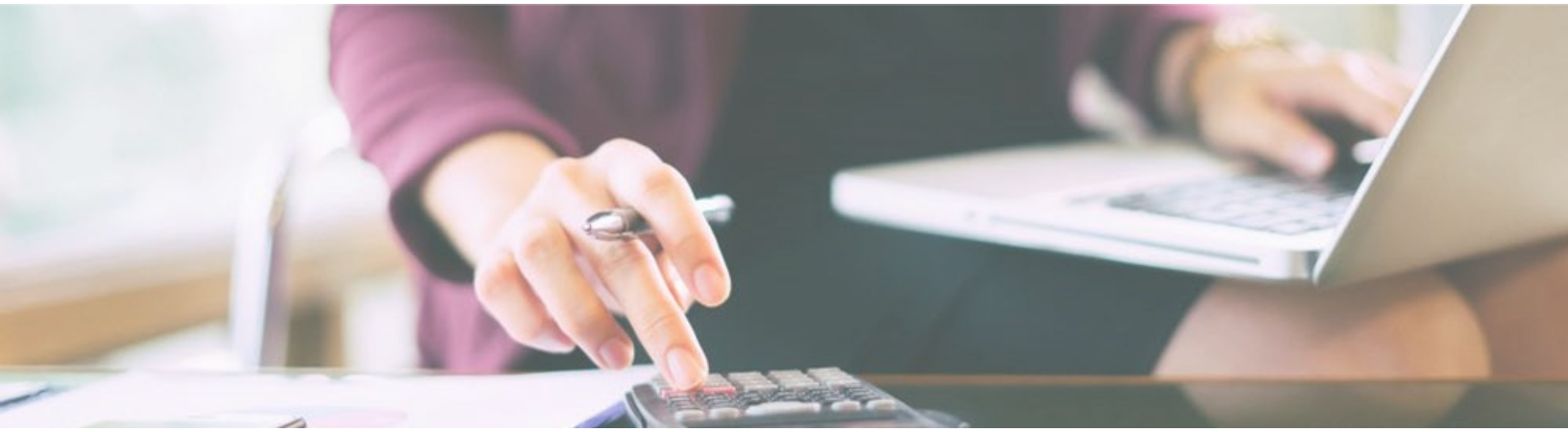

COVID-19 guidelines for providers

Follow these guidelines for dates of service on or before the end of the Public Health Emergency on May 11, 2023.

Billing & coding

Coding for COVID-19 diagnoses

If the primary treatment you're providing is for COVID-19, make sure to report COVID-19 as the primary diagnosis. Use ICD-10 code U07.1.

Coding for services that result in COVID-19 testing

Provider offices, urgent care and emergency rooms

Anytime an E&M visit results in COVID-19 test being ordered, you must add modifier CS or CR. Both identify the service as being related to COVID-19.

If you have claims that resulted in the ordering of a COVID-19 test and they denied or were processed with member liability, you should rebill claims using a CR or CS modifier dating back to February 4, 2020. This modifier should not be added to services billed for treatment of COVID-19, such as labs and x-rays.

Facilities

If a hospital visit results in a COVID-19 test being ordered due to a patient's symptoms, also use condition code DR. The DR condition code should not be used for tests ordered for asymptomatic patients as part of pre-procedural testing or prior to performing other outpatient services per hospital protocol.

These guidelines apply only to services rendered on or before May 11, 2023.
See our online Provider Manual for current **billing / coding** and **virtual care** information.

Coding for COVID-19 testing, including antibody

Testing for COVID-19, including antibody testing, is only covered when it's medically necessary. The test must be ordered by a physician or advanced practice provider (APP), a physician assistant or nurse practitioner. **We only cover one COVID-19 test per day.**

When you order a COVID-19 test, whether molecular or serologic/antibody:

- For most diagnoses, the SC modifier is not necessary to indicate that the test was medically necessary
- The SC modifier must be added for select codes that are generic or typically unrelated. See the complete list in “Billing for COVID-19 lab tests” below.
- Some diagnoses will always deny for member liability. If COVID-19 lab test is billed with these diagnoses, regardless of additional diagnoses billed or if the SC modifier is added, the claim will deny. See the complete list in “Billing for COVID-19 lab tests” below.

Make sure to keep medical necessity documentation. We reserve the right to audit for medical necessity.

Billing for COVID-19 lab tests

Diagnoses that require the SC modifier to determine medical necessity

If a COVID-19 lab test is billed with the following diagnosis codes, an SC modifier must be used if the test was medically necessary. If the test was not medically necessary, the claim will deny and the member will be responsible for the costs*.

Some diagnoses will always deny for member liability. If a COVID-19 lab test is billed with these diagnoses, regardless of additional diagnoses billed or if the SC modifier is added, the claim will deny. See "Diagnoses that will deny for member liability" below

**Medicaid members cannot be held liable for denied amounts. Providers should not bill Medicaid members for any non-covered balance. Medicare members cannot be held liable for denied amounts unless you have a pre-service organization determination on file.*

Diagnosis code	Diagnosis description
Z20.828	Contact with and (suspected) exposure to other viral communicable diseases
Z20.89	Contact with and (suspected) exposure to other communicable diseases
Z20.9	Contact with and (suspected) exposure to unspecified communicable disease
Z20.818	Contact with and (suspected) exposure to other bacterial communicable diseases
Z03.818	Encounter for observation for suspected exposure to other biological agents ruled out

Diagnoses that will deny for member liability

If a COVID-19 lab test is billed with any of the following diagnosis codes, the test is considered not medically necessary. The claim will deny and the member will be responsible for the costs*.

If a COVID-19 lab test billed with these diagnoses, regardless of additional diagnoses billed or if the SC modifier is added, the claim will deny.

**Medicaid members cannot be held liable for denied amounts. Providers should not bill Medicaid members for any non-covered balance. Medicare members cannot be held liable for denied amounts unless you have a pre-service organization determination on file.*

Diagnosis code	Diagnosis description
Z0000	Encounter for general adult medical examination without abnormal findings
Z0001	Encounter for general adult medical examination with abnormal findings
Z00129	Encounter for general adult medical examination with abnormal findings
Z008	Encounter for other general examination
Z01411	Encounter for gynecological examination (general) (routine) with abnormal findings
Z01810	Encounter for preprocedural cardiovascular examination
Z01818	Encounter for other preprocedural examination
Z0184	Encounter for antibody response examination
Z0189	Encounter for other specified special examinations
Z0389	Encounter for observation for other suspected diseases and conditions ruled out
Z0489	Encounter for examination and observation for other specified reasons
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z111	Encounter for screening for respiratory tuberculosis
Z113	Encounter for screening for infections with a predominantly sexual mode of transmission
Z114	Encounter for screening for human immunodeficiency virus [HIV]Z1152
Z1152	Encounter for screening for COVID-19
Z1159	Encounter for screening for other viral diseases
Z119	Encounter for screening for infectious and parasitic diseases, unspecified
Z1211	Encounter for screening for malignant neoplasm of colon
Z125	Encounter for screening for malignant neoplasm of prostate
Z131	Encounter for screening for diabetes mellitus
Z136	Encounter for screening for cardiovascular disorders
Z1383	Encounter for screening for respiratory disorder NEC
Z1389	Encounter for screening for other disorder
Z139	Encounter for screening, unspecified
Z228	Carrier of other infectious diseases
Z298	Encounter for other specified prophylactic measures
Z299	Encounter for prophylactic measures, unspecified
Z362	Encounter for other antenatal screening follow-up
Z3689	Encounter for other specified antenatal screening
Z419	Encounter for procedure for purposes other than remedying health state, unspecified
Z539	Procedure and treatment not carried out, unspecified reason
Z655	Exposure to disaster, war and other hostilities
Z711	Person with feared health complaint in whom no diagnosis is made

Z7184	Encounter for health counseling related to travel
Z7189	Other specified counseling
Z719	Counseling, unspecified
Z7252	High risk homosexual behavior
Z789	Other specified health status
Z79818	Long term (current) use of other agents affecting estrogen receptors and estrogen levels
Z79891	Long term (current) use of opiate analgesic
Z79899	Other long term (current) drug therapy
Z020	Encounter for examination for admission to educational institution
Z021	Encounter for pre-employment examination
Z022	Encounter for examination for admission to residential institution
Z023	Encounter for examination for recruitment to armed forces
Z026	Encounter for examination for insurance purposes
Z0271	Encounter for disability determination
Z0282	Encounter for adoption services
Z0289	Encounter for other administrative examinations
Z029	Encounter for administrative examinations, unspecified
Z578	Occupational exposure to other risk factors
Z579	Occupational exposure to unspecified risk factor

Coding and payments for COVID-19 related services

Effective dates along with all known current and past reimbursement amounts are available in our fee schedules (login required).

Codes without posted rates may not be covered.

To report lab testing services that diagnose the presence of the novel coronavirus, use the following codes. For more information:

- U0001 and U0002, see the CMS FAQ
- U0003 and U0004, see the CMS ruling
- 87635, see the AMA's website

Vaccine billing & reimbursement

COVID-19 vaccines are available to our members with no out-of-pocket costs*. Providers shouldn't collect any member cost share, such as copays, for any doses of COVID-19 vaccines or the administration of the vaccine.

The vaccine is currently being distributed at no cost to providers. You may bill for the administration of all doses of the vaccine using the following guidelines, which vary depending on your patient's plan type.

For Medicare members

Starting Jan. 1, 2022, Priority Health will pay for the COVID-19 vaccine and its administration for all Medicare members enrolled in our plan. At that time, you'll begin to submit those claims to Priority Health using the codes that will be listed in our Medicare fee schedules (login required).

For Medicaid members

Following state guidelines, you should bill the vaccine service with a billed amount of $0 plus the administrative service on the claim. We'll reimburse for the administrative fee at 100% of Medicaid rates.

We'll reimburse FQHCs, RHCs, THCs and Tribal FQHCs for COVID-19 vaccine administration when a Medicaid member doesn't receive another eligible qualifying clinic visit on the same date of service.

Submit claims for the administration of the vaccine to Priority Health using the codes listed in our Medicaid fee schedules (login required).

For commercial group and individual members

We'll add the COVID-19 vaccine to our Preventive Care Guidelines, which means most members will have $0 cost share. Some grandfathered plans—a plan that has not changed since 2010— or commercial retiree plans that aren't subject to the Affordable Care Act may have member costs.

Submit claims for the administration of the vaccine to Priority Health using the codes listed in our Commercial fee schedules (login required).

**Some grandfathered commercial plans, which are plans that haven't changed since 2010, or commercial retiree plans that are not subject to the Affordable Care Act may have member costs.*

Virtual visits

Billing for virtual services

As we continue to evolve our response to COVID-19, we've transitioned back to our normal billing process for virtual services but continue to reimburse at the higher non-facility rate. Submit your virtual service billing with the correct place of service code as follows:

- **POS 02**: for virtual services performed with a patient who's in a location other than their own home
- **POS 10**: for virtual services performed with a patient who's in their own home

Notes: (1) Commercial billing no longer requires the GT and 95 modifiers for professional services. (2) All telemedicine services for Medicaid members must be reported with POS 02 and modifier GT per MDHHS policy.

Temporary code additions for the PHE for the COVID-19 pandemic

The following code list is extracted from our Telemedicine policy #91604 version R6 (pages 14-22), effective through May 11, 2023, for Commercial and individual/ACA plans.

Note: Coverage for some of these codes carried over post-PHE. See our current Telemedicine policy for the latest Commercial / individual / ACA coverage list.

Diagnosis code	Diagnosis description
77427	Radiation treatment management, 5 treatments
90853	Group psychotherapy (other than of a multiple-family group)

90953	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90956	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90959	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92521	Evaluation of speech fluency (eg, stuttering, cluttering)
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92550	Tympanometry and reflex threshold measurements
92552	Pure tone audiometry (threshold); air only
92553	Pure tone audiometry (threshold); air and bone
92555	Speech audiometry threshold;
92556	Speech audiometry threshold; with speech recognition

92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age, with programming
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming
92563	Tone decay test
92565	Stenger test, pure tone
92567	Tympanometry (impedance testing)
92568	Acoustic reflex testing, threshold
92570	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour
92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)
93750	Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)
94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day
94003	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day
94004	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day

94005	Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or
94625	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)
94626	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming
95971	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
95972	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
95983	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional
95984	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving,

	amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
96110	Developmental screening (e.g., developmental milestone survey, speech and language delay screen) with scoring and documentation, per standardized instrument.
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hou
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)
96125	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96127	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or

	caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and

	sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
97150	Therapeutic procedure(s), group (2 or more individuals)
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
97161	Physical therapy evaluation: low complexity
97162	Physical therapy evaluation: moderate complexity,
97163	Physical therapy evaluation: high complexity,
97164	Re-evaluation of physical therapy established plan of care,
97165	Occupational therapy evaluation, low complexity,
97166	Occupational therapy evaluation, moderate complexity,
97167	Occupational therapy evaluation, high complexity
97168	Re-evaluation of occupational therapy established plan of care
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97755	Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients

98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients
S9152	Speech therapy, re-evaluation *(Not payable for Medicre)*
99221	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99222	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
99223	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
99234	Hospital inpatient or observation, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99235	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.
99236	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.
99238	Hospital inpatient or observation discharge day management; 30 minutes or less
99239	Hospital inpatient or observation discharge day management; more than 30 minutes
99281	Emergency department visit for the evaluation and management of a patient,
99282	Emergency department visit for the evaluation and management of a patient,
99283	Emergency department visit for the evaluation and management of a patient,
99284	Emergency department visit for the evaluation and management of a patient,

99285	Emergency department visit for the evaluation and management of a patient,
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
99304	Initial nursing facility care, per day, for the evaluation and management of a patient,
99305	Initial nursing facility care, per day, for the evaluation and management of a patient,
99306	Initial nursing facility care, per day, for the evaluation and management of a patient,
99315	Nursing facility discharge day management; 30 minutes or less
99341	Home or residence visit for the evaluation and management of a new patient,
99342	Home or residence visit for the evaluation and management of a new patient
99344	Home or residence visit for the evaluation and management of a new patient,
99345	Home or residence visit for the evaluation and management of a new patient,
99347	Home or residence visit for the evaluation and management of an established patient
99348	Home or residence visit for the evaluation and management of an established patient
99349	Home or residence visit for the evaluation and management of an established patient
99350	Home or residence visit for the evaluation and management of an established patient,
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99471	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
99472	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
99474	Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient

99475	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
99477	Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or younger, who requires intensive observation, frequent interventions, and other intensive care services
99478	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)
99479	Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)
99480	Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)
99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home
G0422	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session
G0423	Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session
G0424	Pulmonary rehabilitation, including exercise (includes monitoring), 1 hour, per session, up to two sessions per day
G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month *(Covered for Medicare only)*
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month *(Covered for Medicare only)*
G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure) *(Covered for Medicare only)*

Virtual care policy changes

We're also expanding the list of services that are payable when done virtually. We're making this change because more providers are offering more virtual services to ensure patients get the care they need during the COVID-19 pandemic. Our updated list follows recommendations from the AMA, CMS and MDHHS for care that is safe and effective virtually.

Not all services are covered when provided virtually. The codes we cover are those that are medically appropriate and can be accomplished as described by the code being used. For example, preventive medicine visits (codes 99381-99397) may not be suitable when done virtually because age and gender exam elements required for these services

can't be accomplished through virtual methods. In addition, urgent care is no longer a covered virtual service.

This policy applies to all product lines, including commercial group, individual, Medicare and Medicaid.

Virtual billing & reimbursement

Professional providers

For existing virtual care codes, we'll continue to pay the same rates paid prior to the COVID-19 pandemic.

For expanded virtual care codes: As of Jan. 1, 2022, we're continuing to reimburse the higher non-facility rate for virtual care. Submit your virtual service billing either POS 02 (for patients who are at a location other than their own home) or POS 10 (for patients who are in their own home). Commercial billing still doesn't require GT or 95 modifiers.

Facilities (RHC, FQHC, facility-based providers)

Continue to bill as you did prior to COVID-19. Use a GT or 95 modifier to indicate facility services were done virtually.

- **RHC/FQHCs**: Use the following codes for virtual visits: G0071, 99421, 99422, 99423, 99441, 99442, 99443, G2012.

- Distant site telehealth services furnished by facility-based providers, RHC and FQHCs are reported with the appropriate CPT or HCPCS code that falls within their scope of practice and within their fee schedule. Effective July 1, retrospective to Jan. 27, 2020, G2025 can be billed for distance services.

Virtual visit coding guidelines

Visits must follow the guidelines of each code, including the time requirements.

Providers and facilities cannot:

- Use codes that specify in-person or describe services that can only be performed in-person
- Bill for services they are not contracted to provide
- Perform services outside scope of practice, licensure or credentialing
- Bill for a code that requires both an audio and visual component if both audio and visual components are not present throughout the entirety of the visit

Coding guidelines for audio-only visits

You can bill real-time, interactive audio-only virtual visits that have been requested by the patient, so you can serve your patients who don't have internet access or audio-visual capabilities.

Effective Jul. 1, 2020, all audio-only visits must be billed using audio-only visit codes (99441 - 99443, 98966 - 98968). No other codes can be billed for audio-only visits for commercial and Medicaid members. You should bill for these visits using the place of service you normally would, based on your office location.

For Medicare members, additional codes are accepted. See CMS's list of services that can be provided using audio only.

HIPAA compliance

Given the government's notification, we're temporarily suspending the requirement for Health Insurance Portability and Accountability Act (HIPAA)-compliant systems through the end of the public health emergency. This means if providers do not have a virtual care tool in place, they can use non-public facing tools, like FaceTime, Facebook Messenger video chat, Skype, etc. Providers cannot use public-facing tools like Facebook Live, TikTok or chat rooms, like Slack. All other elements of our medical policy remain in effect, including documentation requirements. See the Office of Civil Rights FAQ for more information.

Care management virtual and phone visits

To support ongoing care management, we've expanded your options. The following codes can be performed via telehealth G9001, G9002, G9007, G9008, 99484, 99490, 99492, 99493, 99494, 99495, 99496, 98966, 98967, 98968.

Make sure to review the other information on this page for information on member cost share, audio-only options, and billing virtual services.

More information

See our telemedicine/virtual visit policy for more information and learn more about billable codes on our virtual visits billing page. Behavioral health providers, see our behavioral health virtual care policy and outpatient billable codes.