Telehealth

Frequently asked questions to support physicians working with Humana

To support providers with caring for their Humana patients while promoting both patient and provider safety, we expanded the scope, reimbursement rules and channels for telehealth services. We have received many questions and have provided answers to the most frequently asked questions. This FAQ will be updated as we reevaluate our telehealth policy in light of the COVID-19 public health emergency.

At a minimum, Humana Medicare Advantage plans will always apply the same waivers CMS has announced for CMS telehealth. We will also align with applicable federal and state-specific requirements[1] for telehealth coverage for our commercial and Medicaid insurance products. Our policy will be reviewed periodically for changes based on the evolving COVID-19 public health emergency and updated CMS or federal and state-specific requirements.

Humana has developed a new claims payment policy that outlines our billing expectations and reimbursement for telehealth and other virtual services during the COVID-19 public health emergency. Please refer to this policy for relevant guidance.

For information about service provided to a patient covered by a Humana Medicaid plan, please see the applicable guidance from the relevant state Medicaid agency:

- Florida Agency for Health Care Administration: COVID-19 Alerts for Facilities and Medicaid Providers
- Illinois Department of Healthcare and Family Services: Coronavirus (COVID-19) Updates
- Kentucky Department for Medicaid Services: KY Medicaid COVID-19 Information

Prior to any claim submissions, please refer to applicable CMS, federal and state-specific regulations and guidance or Humana policy, and check Humana's COVID-19 provider website regularly for the latest information.

NEW FAQs - DATED 5/15/20

1. Do covered services provided using telecommunications technology require use of video?

ANSWER: Some services are coverable during the COVID-19 public health emergency (PHE) when provided using real-time, interactive audio-video telecommunications. (Services such as telephone evaluation and management services do not require the use of video.) Some services that are coverable when provided using real-time, interactive audio-video telecommunications are also coverable when video was not used; however, because video is clinically significant to services that normally require face-to-face interaction, such services provided without video are only coverable when it was impossible to use video. In other words, PHE exceptions to normal requirements, designed to ensure

that patients receive critical services in unprecedented times, do not imply that otherwise-applicable standards can be ignored when it is practical to continue to meet them.

2. **If a service is provided to someone registered as an outpatient of a hospital while that patient is in a location that is a temporary expansion location, should charges for services be billed with modifier PN or modifier PO?**

   ANSWER: Original Medicare permits hospitals to establish some locations, including a patient's home, as temporary expansion locations. If a site has been established, according to Centers for Medicare & Medicaid Services (CMS) guidelines, as a temporary expansion location of a hospital, the hospital should submit charges for services provided, via telehealth, to a patient at that site with the modifier(s) that the hospital would use to submit charges for those services to Original Medicare.

3. **When billing for timed services provided via telehealth, what can be accounted for in calculating time?**

   ANSWER: Consistent with CMS guidance, codes that describe medical discussion should only be submitted for services involving medical discussion; and the time used to select a specific timed code cannot account for administrative or other non-medical discussion with the patient.

4. **Will Humana follow CMS's lead and increase reimbursement rates for telephone E/M CPT codes?**

   ANSWER: Like CMS, Humana will increase rates for the Medicare fee schedule and other fee schedules that are based on current Medicare allowable amounts, for telephone E/M services. Increases will apply to services provided during the PHE, for dates of service beginning March 1. Providers should bill the procedure codes that most accurately describe the services that they provided.

5. **Can rural health centers (RHCs) and federally qualified health centers (FQHCs) bill for telehealth and other virtual services?**

   ANSWER: Yes, RHCs and FQHCs can furnish and bill telehealth and other virtual services. Modifier 95 should be used to indicate the service was provided via telehealth. Modifier 95 is necessary to ensure appropriate cost-sharing determination. Each RHC and FQHC should continue to bill using the claim form (or electronic equivalent) it would have used before the PHE.

FAQs - DATED 5/1/20

1. **If a telehealth consultation discusses and addresses a Medicare Risk Adjustment condition, will CMS recognize the diagnosis for risk adjustment purposes?**

   ANSWER: In order to submit the diagnoses from a visit for risk adjustment purposes, the visit must be an allowable inpatient, outpatient or professional service, ***AND*** the visit must be a face-to-face encounter. CMS recently released guidance clarifying the face-to-face encounter requirement in the context of

telehealth and other virtual services. CMS clarified that telehealth services provided using an interactive ***audio and video*** telecommunications system that permits real-time interactive communication satisfy the face-to-face requirement for purposes of risk adjustment data eligibility. This clarifying guidance applies to all telehealth services provided in 2019 and 2020.

COVID-19 telehealth and other virtual services that are eligible for risk adjustment						
Technology solution/visit type	Medicare-covered services	Qualifies for risk adjustment	Equivalent to face-to-face visit	Physician location	Submission POS[1]	Common CPT®[2] and HCPCS[3] codes
Telehealth with interactive audio and video	✓	✓	✓	Home/office/facility	Use CPT telehealth modifier "95" with any POS	99201 – 99215 (office or outpatient visits) G0425 – G0427 (telehealth consultations, emergency department or initial inpatient)
Telephonic visit (audio only)	✓	✗	✗	Home/office/facility	Any POS	99441 -- 99443
Virtual check-in (5 – 10 min. visit)	✓	✗	✗	Home/office/facility	Any POS	G2010 and G2012
E-visit (use of patient portal)	✓	✗	✗	Home/office/facility	Any POS	99421, 99422, 99423, G2061, G2062 and G2063
For a complete list, visit: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes						
Diagnoses resulting from telehealth services can meet the risk adjustment face-to-face requirement when the services are provided using an interactive audio and video telecommunications system that permits real-time interactive communication.						
[1] POS = place of service [2] CPT® = Common Procedural Terminology [3] HCPCS = Healthcare Common Procedural Coding System						

Source: Centers for Medicare & Medicaid Services (CMS), Dept. of Health & Human Services (HHS), April 10, 2020

2. Will this affect Risk Adjustment Processing Systems (RAPS) and Encounter Data Systems (EDS) Submissions to CMS?

ANSWER: The CMS guidance related to diagnoses from telehealth services applies to both submissions to the Risk Adjustment Processing System (RAPS) and the Encounter Data System (EDS). While Medicare Advantage (MA) organizations and other organizations that submit diagnoses for risk adjusted payment identify which

diagnoses meet risk adjustment criteria for their submissions to RAPS, MA organizations (and other organizations as required) report all the services they provide to beneficiaries to the EDS and CMS identifies those diagnoses that meet risk adjustment filtering criteria. In order to report services to the EDS that have been provided via telehealth and that satisfy the face-to-face encounter requirement, use CPT telehealth modifier 95 with any place of service**.**

Please note it is important to use specific codes when services provided are telephonic only, e-visits or virtual check-ins, so that MA organizations and CMS can identify that telehealth services provided were audio only or otherwise not acceptable for risk adjustment purposes. Please refer to the "COVID-19 Telehealth and Other Virtual Services Eligible for Risk Adjustment Grid" above.

3. **What is the expectation on how a provider would assess and document vitals or conduct a physical exam via telehealth for an Annual Wellness Visit (AWV) or Annual Physical Exam?**

ANSWER: Physicians and healthcare providers should continue to apply accurate documentation to their medical note for telehealth visits on information they can collect during the telehealth visit. On March 30, 2020, CMS published an interim final rule (Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency) to provide additional flexibility to physicians during the COVID-19 pandemic. CMS has removed any requirements regarding documentation of history and/or physical exam in the medical record for office/outpatient E/M encounters provided via telehealth.

Source: Centers for Medicare & Medicaid Services (CMS) Interim Final rule Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, March 30, 2020, https://www.cms.gov/files/document/covid-final-ifc.pdf

FAQs - DATED 4/13/20

1. **Can the Practitioner Assessment Form (PAF) (CPT code 96160) be done via telehealth and can it be done using real-time interactive audio only? (REVISED)**

ANSWER: Yes, for providers with a current Practitioner Assessment Form (PAF) contract amendment in place, Humana will continue to pay providers for completing elements of the PAF they are able to address through telehealth or other virtual technology. We will continue to reassess the PAF program and communicate any updates with our physician groups at that time. While our PAF preferred telehealth method is the use of both real-time interactive audio and video, telehealth visits using real-time interactive audio only will be accepted.

- To indicate that a PAF telehealth visit was performed using both real-time interactive audio and video, CPT code 96160 should be billed in conjunction with one of the PAF program E/M codes with modifier 95 appended and the CMS place of service (POS) code that would have been reported if the service had been furnished in person.
- To indicate that a PAF telehealth visit was performed using real-time interactive audio only, the CPT code 96160 should be billed in conjunction with one of the telephone evaluation and management CPT codes, 99441 through 99443.
- Visits performed using real-time interactive audio only do not satisfy the face-to-face requirement for purposes of risk adjustment data eligibility.

2. **Can the Member Summary with clinical inference be done via telehealth and can it be done using real-time interactive audio only? (REVISED)**

   ANSWER: Yes, for providers with an Active Member Summary with clinical inference contract amendment in place, Humana will continue to pay providers for completing the clinical inference section using telehealth or other virtual technology. We will continue to reassess the Active Member Summary with clinical inference program and communicate any updates with our physician groups at that time.

   - To indicate that a Member Summary visit was performed via a real-time interactive audio and video telecommunications service, please bill the applicable code for the visit with modifier 95 appended and the CMS place of service (POS) code you would have reported if the service had been furnished in person.
   - To indicate that a Member Summary visit was performed via an audio-only service, please use one of the telephone evaluation and management CPT codes, 99441 through 99443.

3. **If a telehealth consultation discusses and addresses a HEDIS/Stars quality gap, is Humana going to be able to capture that measure and give providers credit?**

   ANSWER: From a HEDIS perspective, telehealth is always acceptable for numerator compliance, unless the National Committee for Quality Assurance (NCQA) specifically excludes telehealth within their Technical Specifications. In the most recent guidance, these exclusions only apply to HEDIS measures targeting child and adolescent care. As always, it is important that related claims are coded appropriately and that services are documented accurately and completely in your patients' outpatient medical record. Please reference this guide for coding information:

   Telephonic and interactive video/audio consultations can be administered for the following HEDIS measures:

   a. Medication Reconciliation Post-Discharge (MRP)
   b. Care for Older Adults (COA) – Medication Review, Functional Status Assessment and Pain Screening, Advance Care Planning.
   c. Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy, but only if the telehealth visit is with a nephrologist
   d. Transitions of Care (TRC)
   e. Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (FMC)

   During a telehealth visit, information can also be gathered from patients regarding the administration and results of prior care. Submission of medical records with this care documented addresses these Stars HEDIS measures:

   a. Comprehensive Diabetes Care (CDC) – Eye Exam and Blood Sugar Controlled
   b. Breast Cancer Screening (BCS)
   c. Colorectal Cancer Screening (COL)

   Additionally, healthcare providers are able to have conversations with their patients that impact HEDIS and other Stars measures that relate to care coordination and medication management. These discussions may also improve your patient's experience and adherence with care plans and maintenance medication for chronic conditions.

Prescriptions can be provided for the following medications:

a. Disease-Modifying Anti-Rheumatic Drug (DMARD) to address Therapy for Rheumatoid Arthritis (ART)
b. Osteoporosis medications to address Osteoporosis Management in Women Who Had a Fracture (OMW)
c. Statins for Statin Therapy for Patients With Cardiovascular Disease (SPC) and Statin Use in Persons with Diabetes (SUPD)

4. **Are partial hospitalization and intensive outpatient services performed by telehealth billable services?**

ANSWER: Yes, partial hospitalization and intensive outpatient services are temporarily billable as telehealth services during the COVID-19 public health emergency. Modifier 95 should be used to indicate the service was provided virtually. Please refer to applicable CMS guidance and state guidance.

5. **Is group therapy conducted by telehealth a billable service?**

ANSWER: Yes, CPT code 90853 is temporarily billable as a telehealth service during the COVID-19 public health emergency. Modifier 95 should be used to indicate the service was provided virtually according to Humana Policy. Please refer to applicable CMS guidance, state guidance and Humana policy for additional information.

6. **Is psychological testing performed by telehealth a billable service?**

ANSWER: Yes, CPT codes 96130-96133, 96136-96139 and 96121 are billable as telehealth services during the COVID-19 public health emergency. Modifier 95 should be used to indicate the service was provided virtually according to Humana policy. Please refer to applicable CMS guidance, state guidance and the Humana policy for additional information.

7. **Are Applied Behavioral Analysis services performed by telehealth billable services?**

ANSWER: Yes, when ABA services are covered by a plan, service codes 90889, H2012, H2019, H0031, H0032, 97151-97158, 0362T, and 0373T are billable as telehealth services. Modifier 95 should be used to indicate the service was provided virtually according to Humana policy. Please refer to applicable CMS guidance, state guidance and Humana policy for additional information.

REVISED FAQs - DATED 4/1/20

SERVICE AVAILABILITY

1. **Will Humana reimburse for phone-based services or interactions with a member (non-video); does this qualify as a telehealth service?**

ANSWER: Yes, if a telehealth service can appropriately be furnished without real-time interactive video, Humana will cover it as long as it is provided through real-time interactive audio, and doing so is permitted by applicable Medicare and state requirements, and the service meets any other relevant coverage criteria as outlined in Humana's revised COVID-19 Telehealth and Other Virtual Services Claims Payment Policy. Note that some state laws may restrict the ability of a provider to render telehealth services by telephone. Providers may still be subject to these state-level restrictions and must determine applicability. Refer to CMS and state guidelines[1] for more information.

In addition to the telehealth services discussed above, Humana plans allow other virtual services, often referred to as virtual check-ins, e-visits and telephone evaluation and management (E/M) services, to provide further access to virtual care. Please refer to Humana's policy for further information.

2. **What are the billing codes for phone-based services or interactions with a member (non-video)?**

ANSWER: For guidance on billing Humana plans for services provided remotely without video, please refer to Humana's policy and any relevant state requirements.

3. **Will Humana reimburse for email interactions with a member; does this qualify as a telehealth service?**

ANSWER: No, email interactions do not qualify as true telehealth services. Commercial, Medicaid and Medicare Advantage telehealth services must be rendered through real-time interactive audio only or real-time audio and video.

However, Humana plans do allow other virtual services in addition to telehealth services. Those permitted virtual services include e-visits using online patient portals and virtual services in which a practitioner reviews video and/or images submitted by their patient using various telecommunications modalities. Please refer to Humana's policy for further information.

4. **Are telehealth services by out-of-network providers covered benefits for members in an HMO product?**

ANSWER: Humana will cover out-of-network telehealth claims related to COVID-19 even if the HMO does not have out-of-network benefits. Telehealth claims not related to COVID-19 will be processed in accordance with the plan's out-of-network benefit if the HMO has out-of-network benefits. Medical necessity, as well as applicable CMS guidelines and other plan rules, will continue to apply.

5. **Should providers utilize the SAME service code, place of service (POS) code and modifier for telehealth services as if they were in person?**

ANSWER: When billing for a telehealth service provided to one of your patients covered by a Humana MA or commercial plan, bill with the same service code and same place of service (POS) code you would have used if the service had been rendered in person. Also, report Modifier 95 to indicate that the service was rendered via telehealth. There are unique services codes you should bill for other virtual services such as e-visits, virtual check-ins and telephone E/M services. See Humana policy for further information. Follow the appropriate state Medicaid guidance when billing for a telehealth or other virtual service provided to a patient covered by a Humana Medicaid plan.

6. **If a member is out of the service area, where only emergent or urgent care would be covered by the plan, and requests a telehealth visit for routine care, will Humana cover the telehealth visit?**

   ANSWER: Yes, Humana will cover a telehealth visit that occurs outside the member's service area. Medical necessity, as well as applicable CMS guidelines and other plan rules, will continue to apply.

7. **Can an annual wellness visit be performed by telehealth?**

   ANSWER: Yes, telehealth can be used for annual wellness visits if provided consistent with applicable CMS guidance, state guidance and Humana policy.

8. **Can any provider offer telehealth services? What are the "qualification rules" for offering those services?**

   ANSWER: The provider must satisfy applicable federal and state qualified health care practitioner requirements including, but not limited to, licensure, certification and registration requirements. Check CMS guidelines or the applicable state-specific rules for the most updated list of distant site practitioners. Humana does not currently have additional credentialing requirements for the provision of telehealth for its contracted providers.

9. **Regardless of whether it is COVID-19 related, can a provider use his or her own platform for telehealth visits?**

   ANSWER: Yes, providers may use their own platforms to conduct telehealth visits for their patients. Providers should note that the Office for Civil Rights (OCR) has issued guidance regarding the use of audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency. Specifically, OCR has stated that providers can use any non-public-facing remote communication product that is available to communicate with patients.

   This includes popular applications that allow for video chats and are technology vendors that will enter into Health Insurance Portability and Accountability Act (HIPAA) compliant business associate agreements (BAAs), such as:

   - Skype for Business
   - Updox
   - VSee
   - Zoom for Healthcare
   - Doxy.me
   - Google G Suite Hangouts Meet

   Providers should notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications. Publicly facing applications such as Facebook Live, Twitch, TikTok and similar video communication applications should **not** be used by providers.

10. **Are home health services performed by telehealth billable services?**

    ANSWER: Yes, check CMS guidelines or the applicable state-specific rules for the most updated list of distant site practitioners. If the distant site practitioner requirements are satisfied, the home health service must also be one that is approved for telehealth. Because home health service rules continue to evolve, please check Humana's COVID-19 provider website regularly for updates.

11. **Are therapy sessions conducted by telehealth billable services?**

    ANSWER: Yes, when the therapy service is provided consistent with CMS guidelines, state regulations and Humana policy.

12. **For CPT codes 99441, 99442, and 99443 specifically, are professionals who are not MDs and are not DOs, such as licensed professional counselors (LPC), licensed clinical social workers (LCSW) and licensed marriage and family therapists (LMFT), eligible for telehealth billing? For CPT codes 98966, 98967, and 98968, are professionals with temporary associate licenses eligible for telehealth billing?**

    ANSWER: All CPT codes associated with a given plan AND delivered by an appropriately licensed provider are eligible for telehealth reimbursement per CMS guidelines, state regulations and Humana policy.

13. **Is a physical therapist considered an eligible provider to deliver services via telehealth? (REVISED)**

    ANSWER: Previously, CMS did not consider a physical therapist eligible to bill for services provided via telehealth. However, in the interim final rule with comment period CMS-5531-IFC, CMS eased restrictions to permit providers to be reimbursed for services provided during the PHE, for dates of service March 1 and later, via telehealth that must ordinarily be furnished in person. As discussed above, at a minimum, Humana applies the same waivers that Original Medicare does. Therefore, Humana Medicare Advantage plans now permit providers to bill for services provided via telehealth, including those that would ordinarily only be covered if furnished in person, to the same extent that Original Medicare does. (Humana was already permitting providers to bill for such services provided to members of commercial plans when CMS published CMS-5531-IFC.)

    Additionally, physical therapists, occupational therapists and speech-language pathologists continue to be eligible to bill for and be reimbursed for other virtual services, such as virtual check-ins (G2010 and G2012), e-visits (G2061-G2063) and telephone evaluation and management (E/M) services (98966-98968). For further information, please refer to Humana policy, state regulations, and applicable state-specific rules.

14. **Will Humana be lifting restrictions on originating site, following CMS lifting of restrictions due to COVID-19?**

    ANSWER: Yes, Humana will adopt all waivers CMS publishes for services provided via telehealth to its Medicare Advantage members, including those pertaining to originating site requirements. In

accordance with current CMS policy, the originating site may be the patient's home. For further details, please refer to Humana policy and the CMS website.

MEMBER COST-SHARING

Member "cost-sharing" refers to any portion of the amount allowed for a covered service that the member must pay the provider, including deductible, co-pay and coinsurance. Where Humana is waiving cost-sharing, commercial members who seek care from out-of-network providers could experience balance billing. We encourage commercial members to use participating providers to avoid this situation. We will also work with out-of-network commercial providers to negotiate the reduction or elimination of balance billing related to Coronavirus testing and treatment.

1. **Is member cost-sharing waived for telehealth services for all segments including commercial, Medicaid and Medicare?**

   ANSWER: Yes, member cost-sharing is waived for in-network telehealth and other virtual services. In addition, member cost-sharing is waived for out-of-network COVID-19-related services, including but not limited to those rendered via telehealth or other virtual methods. Medical necessity, as well as applicable CMS guidelines and other plan rules, will continue to apply. See Humana policy for more information.

   As noted above, commercial members who seek care from out-of-network providers could experience balance billing.

2. **Is Humana covering the following procedure codes with no out-of-pocket costs?**

Virtual Check-ins	E-Visit	Telephone E/M
G2010	99421-99423	98966-98968
G2012	G2061-G2063	99441-99443

   ANSWER: Yes, Humana will cover in- and out-of-network virtual telehealth services related to COVID-19, including virtual check-ins, e-visits and telephone E/M services. For telehealth and other virtual services related to COVID-19, Humana will waive member cost-sharing for the services, regardless of the provider's network status. Member cost-sharing waivers will also apply to all in-network telehealth and other virtual service claims not related to COVID-19. Cost-sharing waivers do not apply to non-COVID-related out-of-network claims, which will be processed in accordance with the plan's out-of-network benefit. Medical necessity, as well as applicable CMS guidelines, state regulations and Humana policy rules, will continue to apply to all services being delivered via telehealth and other virtual methods.

3. **Is member cost-sharing waived for telehealth services that are not urgent care?**

   ANSWER: Yes. Please see question 1 and 2 of this section for additional information about the application of cost-sharing waivers to services delivered via telehealth and other virtual methods. See Humana policy for more information.

4. **Is Humana waiving cost-sharing for the initial office visit COVID-19 testing, and should the office visit and testing be billed on the same claim?**

   ANSWER: Yes, Humana is waiving the office visit cost-sharing, and it's not necessary to bill the office visit and the testing on the same claim. However, to ensure that the cost-sharing is waived, a claim for an office visit related to COVID-19 testing should include Modifier CS and the appropriate ICD-10-CM diagnosis code(s) indicating that the service was related to COVID-19 testing.

5. **Is cost-sharing waived for testing and follow-up PCP visits related to COVID-19?**

   ANSWER: Yes, cost-sharing is waived for COVID-19 testing including for the PCP visit where the test is ordered or administered. The cost-sharing waiver also includes follow-up visits via telehealth and other virtual methods. However, to ensure that the cost-sharing is waived a claim for an office visit related to COVID-19 testing should include Modifier CS and the appropriate ICD-10-CM diagnosis code(s) indicated that the service was related to COVID-19 testing.

   As noted above, commercial members who seek care from non-par providers could experience balance billing.

6. **Is cost-sharing waived for testing and follow-up specialist visits via telehealth?**

   ANSWER: Yes, cost-sharing is waived for COVID-19 testing, including a specialist visit where the test is ordered or administered. The cost-sharing waiver also includes follow-up visits via telehealth and other virtual methods. However, if the follow-up specialist care is not COVID-related, member cost-sharing will be waived only if delivered by a participating/in-network provider. Note that, to ensure that, when appropriate, cost-sharing is waived, a claim for an office visit related to COVID-19 testing should include modifier CS and the appropriate ICD-10-CM diagnosis code(s) indicating that the service was related to COVID-19 testing.

   As noted above, commercial members who seek care from non-par providers could experience balance billing.

PROVIDER PAYMENT

1. **For covered services provided via telehealth, are reimbursement rates the same as in-person (in-office), or are they reduced?**

   ANSWER: Humana is reimbursing an office visit furnished via telehealth by an in-network practitioner at the same rate as an in-person office visit.

   To enable such claims processing, Humana strongly recommends that a provider submit a charge for a telehealth service with the place of service (POS) code that would have been reported had the service been furnished in person and to append modifier 95 to identify that the service was furnished via telehealth. See Humana policy for more information.

2. **How is a capitated, value-based provider reimbursed for telehealth services? Is there a separate fee-for-service payment or is reimbursement included in the provider's capitation payment?**

   ANSWER: Claims will be paid for encounters based on the CPT code that was billed. If the service is included in the provider's capitation payment when performed at the provider's physical location, then it will also be included in the provider's capitation payment when delivered via telehealth. This also applies to sub-capitated specialist providers.

3. **Are waived member cost-share amounts that are funded by Humana charged back to value-based providers through their Service Fund accounting?**

   ANSWER: Yes.

OTHER

1. **When is the effective date of Humana's modified telehealth policy? Will it be applied retroactively to claims already submitted? (REVISED)**

   ANSWER: The effective date of Humana's decision to expand coverage of telehealth and other virtual services is March 6, 2020. The effective date of Humana's waivers of COVID-related cost-share is February 4, 2020. The changes will be applied retroactively to claims previously submitted for dates of service on and after the relevant effective date(s).

2. **Where can providers locate additional information regarding Humana's telehealth policy, billing requirements and fee schedule for telehealth due to the COVID-19 pandemic?**

   ANSWER: Please see Humana's COVID-19 telehealth and other virtual services policy, which includes billing requirements and reimbursement information.

3. **Are telehealth services billable services for Federally Qualified Health Centers (FQHCs)? Are there any exclusions for FQHCs?**

   ANSWER: Refer to CMS fact sheets for FQHC and RHCs.

[1]Humana is not affiliated with the Center for Connected Health Policy. This link is provided as a resource for your convenience. Humana has not independently verified the information contained on this website.