Telehealth – Federal and State Regulatory Waivers and Flexibilities

1135 CMS Waivers

Flexibility for Medicare Telehealth Services

Law/Regulatory Citation	What is Waived	Authority
Eligible Practitioners 42 CFR § 410.78 (b)(2)	CMS is waiving the requirements of section 1834(m)(4)(E) of the Act and 42 CFR § 410.78 (b)(2) which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.	Additional Blanket Waivers released 4/29
Audio-Only Telehealth for Certain Services 42 CFR § 410.78(a)(3)	CMS is waiving the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services (see designated codes https://www.cms.gov/Medicare/MedicareGeneral-Information/Telehealth/Telehealth-Codes). Unless provided otherwise, other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.	Additional Blanket Waivers released 4/29

Hospitals

Law/Regulatory Citation	What is Waived	Authority
Telemedicine 42 CFR §482.12(a) (8)–(9) and §485.616(c)	CMS is waiving the provisions related to telemedicine at 42 CFR §482.12(a) (8)–(9) for hospitals and §485.616(c) for CAHs, making it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off-site hospital. This allows for increased access to necessary care for hospital and CAH patients, including access to specialty care.	Additional Blanket Waivers released 3/30
Responsibilities of physicians in critical access hospitals (CAHs) 42 C.F.R. § 485.631(b)(2)	CMS is waiving the requirement for CAHs that a doctor of medicine or osteopathy be physically present to provide medical direction, consultation, and supervision for the services provided in the CAH at § 485.631(b)(2). CMS is retaining the regulatory language in the second part of the requirement at § 485.631(b)(2) that a physician be available "through direct radio or telephone communication, or electronic communication for consultation, assistance with medical emergencies, or patient referral." Retaining this longstanding CMS	Additional Blanket Waivers released 3/30

Law/Regulatory Citation	What is Waived	Authority
	policy and related longstanding subregulatory guidance that further described communication between CAHs and physicians will assure an appropriate level of physician direction and supervision for the services provided by the CAH. This will allow the physician to perform responsibilities remotely, as appropriate. This also allows CAHs to use nurse practitioners and physician assistants to the fullest extent possible, while ensuring necessary consultation and support as needed.	
Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) **Physician supervision of NPs in RHCs and FQHCs** 42 C.F.R. 491.8(b)(1)	CMS is modifying the requirement that physicians must provide medical direction for the clinic's or center's health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continues to be responsible for providing medical direction for the clinic or center's health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff. This allows RHCs and FQHCs to use nurse practitioners to the fullest extent possible and allows physicians to direct their time to more critical tasks.	Additional Blanket Waivers released 3/30

Long Term Care Facilities and Skilled Nursing Facilities and/or Nursing Facilities

Law/Regulatory Citation	What is Waived	Authority
Physician Visits in Skilled Nursing Facilities/Nursing Facilities 42 CFR §483.30	CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.	Additional Blanket Waivers released 3/30
Physician Visits 42 C.F.R. 483.30(c)(3)	CMS is waiving the requirement at § 483.30(c)(3) that all required physician visits (not already exempted in § 483.30(c)(4) and (f)) must be made by the physician personally. CMS is modifying this provision to permit physicians to delegate any required physician visit to a nurse practitioner (NPs), physician assistant, or clinical nurse specialist who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the State and performing within the state's scope of practice laws. These actions will assist in potential staffing shortages, maximize the use of medical personnel, and protect the health and safety of residents during the PHE. We note that we are not waiving the requirements for the frequency of required physician visits at § 483.30(c) (1). As set out above, we have only modified the requirement to allow for the requirement to be met by an NP, physician assistant, or clinical nurse specialist, and via telehealth or other remote communication options, as appropriate.	Additional Blanket Waivers released 3/30

End-Stage Renal Dialysis (ESRD) Facilities

Law/Regulatory Citation	What is Waived	Authority
Monthly Physician Visits 42 CFR §494.90(b)(2) and §494.90(b)(4)	CMS is modifying the requirement that at §494.90(b)(4) requires the ESRD dialysis facility to ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician's assistant providing ESRD care at least monthly, and periodically while the hemodialysis patient is receiving in-facility dialysis. CMS is waiving the requirement for a monthly in-person visit if the patient is considered stable and also recommends exercising telehealth flexibilities, e.g. phone calls, to ensure patient safety.	Additional Blanket Waivers released 3/30

All Providers

Law/Regulatory Citation	What is Waived	Authority
Provider Locations	CMS will waive the physician or non-physician practitioner licensing requirements when the following four conditions are met: 1) must be enrolled as such in the Medicare program; 2) must possess a valid license to practice in the state which relates to his or her Medicare enrollment; 3) is furnishing services – whether in person or via telehealth – in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and, 4) is not affirmatively excluded from practice in the state or any other state that is part of the 1135 emergency area. In addition to the statutory limitations that apply to 1135-based licensure waivers, an 1135 waiver, when granted by CMS, does not have the effect of waiving state or local licensure requirements or any requirement specified by the state or a local government as a condition for waiving its licensure requirements. Those requirements would continue to apply unless waived by the state. Therefore, in order for the physician or non-physician practitioner to avail him- or herself of the 1135 waiver under the conditions described above, the state also would have to waive its licensure requirements, either individually or categorically, for the type of practice for which the physician or non-physician practitioner is licensed in his or her home state.	Additional Blanket Waivers released 3/30

Law/Regulatory Citation	What is Waived	Authority
Provider Enrollment	Allow physicians and other practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location. Allow opted-out physicians and non-physician practitioners to terminate their opt-out status early and enroll in Medicare to provide care to more patients.	CMS Blanket Waiver 3/13 & Additional Blanket Waivers released 3/30

Community Mental Health Centers (CMHC)

Law/Regulatory Citation	What is Waived	Authority
Provision of Services 42 CFR 485.918(b)(1)(iii)	CMS is waiving the specific requirement at § 485.918(b)(1)(iii) that prohibits CMHCs from providing partial hospitalization services and other CMHC services in an individual's home so that clients can safely shelter in place during the PHE while continuing to receive needed care and services from the CMHC. While this waiver will now allow CMHCs to furnish services in client homes, including through the use of using telecommunication technology.	Additional Blanket Waivers released 4/29

Virginia Medicaid Flexibilities

Subject	Guidance/Flexibilities	Authority
Coverage of Targeted Services Delivered Via Telehealth **Reimbursement**	DMAS will reimburse for Medicaid-covered services delivered via telehealth where the following conditions are met: • Providers must assure the same rights to confidentiality and security as provided in face-to-face services. • DMAS is waiving the requirement that services delivered via telehealth (real-time, two- way communications) must utilize both audio and visual connection. • DMAS is waiving the requirement that provider staff must be with the patient at the originating site in order to bill DMAS for the originating site facility fee. • Providers shall submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service delivered. • Providers are asked to update their systems and procedures as soon as possible to enable the use of modifiers (GT or GQ) or telehealth POS (02) when billing for services delivered via telehealth. • Providers using telehealth POS (02) or modifiers for telehealth services covered under the prior policy shall continue to use the modifier GT (via interactive audio and video telecommunications system) or GQ (via synchronous telecommunications system), or POS code (02) when billing for services delivered via telehealth. • Both services delivered via telehealth and billed using telehealth modifiers, and services delivered via telehealth and billed without modifiers will be reimbursed at the same rate as the analogous service provided face-to-face. • Providers shall maintain appropriate documentation to support medical necessity for the service delivery model chosen, as well as to support medical necessity for the ongoing delivery of the service through that model of care.	DMAS Memo 3/19
Coverage of Targeted Services Delivered Via Telehealth **Home as Originating Site**	DMAS will allow the home as the originating site. This is particularly important for members who are quarantined, those who are diagnosed with or demonstrating symptoms of COVID-19, or those who are at high risk of serious illness from COVID-19. Clinicians shall use clinical judgment when determining the appropriate use of home as the originating site. No originating site fee shall be paid for telehealth in the home.	DMAS Memo 3/19
Coverage of Targeted Services Delivered Via Telehealth **Telehealth in the Delivery of Behavioral Health Services**	DMAS will allow for telehealth (including telephonic) delivery of all behavioral health services with several exceptions. Services that will be allowable via telehealth include: • Care coordination, case management, and peer services • Service needs assessments (including the Comprehensive Needs Assessment and the IACCT assessment in mental health and the Multidimensional Assessment in ARTS) and all treatment planning activities • Outpatient psychiatric services	DMAS Memo 3/19

	• Community mental health and rehabilitation services • Addiction Recovery and Treatment Services Activities including assessments, therapies (individual, group, family), care coordination, team meetings, and treatment planning are allowable via telehealth. Behavioral health providers delivering services via telehealth (including telephonic communications) shall simply bill and submit a claim as they normally would in their regular practice.	
Coverage of Targeted Services Delivered Via Telehealth **Early Intervention Services**	Early Intervention (EI) providers are permitted to use telehealth or remote care delivery for all ongoing services to include developmental services, physical therapy, occupational therapy, and speech-language pathology to include monitoring of successful program and instructional implementation, coaching, treatment teaming and service plan development.	DMAS Memo 3/19
Coverage of Targeted Services Delivered Via Telehealth **Face-to-Face Service Delivery Guidance for All DMAS-Covered Services**	• All providers shall limit the amount of face-to-face contacts with members. • Face-to-face meetings shall be replaced with phone calls with members and/or documentation from providers. • Existing face-to-face requirements continue to apply in cases where there is a compelling concern for the member's health, safety and welfare based on the professional judgement of licensed staff.	DMAS Memo 3/19

CCC+

Subject	Guidance/Flexibilities	Authority
Waiver Face-to-Face Requirements – CCC Plus Managed Care Program	**For CCC Plus members in nursing facilities** Face-to-face meetings shall be replaced with phone calls with the member, family/authorized representatives, nursing facility staff and/or documentation. Details on how the information was obtained in lieu of the face-to-face meeting must be documented within the member's record. **For CCC Plus members residing in the community** Face-to-face meetings shall be replaced with phone calls with members and/or documentation from providers. Details on how the information was obtained in lieu of the face-to-face meeting must be documented within the member's record. **Quality Management Reviews (QMRs)** All QMR reviews will be desk audit only. All needed materials will be requested from the provider to conduct the review. Providers will be allowed flexibility in instances where they have limited staff to submit records. **Annual Level of Care Evaluations (LOCERI)** All face-to-face requirements to conduct the annual level of care evaluations (LOCERI) are waived. This waiving of face-to-face requirement is for both past due and currently due level of care evaluations. For CCC Plus Waiver members who have had a face-to-	DMAS Memo 3/19 *Revised by DMAS Memo 4/22

Subject	Guidance/Flexibilities	Authority
	face assessment (initial or reassessment) between October 1, 2019 and March 12, 2020, the information from this assessment may be used to submit LOCERI data in lieu of the face-to-face meeting to complete and submit the annual level of care evaluation. **The due dates for re-evaluations for level of care have been extended from 12 months to 18 months*.** **Program Documentation** Providers shall document in their records the member's verbal consent, authorization, and confirmation of participation. The provider shall obtain written signatures within 45 days after the end of the emergency.	
CCC Plus Waiver Face-to-face visits	For CCC Plus Waiver members, face-to-face Agency RN and Services Facilitation (SF) visit requirements are waived with the exception of instances when there is concern for the member's health, safety, and welfare. Face-to-face meetings shall be replaced with phone calls or virtual communication (telehealth) with members and documentation by providers. Visits to initiate services must be conducted face-to-face in order to ensure adequate service plan development.	DMAS Memo 3/19
CCC Plus Waiver Documentation	• Required DMAS forms shall be used to document the interaction during these phone calls. • Providers shall document in their records the member's verbal consent, authorization, and confirmation of participation. The provider **shall not be required to*** obtain written signatures within 45 days after the end of the emergency. • Providers shall use existing procedure codes when billing for telehealth visits.	DMAS Memo 3/19 *Revised by DMAS Memo 4/22
CCC Plus Waiver CCC Plus Waiver Service Authorization Extension	To ensure continuity of care for members, service authorizations for certain CCC Plus waiver services will be extended. All personal care, respite, private duty nursing (PDN), and Personal Emergency Response Systems (PERS) service authorizations with end dates between March 12, 2020 and May 31, 2020 will be extended by two months. PDN providers shall continue to be responsible for obtaining MD orders for services.	DMAS Memo 3/19

Developmental Disability

Subject	Guidance/Flexibilities	Authority
Developmental Disability Waivers	Face-to-face visits by Support Coordinators • Requirements for face-to-face visits by support coordinators will be suspended until the end of the emergency. In the interim, it is expected that Support Coordinators will conduct telephonic check-ins and request the same updates as would be gained during a face-to-face visit regarding, health, safety and satisfaction with services. Telehealth support DMAS and DBHDS support the completion of annual plan meetings, case management visits, the VIDES and the SIS via telehealth or telephone until the end of the emergency.	DMAS Memo 3/19 & 4/22 *Revised in DMAS Memo 4/22

Behavioral Health

Subject	Guidance/Flexibilities	Authority
Behavioral Health Services (Applicable across MCOs and FFS)	For any services without specific guidance below: • Face-to-face services shall not be required, but documentation shall justify the rationale for the service through a different model of care. • Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care. • Current service authorization requirements remain the same.	DMAS Memo 3/19
Behavioral Health Services Specific Service Considerations & Limitations	Therapeutic Day Treatment (TDT), Intensive In-Home Services (IIH), Mental Health Skill- Building, Behavioral Therapy, Intensive Community Treatment and Psychosocial Rehabilitation. • Service delivery may be provided outside of the school setting, office setting, or clinic setting for the next 60 days. • Face-to-face services shall not be required, but documentation shall justify the rationale for the service through a different model of care. • Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.	DMAS Memo 3/19
Behavioral Health Services Day Treatment/Partial Hospitalization Programs for Adults	Face-to-face services shall not be required for reimbursement of the services, but documentation shall justify the rationale for the service through a different model of care. Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.	DMAS Memo 3/19
Behavioral Health Services Psychiatric Inpatient Hospitalizations	Therapy, assessments, case management, team meetings, and treatment planning may occur via telehealth.	DMAS Memo 3/19
Behavioral Health Services IACCT Assessment, Psychiatric Residential Treatment Facility, and Therapeutic Group Homes	• IACCT Assessments may occur via telehealth or telephone communication. • IACCT Assessments may be completed by out-of- network providers, but these individuals must be an independent evaluator separate from the residential facility.	DMAS Memo 3/19
Addiction and Recovery Treatment Services (ARTS)	• Face-to-face services shall not be required, but documentation shall justify the rationale for the service through a different model of care.	DMAS Memo 3/19
Addiction and Recovery Treatment Services (ARTS) ASAM Levels 3.1 and Above	• Face-to-face services shall not be required, but documentation shall justify the rationale for the service through a different model of care.	DMAS Memo 3/19

Subject	Guidance/Flexibilities	Authority
	• Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care. • Therapy, assessments, case management, care coordination, team meetings, and treatment planning can occur via telehealth or telephonic consults. • Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.	
OTP and OBOT Services Counseling and Other Requirements	DMAS is allowing the counseling component of Medication Assisted Treatment (MAT) to be provided via telehealth or telephone communication. If an OBOT or OTP member is unable to participate in counseling services due to COVID-19, DMAS will not penalize the OBOT or OTP provider for the missed services. The provider must have emergency procedures in place to address the needs of any member in a psychiatric crisis. The provider should also ensure that the member continues to have access to medications to treat OUD, as well as care coordination activities as appropriate. OBOT and OTP providers may continue to bill for care coordination that is provided telephonically and in the absence of counseling services, if necessary and appropriate.	DMAS Memo 3/19
OTP and OBOT Services Home as Originating Site for Counseling Services	DMAS will additionally allow a member's home to serve as the originating site for members. This is particularly important for those who are quarantined, are diagnosed with and/or demonstrating symptoms of COVID-19, and/or are at high risk of serious illness from COVID-19. Clinicians shall use clinical judgment when determining the appropriate use of home as the originating site. The originating site fee will not be available.	DMAS Memo 3/19
OTP and OBOT Services Face-to-Face Contact Requirements	Face-to-face contact requirements are waived for care coordinators, counselors, and peer recovery support specialists within OBOT or OTP. Staff members may use telehealth, including telephonic communication, and should use the same billing codes. Any type of contact with the member shall be documented, including the method of contact (face-to-face, telehealth, telephonic.)	DMAS Memo 3/19
OTP and OBOT Services Billing for Telehealth Services	Services provided via telehealth or telephonically shall be billed using the currently approved CPT and HCPCS codes allowed under the ARTS reimbursement structure. Documentation shall include the mode of service delivery.	DMAS Memo 3/19
Providing Medication for Members with OUD Guidance on Use of Telehealth for Members and Providers Affected by COVID-19 Ryan Haight Act of 2008	During the federal Health and Human Services (HHS) Public Health Emergency, the Drug Enforcement Agency (DEA) has lifted the requirements under the Ryan Haight Act of 2008 for prescribing practitioner to have conducted at least one in-person medical evaluation of the patient before prescribing a controlled substance scheduled II – V, including buprenorphine and buprenorphine/naloxone for treatment of addiction. For as long as the federal HHS designation of a public health emergency remains in effect, DEA- registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met: • The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice. • The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system. • The practitioner is acting in accordance with applicable Federal and State law. Provided the practitioner satisfies the above requirements, the practitioner may issue the prescription using any of the methods of prescribing currently available and in the	DMAS Memo 3/19

Subject	Guidance/Flexibilities	Authority
	manner set forth in the DEA regulations. Thus, the practitioner may issue a prescription either electronically (for schedules II-V) or by calling in an emergency schedule II prescription to the pharmacy, or by calling in a schedule III-V prescription to the pharmacy	
Providing Medication for Members with OUD **Preferred OBOT Prescription Management**	During the Governor's State of Emergency, DMAS asks Preferred OBOTS to consider giving individuals who are deemed 'clinically stable' longer prescription lengths of buprenorphine- containing products, as permitted by the Virginia Board of Pharmacy. 'Clinically stable' should be determined by the prescribing provider's clinical judgment and care team. DMAS encourages providers to consider a minimum two-week supply of buprenorphine-containing products, and telehealth or telephonic follow up when clinically appropriate to lessen an individual's risk of coming into contact with persons who may be carrying the virus.	DMAS Memo 3/19
Providing Medication for Members with OUD **Billing Medicaid for Telehealth Services for Prescribing Medications**	Services provided via telehealth or telephone shall be billed using the currently approved CPT and HCPCS codes allowed under the ARTS reimbursement structure. Documentation shall include the mode of service delivery. DMAS is waiving the requirement to use the specific telehealth billing codes in this time of emergency.	DMAS Memo 3/19
Providing Medication for Members with OUD **Home as Originating Site**	DMAS will allow a member's home to serve as the originating site for prescription of buprenorphine in accordance with the Ryan Haight Act which allows exceptions in the event of a Public Health Emergency. Clinicians shall use clinical judgment when determining the appropriate use of home as the originating site. The originating site fee will not be available. (This does not apply for prescribing the initial dose of a controlled substance. Providers must follow the DEA requirements noted above for the initial visit.) For providers who are treating members in the home, contingency plans and emergency procedures shall be developed and documented.	DMAS Memo 3/19

Home and Community Based Services (HCBS)

Subject	Guidance/Flexibilities	Authority
Home and Community Based Services (HCBS) Waivers	Monthly monitoring may be in the form of telehealth visits including phone calls. Monthly monitoring shall be performed by the CCC plus waiver provider including the personal care agency, services facilitator, or adult day health center for those enrolled in the waiver. Monthly monitoring for those enrolled receive monthly monitoring when services in a DD waiver shall be conducted by the support coordinator.	DMAS Memo 4/22

Subject	Guidance/Flexibilities	Authority
Home and Community Based Services (HCBS) Waivers	For services facilitation providers, the Consumer (Individual) Training (S5109) may be conducted using telehealth methods.	DMAS Memo 4/22
Home and Community Based Services (HCBS) Waivers	Face-to-face visit requirements with members are now waived for initial visits and transfers for personal care, respite, and companion services. Face-to-face visits shall be replaced with telehealth methods of communication including phone calls and video conferencing. Documentation of visits conducted through telehealth must meet the standards required for face-to-face visits. Details on how the information was obtained in lieu of the face-to-face meeting must be documented within the member's record and on documentation submitted to the appropriate service authorization entity. Existing face-to-face visit requirements continue to apply in cases where there is a compelling concern for the member's health, safety and welfare based on the professional judgement of the provider. This applies to both agency-directed and consumer-directed service. This is a change from the March 19, 2020 previous Medicaid Memo and is effective March 31, 2020.	DMAS Memo 4/22

Programs of All-Inclusive Care for the Elderly (PACE)

Subject	Guidance/Flexibilities	Authority
Programs of All-Inclusive Care for the Elderly (PACE)	PACE sites may use remote technology (telehealth options) as appropriate for participant assessments, care planning, monitoring, community and other activities that would normally be provided as a face to face service.	DMAS Memo 3/19

Virginia Telehealth Executive Orders

Title	Date Issued	Purpose of Order	Duration/Expiration
Executive Order 57	April 17, 2020	Provides licensure relief to health care professionals (HCPs). Specifically: • HCPs may use any non-public facing audio or remote communication product that is available to communicate with patients. This applies to telehealth provided for any reason regardless of whether the telehealth service is related to the diagnosis and treatment of COVID-19;	June 10, 2020
Executive Order 58	April 23, 2020	Implements changes to Medicaid and Family access to Medical Insurance Security (FAMIS) to increase access to care. Specifically: • Personal care, respite, and companion providers in the agency- or consumer- directed program, who are providing services to individuals over the age of 18, may work for up to 60 days, as opposed to the current 30-day limit in § 32.1-162.9:1, while criminal background registries are checked. Consumer-directed Employers of Record must ensure that the attendant is adequately supervised while the criminal background registry check is processed. Agency providers must adhere to current reference check requirements and ensure that adequate training has occurred prior to the aide providing the services in the home. Agency providers shall conduct weekly supervisory visits through telehealth methods when the aide works prior to receiving criminal background registry results. This section does not apply to services provided to individuals under the age of 18, with the exception of parents of minor children in the consumer-directed program; and	June 10, 2020

Commercial Plan	COVID-19 Telehealth Coverage (for professional 837P/CMS-1500 claims)	Reference Link(s)	These two columns pertain mainly to Professional Services Billings	
			Phone only = TeleVideo?	Place of Service (POS) Requirements
Aetna	Yes. In-network providers delivering live videoconferencing and telephone-only for all commercial plans.	Aetna- COVID-19 FAQS Aetna - Resource Center CVS/Aetna Response	Y	POS = 02
Anthem	Yes - for 90 days from 3/17/2020 - Will waive member cost-sharing medical and behavioral health services from providers. Self-insured plan sponsors may opt out of this program.	Anthem - Provider Information Anthem - Provider Communication Anthem Press Release	N	POS = 11
Carefirst	Yes -Cost-sharing is waived for telemedicine services. Providers are encouraged not to collect member cost sharing for these services. Self-insured plans cover on a case-by-case basis.	Carefirst - COVID Provider info Carefirst - Resource Center Carefirst - Press Release	N	POS = 2
Humana (Commercial products)	Yes. As of 3/24/20, the guidance indicates coverage for video or telephone care (in-network providers), including routine visits for primary or specialty care.	Humana Covid 19 Resources Humans - Medical Resources	Y	POS = 11
Cigna	Yes. Telehealth coverage is available for screening telephone consults, virtual visits for screening for suspected or likely COVID-19 exposure, and virtual visits for treatment of a confirmed COVID-19 case. Cost sharing is waived for all the above.	Cigna - Resource Center CIGNA - Press Release Cigna - Interim Billing Guidance for Providers	Y	POS = 11

Optima	Yes - Optima Health will cover the following in full: all telehealth visits (audio, video or e-visit) with any in-network care provider visits through June 7, 2020.	Optima - COVID-19 Optima - Press Release Optima - Provider Info	Y	POS = 02
Magellan	Yes - Allow behavioral health for all routine services and certain psych testing, ABA, IOP and PHP.. Incldues telephone-only sessions,	Magellan - COVID-19 Magellan - Telehealth	BH covered, including teleBH visits	POS = 2
Piedmont	Waive out-of-pocket costs but only at Centra 24/7.	Piedmont Health - Main Page Piedmont Health - FAQs Piedmont - Press Release	Unclear - seems only via their Centra 24/7	
UnitedHealthcare	Yes. Cost-sharing waived for in-network telehealth services for medical, outpatient behavioral and PT/OT/ST services from March 31, 2020 until June 18, 2020 for Medicare Advantage, Medicaid, and Individual and fully insured Group Market health plan with opt-in available for self-funded employers.	United - Additional COVID Resources UnitedHealthcare-Covid 19 Telehealth Services FAQs UnitedHealthcare-Covid 19 Coding & Reimbursement	Y	POS = 11
Virginia Premier	Yes - Will cover telehealth and waive HIPAA requirements. Will allow home as an originating site.	Virginia Premier - Resource Page VA Premier - COVID Medicaid Memo VA Premier - Member Update	Y	POS = 2
Virginia Association of Health Plans		VAHP - Plan Updates VAHP - Telehealth Chart		

Commercial Insurer Coverage of Physical Therapy Telehealth

INSURANCE	Duration	TELEHEALTH PT?	CODES ALLOWED	POS*	Modifier*
Aetna	March 4-June 4 2020	Yes	Eval-low or med complexity 97161/97162	2	95
			97110, 97112, 97116, 97535, 97755. 97760		95
Anthem-varies by state and individual policy	March 17-June 4 2020	Yes-most policies	Codes vary by individual policy	2	95
				2	95
Cigna	March 2-May 31 2020	Yes	Eval-low or med complexity 97161/97162	2	95
			9110 (2 units per visit)		95
Humana and Humana Military	Not Specified	Yes	Regular CPT codes	2	95
Medicare	Duration of State of Emergency	NO	Not billable by PTs	2	95
Medrisk-Work Comp	Not Specified	Yes	Regular CPT codes	2	95
One Call -Work Comp	Not Specified	Yes	Regular CPT codes	2	95
Optima Health	March 7-June 7 2020	Yes	Regular CPT codes	2	95
					95
United Healthcare	March 18-June 18 2020	Yes	Regular CPT codes	2	95
			All eval codes, Re-eval, 97110, 91112, 97116, 97530, 97760, 97761	2	95
Veterans Admin	Duration of State of Emergency	Yes	Regular CPT codes	2	95
Magellan	Duration of State of Emergency	Yes	Regular CPT codes	2	95