Question For: Third Party Payer

Question: 1. Virtual Care Visit “If a two way audio-video internet-based system (with a HIPPA/HITECH compliant web link) could allow a patient to have an interactive virtual care visit from their personal device or computer with internet capabilities to their provider, the provider can complete the components of an E/M service. While not all conditions lend themselves to a virtual care visit, many chronic condition follow-up appointments and acute care visits not requiring a “hands-on” assessment can be done safely and efficiently with this tool. While there is an E/M code for online visits, there is not a CPT code that defines an E/M service being performed face-to-face in this fashion. Would your system accept 99499-GT?

Additional Details:

Code(s): 99499-GT

Setting(s): Virtual Visit

Provider(s): physician, Nurse Practitioner

Submitted by: Judy Papke, Reimbursement Policy Analyst
Marshfield Health System
715-221-5412
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RESPONSES:

Anthem: Will accept the code and modifier. However, as indicated in our December response, services rendered without direct (face-to-face) patient contact are considered to be an integral component of the overall medical management service and are not eligible for separate reimbursement. Please see Anthem’s Bundled Services and Supplies policy 0008 available through the Availity link out to MyAnthem for more information.

Cigna: Per Cigna Behavioral Health, Cigna covers telehealth services for some customers in the 24 states that require coverage, following specific mandates for each state: AZ, CA, CO, DC, GA, HI, IL, KY, LA, ME, MD, MA, MI, MS, MO, MT, NM, OK, OR, TN, TX, VT, and VA.

Humana: Will accept the code. However, this is non-covered for both Commercial and Medicare.

Physician’s Plus: We currently do not reimburse for virtual care of any type and this would include 99499-GT.

Security Health Plan: Our current Telehealth policy denies virtual visits on a personal device/computer, but we are in negotiations with a provider to allow this based on an established set of criteria. If other providers want to include this service in their contract, our policy will be updated at that time with the criteria to allow virtual visits to be paid.

Unity: Unity does cover 99499, however, telemedicine visits require prior authorization.

WPS: The majority of our plans do not cover any procedures billed with modifier GT. There may be some self-funded plans however where this is allowed.
Question For: Third Party Payer

Question: Digital breast tomosynthesis (both screening & diagnostic) is typically billed with mammography and computer aided detection (CAD).

Additional Details: Do you provide coverage for tomo?

Code(s): 77061-77063

Setting(s):

Provider(s): MDs

Submitted by: Jody McClain, Director, Coding & Charge Capture
UW Health
608-828-1801
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RESPONSES:

Anthem: As indicated in our March response, digital breast tomosynthesis is considered investigational and not medically necessary for all indications per Medical Policy RAD.00060 which can be found on our public provider website at this link https://www.anthem.com/medicalpolicies/policies/mp_pw_c142751.htm. These codes are also included in Anthem’s Bundled Services and Supplies policy section 1 as not eligible for reimbursement. There is additional information in Anthem’s Three Dimensional 3D Radiology Services Reimbursement Policy 0040 available on the secure MyAnthem portal accessed through Availity.

Cigna: Cigna does not cover tomosynthesis-guided localization/biopsy because it is experimental, investigational, or unproven.

Humana: Humana considers this to be experimental & Investigational. It is not covered for Commercial or Medicare

Physician’s Plus: Currently we provide coverage for all tomosynthesis codes. Coverage is currently in review for 2016 and we will send out update when decision has been made.

Security Health Plan: Not at this time, no.

Unity: Unity allows coverage for 77063, however, 77061 and 77062 are not covered services at this time.

WPS: WPS does not provide coverage for tomosynthesis and denies as experimental investigational.
Question For: Third Party Payer

Question: We are receiving denials for 95957 w/95951. Some has indicated that it's included in 95951. However, the definition of the code in CPT and CPT Assistant (November 2010) indicates that 95957 requires additional, separate work and is billable along with any of the EEG codes when medically necessary. What is needed in the documentation for 95957 to be paid?

Additional Details:

Code(s): 95957

Setting(s): Billed w/95951

Provider(s): MDs, APPs

Submitted by: Jody McClain, Director, Coding & Charge Capture
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608-828-1801
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RESPONSES:

Anthem: This code combination does not appear in any of Anthem’s clinical claim edits. If there have been denials, please submit examples to your local Anthem Network Relations Consultant.

Humana: Humana does not have any standard editing that would deny 95957 when billed with 95951. Both services are allowed separately.

Cigna: Cigna accepts this code combination.

Physician’s Plus: Currently we are reimbursing for both 95957 when billed with 95951 without additional documentation review.

Security Health Plan: There are currently no edits in our system to pend these claims for review. If audited, documentation should support the need to bill both CPT 95957 and CPT 95951.

Unity: Unity will allow CPT 95957 with 95951. Documentation should support the medical necessity for both tests.

WPS: These two codes do not bundle in our coding software
Question For: Third Party Payer

Question: When choosing the level of service for evaluation and management codes 99212-99215 does MDM (medical decision making) have to be one of the 2 components when assigning the LOS. How do you know what 2 components were selected for the LOS?

Additional Details:

Code(s): E/M's 99212-99215

Setting(s): LOS - level of service

Provider(s): All

Submitted by: Dean Cravillion, Director of Business Office
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920-431-1951
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RESPONSES:

Anthem: Full information can be found in the Documentation and Reporting Guidelines for Evaluation and Management Services Reimbursement Policy 0024 on the secure MyAnthem portal accessed through Availity. Although CPT coding guidelines do not specify which out of the three key components must meet or exceed the stated requirements to qualify for reporting a particular level of E/M for an established patient visit, Anthem requires that medical decision making be one of the two key components used to determine the E/M code level selected. The other component can be either patient history or physical examination. Anthem uses a point system described in a tool developed by the Marshfield Clinic in conjunction with CMS to quantify the presenting problem and the amount of comprehensive data that must be reviewed by the examining provider. This point system is used in conjunction with the CMS Documentation Guidelines Table from 1995 and/or 1997 for determining the appropriate level of E/M service to select.

Cigna: MDM does not have to be one of the 2 components. According to code description for cpt 99212, there only has to be 2 of the 3 components listed (problem focused history and/or problem focused exam and/or straightforward medical decision making). The code description for 99212 is: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family. The CPT book provides a section on Evaluation and Management (E/M) Services Guidelines which gives instructions for selecting a level of E/M service based on the components. It further defines the components (for example, what constitutes a problem focused history, an expanded problem focus history, a detailed history, etc.; a problem focused exam, expanded problem focused exam, comprehensive examination, etc.; medical decision making that is straightforward, low complexity, moderate complexity, etc.).
Humana: The 2015 CPT book provides guidance in the section titled “Instructions for Selecting a Level of E/M Service”.

The CPT book lists seven components of an E/M visit, then goes on to note: “The first three of these components (i.e., history, examination, and medical decision making) should be considered the key components in selecting the level of E/M services.”

Later in that section, it states that for an established patient visit, “… two of the three key components (i.e., history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services…”

Medical decision making is one of the three key components available, but does not have to be one of the two components used.

Humana cannot determine what components were selected based on the claim submission.

Physician’s Plus: No, currently MDM does not have to be one of the 2 components for deciding LOS, but Physician’s Plus is looking to implement this policy in the very near future and will give adequate notice to providers of implementation date. If this policy is implemented, Physician’s Plus will choose LOS based on the two highest components, with medical decision making being one of those components.

Security Health Plan: For an established patient E&M, two of the three key components must meet or exceed the stated requirements in CPT guidelines to qualify for a particular level. Medical records must substantiate the level of service billed. If there are 2 of the 3 key components substantiated in the medical record, the charge is supported.

Unity: The level of E/M service reported should not be based on the volume of documentation reported but should instead be based on the documentation of the medical necessity for the service.

WPS: The appropriate E/M code submitted should be based on the Provider’s documentation. Also, MDM is part of determining which E/M code is appropriate as the MDM has four levels/categories; straightforward, low complexity, moderate complexity and high complexity. Documentation also needs to support this.
Question For: Third Party Payer

Question: What is the payer's system criteria to determine a "duplicate service"?

Additional Details:

Code(s): Several - Duplicate Claim Denials

Setting(s): When submitting corrected claims/changes we receive a denial for duplicate claim and the correction/change was never addressed

Provider(s): All

Submitted by: Dean Cravillon, Director of Business Office
Prevea Health
920-431-1951
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RESPONSES:

Anthem: Information on duplicate claim line items can be found in Anthem’s Claim Editing Overview Reimbursement Policy 0027 available on the MyAnthem secure portal accessed through Availity. The relevant section reads: “Duplicate Line Items: identifies a line item as a duplicate submission of a previously submitted claim. Fields that are reviewed to determine duplication are Member ID, Provider ID, procedure code, date of service and billed amount. When the same procedure is performed more than one time per date of service, the subsequent procedure(s) must be reported on the same claim as the first procedure. Appropriate modifiers must be appended, when applicable.”

Humana: DOS, TIN, NPI or same CPT by different providers. Be sure to mark claim as “corrected” or correct Bill Type for Facility claims.

Physician’s Plus: For our billing system, dup logic is based on DOS, same billing providers, DRG, CPT codes and partial modifier match. For our Code Editing system, duplicates are based on same physician/provider for same service & DOS.

Security Health Plan: If the provider submits a correction, and identifies it as such, it will be treated as a correction. If not billed as a corrected claim, it may be processed as a duplicate.

Unity: Duplicate CPT codes/services, are typically defined as the same CPT code reported on separate claim lines on the same DOS w/o an appropriate modifier. These services should be reported with either units (same claim line) or with an appropriate modifier.

WPS: If a provider bills the Frequency Code of 7 (last digit of the bill type) and the original Facets Claim ID, the system will automatically reprocess the original claim with corrected data.

If a provider bills the Frequency Code of 7 (last digit of the bill type) without the original Facets Claim ID on the inbound 837 file, the claim will stop for the Claims staff to review and either manually reprocess the original claim or if one is not found, process the submitted claim as a new claim.

If a provider does not bill the Frequency Code of 7 (last digit of the bill type) on the 837 inbound file the claim could deny as a duplicate.
Question For: Third Party Payer | Medicaid | Medicare

Question: How would you code the following scenario? Patient in operating room, general anesthesia administered. 4cm deep cervical cyst which extended into the submandibular triangle was excised. Incision carried out down to the platysma muscle, mass dissected and was adherent to strap muscles which extended along the medial aspect of the left submandibular gland. Would you code this with an unlisted code, 21556 or 11424?

Additional Details: If unlisted CPT code, what do you require for coverage/payment?

Code(s): Unlisted musculoskeletal procedure 20999

Setting(s):

Provider(s):

Submitted by: Tami Jones, Healthcare Consultant
SVA
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RESPONSES:

Anthem: Payers cannot provide coding advice and recommend using codes that most closely match the services rendered based on CPT/AMA guidelines.

Cigna: Based on the above information, code 21556 best describes the scenario.

Humana: Certified coder should bill the appropriate code based on services performed. If unlisted code is billed, Humana will require records for review.

Physician’s Plus: We are unable to advise providers how to choose codes; code selection would be based off surgical procedure documentation.

Security Health Plan: Medical records must support which CPT code the provider bills. If they do not, the charge may be denied. If providers use an unlisted code, a description is required on the claim. SHP will verify that there is no better, established code the provider should have used. If unlisted code is billed, we would also require notes to verify what was done.

Unity: Unity allows unlisted codes and require a description to be submitted on the claim. These services may require a review by medical management and supporting documentation may be requested from the provider.

WPS: In the scenario above the appropriate code to use would be the unlisted code. Documentation should be submitted along with the claim. All unlisted codes our reviewed prior to being processed.
Question For: Third Party Payer | Medicaid | Medicare

Question: When patients are seen in our Urgent Care/Convenient Care clinic we are submitting the claim as POS 11 (Clinic). Payers have been asking us to change the POS to 20 (Urgent Care facility) to indicate that the patient was in an urgent care setting. Apparently some plan designs have different copay for urgent care settings. We don’t feel that POS 20 is correct because this POS code applies to a location distinct from a hospital emergency department, an office, or a clinic. Our Urgent Care/Convenient Care is clinic based. Box 32 shows convenient care. How do the payers want us to handle this situation?

Additional Details:

Code(s): POS 11 vs POS 20
Setting(s): Clinic
Provider(s): All Providers
Submitted by: Coding/Reimbursement Specialist
Agnesian Health Care
920-926-8365
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RESPONSES:

Anthem: Per Anthem’s Office Place of Service Reimbursement Policy 0042 available on the MyAnthem secure portal accessed through Availity, we follow CPT’s definition of and office place of service described as a “Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.” Anthem typically sets up free standing Urgent Care Clinics differently that Clinics that deliver urgent care services. Provider should bill place of service 11 when delivering services in a clinic setting.

Cigna: If the provider feels POS 11 is more appropriate than POS 20 Cigna would have to accept. However, in order for the urgent care copy to apply providers would have to bill POS 20. Otherwise, the physician copay is going to be applied.

Humana: POS 20 if Urgent Care only. POS 11 if within the walls of a clinic.

Physician’s Plus: If provider meets criteria for clinic status, then we would expect services to be billed under POS 11. If provider meets criteria for UC, then services should be billed under POS 20.

Security Health Plan: If the provider is not a true Urgent Care, they shouldn’t use POS 20. The only other option is POS 11. These charges would be reviewed like any other office visit.

Unity: It is quite difficult to determine if a claim is urgent care when place of service is 11. An E/M with a place of service 11 is typically looked at as an office visit. When we receive these claims, we also evaluate the provider and if he/she is set up as an emergency medicine provider, we will apply the urgent care copay. We also have some additional claim reports that are run to attempt to identify these situations. Place of service 20 is always preferable however, we do appreciate that this is not an option for clinic based services.
From a benefit perspective, there are different benefits for some plans when using place of treatment 11 vs 20. Place of treatment 11 guarantees the services are subject to our office visit benefit. Many of our OV plans have a specialty vs PCP copayment level. When these services are billed with POT 11, the specialty of the provider will drive the copayment that is applied for those plans (i.e. $25 vs $50). We do have some plans that vary copays based on place of service.
Question For: Third Party Payer | Medicaid | Medicare

Question: We are thinking this is going to be a retail service because in the past carriers were not reimbursing for video visits.

Additional Details:

Code(s): Video Visits

Setting(s): Provider completes a video visit with a patient. Does coverage change if it is for Psych?

Provider(s): All - not sure if we are going to utilize in Urgent Care, Surgery, etc.

Submitted by: Dean Cravillion, Director of Business Office
Prevea Health
920-431-1951
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RESPONSES:

Anthem: Please see response to “Virtual Care Visit” question. There is no distinction made between medical and behavioral health care.

Cigna: Per Cigna Behavioral Health, Cigna covers telehealth services for some customers in the 24 states that require coverage, following specific mandates for each state: AZ, CA, CO, DC, GA, HI, IL, KY, LA, ME, MD, MA, MI, MS, MO, MT, NM, OK, OR, TN, TX, VT, and VA.

Humana: Psych or not, video visits are not covered.

Physician’s Plus: No, we do not currently offer coverage for video visits of any specialty.

Security Health Plan: Our current Telehealth policy denies virtual visits on a personal device/computer, but we are in negotiations with a provider to allow this based on an established set of criteria. If other providers want to include this service in their contract, our policy will be updated at that time with the criteria to allow virtual visits to be paid.

Unity: It would be helpful to provide a CPT code that you anticipate reporting for these services. Telemedicine requires prior authorization for Unity members.

WPS: Video visits are not reimbursable
Question For: Third Party Payer | Medicaid | Medicare

Question: In regards to HCPCS code G0455 - Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen, we have providers using commercial fecal specimens or another provider is performing the donor assessment. In the case where the provider is only performing the instillation of the fecal transplant and not performing the donor assessment and/or the preparation of the specimen, should G0455 be reported with the modifier 52 or would it be appropriate to report CPT 45378 - Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)?

Additional Details:

Code(s): G0455

Setting(s):

Provider(s): Gastro, general surgery, FP, IM

Submitted by: Beth Schmitz, Coding Supervisor
Aurora Health Care
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RESPONSES:

Anthem: Per the CPT Code definitions, HCPC G0455 should be reported only when the provider has performed the preparation, instillation as well as the donor assessment. If the services were divided, then the provider who performed the preparation and donor assessment should report CPT 44705 and the provider who did the instillation should report their endoscopy or colonoscopy code, whichever was used to install the fecal transplant.

Cigna: G0455 with modifier 52 or 45378 may be reported for fecal transplant.

Humana: Considered experimental and will be reviewed by a Humana Medical Director.

Physician’s Plus: Through our research and review of other healthcare entities, we have found that G0455 with modifier 52 is most appropriate.

Security Health Plan: Prior authorization is required when billing G0455 or 44705. Installation only should be billed with CPT 44799 if billing CPT 44705 for prep and assessment. If not performing all aspects of CPT 44705, use modifier 52. Our system would not allow a 52 modifier with G0455.

Unity: G0455 is covered with approved prior authorization for Unity. Providers are encouraged to report the most specific code available, CPT or HCPCS to describe the services being performed.

WPS: In this case the use of the modifier 52 on code G0455 would be appropriate.
At the March meeting we were informed that no payment would be allowed for CPT codes 77061, 77062, and 77063 because these codes are considered investigative/experimental. Recently I was told by one of our radiologist that private insurers are reimbursing these codes at the rate of a digital screening mammogram. Is this true?

**Code(s):** 77061, 77062, 77063

**Setting(s):** Facility

**Provider(s):** Radiology

**Submitted by:** Coding/Reimbursement Specialist
Agnesian HealthCare
920-926-8365
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**RESPONSES:**

**Anthem:** Please see response to “Digital breast tomosynthesis” question.

**Cigna:** Cigna does not cover tomosynthesis-guided localization/biopsy because it is experimental, investigational or unproven.

**Humana:** Humana considers this to be experimental & Investigational. It is not covered for Commercial or Medicare.

**Physician’s Plus:** Currently we provide coverage for tomosynthesis. Coverage is currently in review for 2016 and we will send out update when decision has been made.

**Security Health Plan:** Not at this time, no.

**Unity:** Unity does not allow coverage for 77061-77062, however, 77063 is covered.

**WPS:** All of these codes are considered experimental investigational. WPS will pay when billed the standard digital mammogram codes when those codes are billed.
Question: Orthognathic surgery has been proven to assist patients with obstructive sleep apnea. Do you have any policy that would limit payment for orthognathic surgery in our sleep apnea patients? Are there any prior auth requirements? They would potentially be providing the following services based on the severity of the patient’s symptoms.

Additional Details:

Code(s): 21141-21147, 21196, 21121
Setting(s): Orthognathic surgery on patients with obstructive sleep apnea
Provider(s): MDs, PAs
Submitted by: Jody McClain, Director, Coding & Charge Capture
UW Health
608-828-1801
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RESPONSES:

Anthem: Please see Anthem’s Medical Policy SURG.0049 for medical necessity for the codes specified at this link: https://www.anthem.com/medicalpolicies/anthem/va/policies/mp_pw_a053349.htm. There is a separate Medical Policy (SURG.00129) that defines medical necessity criteria for Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea at this link: https://www.anthem.com/medicalpolicies/anthem/va/policies/mp_pw_a050503.htm

Cigna: Cigna’s Coverage Policy as followed: coverage for orthognathic surgery is dependent on benefit language, may be subject to the provisions of cosmetic and/or reconstructive surgery benefit and may be governed by state and/or federal mandates.

Under may benefit plans, orthognathic surgery is not covered when performed solely for the purpose of improving or altering appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance. In addition, orthognathic surgery is specifically excluded under some benefit plans.

Cigna medical plans do not cover orthodontic treatment provided as an adjunct to orthognathic surgery, because such treatment is considered dental in nature and therefore, not covered under the medical benefit.

Under many benefit plans formerly administered by Great-West Healthcare, reconstructive services and surgery are covered when reconstruction services are being performed for one of the following primary purposes: to relieve severe physical pain caused by an abnormal body structure; or to treat a functional impairment caused by an abnormal body structure or restore an individual's normal appearance, regardless of whether a functional impairment exists when the abnormality results from a documented illness that occurred with the preceding 12 months. Please refer to the applicable benefit plan language to determine the terms, conditions and limitations of coverage.

If coverage for orthognathic surgery is available, the following clinical documentation is required to support medical necessity for orthognathic surgery:
• medical history and physical examination with reference to symptoms related to the orthognathic deformity
• description of specific anatomic deformity present
• lateral and anterior-posterior cephalometric radiographs
• cephalometric tracings
• copy of medical records from treating physician documenting evaluation, diagnosis and previous management of the functional medical impairment(s)
• diagnostic quality (clear) photographs that fully demonstrate the dental occlusion

Molds may also be requested depending on the individual circumstances of the case. Cigna covers orthognathic surgery as medically necessary when BOTH of the following criteria are met:
• ANY of the following facial skeletal deformities is present:
  ▪ anteroposterior discrepancies:
    o maxillary/mandibular incisor relationship: overjet of 5 mm or more, or a zero to negative value (norm = 2 mm)
    o maxillary/mandibular anteroposterior molar relationship discrepancy of 4 mm or more (norm = 0–1 mm)
  ▪ vertical discrepancies:
    o presence of a vertical facial skeletal deformity which is two or more standard deviations from published norms for accepted skeletal landmarks
    o open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2 mm
    o deep overbite with impingement of palatal soft tissue
    o supraeruption of a dentoalveolar segment resulting from lack of occlusion when dentition in segment is intact
  ▪ transverse discrepancies:
    o presence of a transverse skeletal discrepancy which is two or more standard deviations from published norms
    o total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4 mm or greater, or a unilateral discrepancy of 3 mm or greater, given normal axial inclination of the posterior teeth
  ▪ asymmetries:
    o anteroposterior, transverse or lateral asymmetries greater than 3 mm, with concomitant occlusal asymmetry

• ANY of the following functional impairments is present:
  ▪ persistent difficulties with mastication and swallowing after causes such as neurological or metabolic diseases have been excluded
  ▪ malnutrition, significant weight loss, or failure-to-thrive secondary to facial skeletal deformity
  ▪ speech dysfunction directly related to a jaw deformity as determined by a speech and language pathologist
  ▪ myofascial pain secondary to facial skeletal deformity that has persisted for at least six months, despite conservative treatment such as physical therapy and splints
  ▪ obstructive sleep apnea when ALL of the following criteria are met: o criteria for positive airway pressure (PAP) met and individual has proved intolerant to or failed a trial of PAP
    o mandibular repositioning appliance (MRA) or tongue-retaining appliance has been considered and found to be ineffective or undesirable
    o craniofacial disproportion or deformities
Cigna does not cover surgical procedures such as rhinoplasty, genioplasty or rhytidectomy performed in conjunction with orthognathic surgery for the sole purpose of improving individual appearance and profile because they are considered cosmetic in nature and not medically necessary.

**Humana:**
This does require an authorization. 21141-21147, 21196 included in Policy. 21121 not included in policy. Members condition needs to meet the requirements of the policy and coverage is based on member’s benefits.

**Physician’s Plus:**
All orthognathic surgery codes and procedures require prior authorization and will continue to do so in 2016

**Security Health Plan:**
At this time there is no prior auth requirement for orthognathic surgery. SHP will allow for a sleep apnea diagnosis.

**Unity:**
These services are considered experimental and therefore not covered.

**WPS:**
There is a medical policy titled Obstructive Sleep Apnea: Surgical Treatments posted on our Arise and WPS websites that may address some of these surgeries. We also use MCG and contract with an outside specialty reviewer for review of these services. They should be prior authorized.
Question For: Psych - with the shortage of providers - will payers reimburse for the service? Is there any limitations of coverage?

Additional Details:

Code(s): 99444 - Video Visit

Setting(s):

Provider(s): MD and other qualified behavioral care providers

Submitted by: Dean Cravillion, Director of Business Office
Prevea Health
920-431-1951
dean.cravillion@prevea.com

RESPONSES:

Anthem: Please see response to “Virtual Care Visit” question. There is no distinction made based on the type of provider delivering the service.

Cigna: Per Cigna Behavioral Health, if billing telepsych the appropriate code for this service should be billed with a T code modifier.

Humana: Video visits are not covered.

Physician’s Plus: No, we do not currently offer coverage for video visits of any specialty.

Security Health Plan: Our current Telehealth policy denies virtual visits on a personal device/computer, but we are in negotiations with a provider to allow this based on an established set of criteria. If other providers want to include this service in their contract, our policy will be updated at that time with the criteria to allow virtual visits to be paid.

Unity: Unsure if this question relates to the one above, please see response above. Unity does not allow coverage for 99444.

WPS: 99444 is not a payable code