other than the home. Effective October 1, 2023, TMHP clarified that POS 10 crosswalks to POS 1 — Office in Texas Medicaid claims processing. Providers should verify POS requirements in the TMPPM Claims Filing Handbook, applicable benefit handbook, and MCO billing guidance.
- **Modifier:**
 - **Audio Visual: 95**
 - Procedure codes that indicate remote (telemedicine) delivery in the description do not need to be billed with the 95 modifier
 -
 - **Audio Only: 93**
 - Procedure codes that indicate telephone or audio-only delivery in their description do not need to be billed with the 93 modifier
 - **Behavioral Health Audio Only: FQ**

Reimbursement:

Refer to the TMHP Online Fee Lookup and applicable fee schedules, including adjusted fee amounts when mandated reductions apply

References:

- [Texas Medicaid Provider Procedures Manual- Telecommunication Services Handbook](#)

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 been in person

Remote Patient Monitoring Codes:

Allowable Codes:

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

POS/Modifier:

POS utilized if visit would have been in person and no modifier

Interprofessional Assessment Codes:

Allowable Codes:

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

POS/Modifier:

POS utilized if visit would have been 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.

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 Services:

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
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](#)

MEDICARE

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 OPSS 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

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](#)

E-Visits/Telephone/Virtual Check Ins:

Allowable Codes:

- **E-Visits:** Not Allowed
- **Virtual Check-In:** Not Allowed

Remote Patient Monitoring:

Home telemonitoring, also known as remote patient monitoring, is a Texas Medicaid benefit that requires scheduled remote monitoring of client health data and transmission of that data from the client’s home to a licensed home health agency, hospital, FQHC, or RHC. Data transmission must comply with HIPAA standards.

Home telemonitoring providers must establish a plan of care (POC) with outcome measures based on the physician’s or requesting provider’s order, and the POC must be reviewed by the client’s physician. An RN, NP, CNS, or PA in the licensed home health agency, hospital, FQHC, or RHC is responsible for reporting data to the physician or requesting provider.

Telemonitoring providers must be available 24 hours a day, 7 days a week. Client data must be reported when a measurement falls outside the physician’s established parameters or at least monthly when no readings fall outside the established parameters.

Eligible Clients

Home telemonitoring is a benefit for clients diagnosed with:

- Diabetes;
- Hypertension; or
- Both diabetes and hypertension.

It is also a benefit for clients age 20 and younger with one or more of the following:

- End-stage solid organ disease;
- Organ transplant recipient status; or
- Requirement for mechanical ventilation.

The physician or requesting provider must ensure the client has a choice of home telemonitoring providers and may discontinue services at any time. NPs, CNSs, and PAs are considered requesting providers and may request home telemonitoring and sign prior authorization forms. Clients are not required to use home telemonitoring services.

FQHC/RHC Home Telemonitoring:

FQHC and RHC providers may be reimbursed outside the encounter rate for home telemonitoring services when all coverage, prior authorization, and documentation requirements are met.

- Procedure code G0511 may be reimbursed to an FQHC or RHC once per month, per client. The following services must be billed by one provider under G0511:
 - Initial equipment setup;
 - Patient education on use of the equipment;
 - Monthly collection and transmission of physiologic data; and
 - Physician or requesting provider services.
- At least 16 days of data collection per month are required for reimbursement. The POS code reported on the claim must reflect the client’s physical location.

Prior Authorization

Initial prior authorization request must be received no more than three business days from the date services begin. Requests received late will be denied for dates of service before the request was received.

Prior authorization requests must include:

- A completed Home Telemonitoring Services Prior Authorization Request Texas Medicaid form;
- The physician or requesting provider's signature dated within 30 days before the start of care;
- The ordered frequency of clinical data transmission;
- The client's qualifying diagnosis or condition and applicable risk factors; and
- Ordered services, including applicable procedure codes or descriptions.

For clients with diabetes or hypertension, approval also requires at least one qualifying risk factor, such as two or more hospitalizations in the prior 12 months, frequent or recurrent emergency department visits, poor medication adherence, risk of falls, or documented care access challenges.

Documentation

The home telemonitoring provider must maintain documentation supporting medical necessity in the client's medical record. Paid services not supported by documentation are subject to recoupment.

Documentation must support:

- Equipment capability to monitor POC data parameters;
- Use of FDA Class II hospital-grade medical equipment;
- Ability to measure and transmit weight, oxygen levels, glucose levels, or blood pressure data;
- Transmission dates, frequency, and clinical data reported to the physician or requesting provider;
- Qualified staff to install equipment and monitor data;
- No duplicate monitoring by another provider;
- Client ability to operate the equipment, or availability of assistance when needed; and
- Written protocols, policies, and procedures addressing user authentication, data origin authentication, system security, unauthorized access prevention, documentation of system use, data storage/maintenance/transmission, and patient profile verification.

Telehealth & Telemedicine:

Not all Medicaid-covered services are authorized by HHSC for telemedicine or telehealth delivery. Providers must confirm, in the individual TMPPM handbook, the service is allowable for the specific delivery method being used, including synchronous audiovisual, audio-only, store-and-forward, or other asynchronous methods.

- For example, if a service is authorized only for synchronous audiovisual delivery, it may not be provided through audio-only, store-and-forward, or other asynchronous methods.

Telemedicine and telehealth services may be reimbursed when the service:

- Is designated for reimbursement by HHSC;
- Is determined by HHSC to be clinically effective and cost-effective;
- Is delivered using an HHSC-approved technology method;
- Is clinically appropriate, safe, and agreed to by the client; and
- Meets any service-specific coverage requirements in the applicable TMPPM handbook.

Reimbursement may not be denied solely because the service was not provided in person, and providers cannot be required to use a specific technology platform to receive reimbursement. However, HHSC encourages face-to-face interaction whenever possible.

More than one medically necessary telemedicine or telehealth service may be reimbursed on the same date and same place of service if billed by providers of different specialties

Intermediate Care Facilities: The use of telemedicine and telehealth services within intermediate care facilities for individuals with intellectual disabilities (ICF-IID) and State Supported Living Centers is subject to the policies established by the Health and Human Services Commission (HHSC)

Texas Medicaid separates Telehealth and Telemedicine by provider/service type, based on Texas Occupations Code definitions

Term	Texas Medicaid Meaning	Key Distinction
Telemedicine Services	Medical services delivered remotely by a Texas-licensed physician or by a health professional acting under physician delegation/supervision.	Generally applies to physician-directed medical services.
Telehealth Services	Health-care services, other than telemedicine medical services or teledentistry, delivered remotely by a licensed, certified, or otherwise authorized health professional.	Generally applies to non-physician or non-medical telehealth services, such as therapy, behavioral health, counseling, nutrition, and similar services.

Telemedicine Service

Texas Medicaid FFS telemedicine services may be delivered using:

- Synchronous audiovisual technology between the distant site provider and client;
- Synchronous audio-only technology between the distant site provider and client; or
- Store-and-forward technology with synchronous audio-only, using clinically relevant images, videos, diagnostic images, or relevant medical records, such as medical history, lab/pathology results, or prescription history.

- **Medicaid MCOs Specifications:** Not required to reimburse telemedicine services provided only by text-only email or fax. MCOs may choose whether to reimburse services delivered through asynchronous audio-only technology, such as voicemail; providers should verify coverage with the specific MCO.
 - Texas Medicaid MCOs must reimburse procedure codes G0406, G0407, G0408, G0425, G0426, and G0427 when delivered via telemedicine services
- **FQHC & RHC Distant Site:** FQHCs and RHCs may be reimbursed as distant-site providers for eligible telemedicine services
 - Practitioners may be employees of the FQHC/RHC or contracted with the facility
- **FQHC & RHC Originating Site:** FQHCs and RHCs may also be reimbursed for an originating site facility fee using Q3014 as an add-on procedure code
 - Must be billed separately from the encounter when both an encounter fee and facility fee are payable for the same client on the same date of service; and
 - Should not be included in cost reporting used to calculate the FQHC PPS/APPS rate or the RHC AIR/PPS per-visit encounter rate.

To receive more than one facility fee for the same client on the same date of service, the FQHC or RHC must maintain documentation supporting medical necessity for multiple distant-site provider consultations. A signed letter from the treating provider may be used and should document that the client had an illness or injury requiring additional diagnosis or treatment by a distant-site provider.

- **Prescriptions:** A distant site provider may issue a valid prescription, including an e-prescription when allowed by law, as part of a telemedicine medical service. The same standards that apply to in-person prescribing also apply to telemedicine, including a valid practitioner-patient relationship, legitimate medical purpose, appropriate Texas licensure, and DEA registration when prescribing controlled substances.
 - Prescriptions must comply with applicable state and federal requirements, including the Texas Controlled Substance Act, Texas Dangerous Drug Act, DEA rules, and Texas Medical Board telemedicine prescribing rules. Chronic pain treatment with scheduled drugs via audio-only is prohibited unless the patient is established, the prescription is identical to the prior visit, and the patient was seen within the last

90 days in person or via audiovisual telemedicine. Acute pain treatment with scheduled drugs through telemedicine is permitted when otherwise compliant.

- **Documentation:** Medical records must be maintained for all telemedicine services and must meet the same standards as comparable in-person services.
 - When the client has a PCP who is not the distant site provider, and the client or parent/legal guardian consents to release of information, the distant site provider must send the PCP a report summarizing the treatment, evaluation, analysis, or diagnosis. Mental health distant site providers are not required to send a PCP treatment summary unless the service is provided to a child in a school-based setting.

Telehealth Services

Texas Medicaid defines telehealth services as health-care services, other than telemedicine medical services or teledentistry, delivered by a health professional who is licensed, certified, or otherwise authorized to practice in Texas and acting within the scope of their license or certification. Telehealth services are reimbursed in accordance with 1 TAC §355.

Texas Medicaid FFS telehealth services may be delivered using:

- Synchronous audiovisual technology between the distant site provider and client;
- Synchronous audio-only technology between the distant site provider and client; or
- Store-and-forward technology with synchronous audio-only, using clinically relevant images, videos, diagnostic images, or relevant medical records, such as medical history, lab/pathology results, or prescription history.

Texas Medicaid MCOs are not required to reimburse telehealth services provided only by text-only email or fax. MCOs may choose whether to reimburse services delivered through asynchronous audio-only technology, such as voicemail; providers should verify coverage with the specific MCO.

- **FQHC & RHC Distant Site:** FQHCs and RHCs may be reimbursed as distant-site providers for eligible telemedicine services
 - Practitioners may be employees of the FQHC/RHC or contracted with the facility
- **FQHC & RHC Originating Site:** FQHCs and RHCs may also be reimbursed for an originating site facility fee using Q3014 as an add-on procedure code
 - Must be billed separately from the encounter when both an encounter fee and facility fee are payable for the same client on the same date of service; and
 - Should not be included in cost reporting used to calculate the FQHC PPS/APPS rate or the RHC AIR/PPS per-visit encounter rate.
- **Documentation:** Medical records must be maintained for all telehealth services and must meet the same standards as comparable in-person services.
 - When the client has a PCP and the client or parent/legal guardian consents to release of information, the distant site provider must send the PCP a medical record or report explaining the treatment provided, along with the provider's evaluation, analysis, or diagnosis. Mental health providers and ECI providers are not required to send the PCP a treatment summary.

Allowable Services:

Eligible telemedicine and telehealth procedure codes are identified in the applicable TMPPM benefit handbooks by service type and delivery method. Providers should verify whether the service is approved for synchronous audiovisual, synchronous audio-only, store-and-forward with audio-only, or other allowable delivery methods before billing

Audio Only:

Behavioral Health Audio-Only Services: May be delivered via synchronous audio-only technology when designated by HHSC and determined to be clinically effective and cost-effective. Providers should confirm the service is approved for audio-only delivery in the applicable TMPPM handbook before billing.

- The provider must obtain informed consent from the client, parent, or legally authorized representative before the service, unless not feasible or doing so could result in death or injury. Verbal consent is allowed and must be documented in the medical record.

Non-Behavioral Health Audio-Only Services: May be delivered via synchronous audio-only technology only when designated by HHSC and determined to be clinically effective and cost-effective. Providers should confirm the service is approved for audio-only delivery in the applicable TMPPM handbook before billing.

Enrollment:

Texas Medicaid providers may provide telemedicine or telehealth services under their existing NPI, with no additional enrollment required

Home health agency and hospital providers who wish to provide telemonitoring services must notify the Texas Medicaid & Healthcare Partnership (TMHP) as follows:

- Current providers must use the Provider Enrollment and Management System (PEMS) to indicate that they provide telemonitoring services
- Newly enrolling or re-enrolling home health agency or outpatient hospital providers must indicate whether they provide telemonitoring services during the enrollment process.

Guidelines for Medicaid MCOs

Texas Medicaid MCOs may not deny reimbursement for medically necessary, covered services solely because they are delivered via telemedicine or telehealth, or based on the provider's choice of telecommunications platform.

MCOs may consider clinical and cost effectiveness when determining coverage, including whether synchronous audio-only or store-and-forward with audio-only technology is appropriate. Providers should refer to individual MCO policies for specific coverage requirements.

Patient Health Information Security

Telehealth and telemedicine services must be provided using software that allows secure authentication of the distant site provider and the client. Both the client's and provider's physical environments must protect the confidentiality of the client's protected health information (PHI).

For services provided to a child, a parent or legal guardian may be present at either the patient site or distant site

- Any other individual may only be present if the parent or legal guardian provides written or verbal consent to the distant site provider

Adult clients must also provide written or verbal consent before any other individual may be present at either site during the service.

Providers must maintain PHI confidentiality in accordance with applicable federal and state laws

All client health information generated or used during a telehealth or telemedicine service must be stored in the client's health record by the distant site provider. If stored electronically, the provider should use software that complies with HIPAA confidentiality and data encryption requirements, as well as applicable HHS HIPAA rules

Modifiers/POS:

- **Modifier:**
 - **Audio Visual: 95**
 - Procedure codes that indicate remote (telemedicine) delivery in the description do not need to be billed with the 95 modifier
 -
 - **Audio Only: 93**
 - Procedure codes that indicate telephone or audio-only delivery in their description do not need to be billed with the 93 modifier
 - **Behavioral Health Audio Only: FQ**

Reimbursement:

- FQHCs are reimbursed at the PPS or APPS rate
- RHCs are reimbursed at the PPS rate

References:

- [Texas Medicaid Provider Procedures Manual- Telecommunication Services Handbook](#)