

Telehealth and Telemedicine Expanded Services for COVID-19 – Updated for Public Health Emergency Ending

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Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a

Policy #: RPM073

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All)

Provider Contract Status: Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions)

Claim Dates: Details below

Navigation Quick Links

[Additional Scope Information](#)

[All Lines of Business, New Patient versus Established Patient Determinations](#)

[Waivers Ended May 11, 2023](#)

[Waivers Ended on August 9, 2023](#)

[Waivers Ended December 31, 2023](#)

[Waivers Ended December 31, 2024](#)

[Waivers Ending on September 30, 2025](#)

[Waivers Ending on December 31, 2025](#)

[Items Not Changing with End of PHE](#)

Reimbursement Guidelines

A. Additional History and Scope Information

1. **Beginning** - Effective for date of service March 6, 2020 in response to the declaration of a public health emergency (PHE) and CMS policy updates, we expanded our policies around telehealth services for all plans and members, making it even easier and safer for patients to connect with their health care provider during the COVID-19 outbreak.
2. This policy temporarily supplements RPM052, “Telehealth And Telemedicine Services” due to the COVID-19 public health emergency (PHE). The policy is meant to outline the expanded coverages and changes, rather than going into the extent and detail contained in RPM052.
3. **PHE Ends** - On January 30, 2023 the Biden Administration announced that the National Emergency (NE) and the Public Health Emergency (PHE) would end on May 11, 2023 (101-day notice).^{31, 65}
 - a. During the Federal PHE, waivers and exemptions were put in place by federal and state regulators to expand telehealth services.
 - b. Some of these waivers and exemptions end with the Federal PHE on May 11, 2023, and others have been extended through the end of 2023 and/or 2024 under the Consolidated Appropriations Act of 2022 and Consolidated Appropriations Act of 2023.
 - c. This policy is now being updated to specify the termination dates for each of the telehealth flexibilities, expansions, waivers, and exemptions from the PHE.
4. Applicable state telehealth expansions for the PHE:
 - a. **Oregon Commercial and Medicaid plans:**

- i. The voluntary temporary agreement between certain insurance carriers and the State of Oregon to provide expanded telehealth options expired on June 1, 2021.
- ii. In June of 2021, House Bill 2508 was signed into law, amending ORS 743A.058 to create new telehealth provisions stipulating that telemedicine shall be reimbursed at the same rate as in-person services. It also set parameters for telehealth services provided during a declared state of emergency. Our plan filings have been updated to reflect these revisions.
- b. **Alaska Commercial plans** – the expanded coverage from the state of Alaska directives has been made permanent. Please refer to [RPM052, “Telehealth And Telemedicine Services”](#) for Alaska telehealth guidelines. (See AS 21.42.422 & SCS HB 29.)
- c. **Texas plans** – All requirements of Texas Insurance Code Section 1455.004 resumed on September 20, 2021. (TDI³⁰) Please refer to [RPM052, “Telehealth And Telemedicine Services”](#) for Texas telehealth guidelines.

B. New Patient versus Established Patient Determinations

Telemedicine services count the same as an in-office visit for the purposes of determining if the patient is a new patient or an established patient when they are receiving future visits and services. This applies to all lines of business. For further detail, see RPM052, Section A.

C. Ended on May 11, 2023.

The following expanded PHE provisions and telehealth waivers end on May 11, 2023 for all plans and lines of business, unless a specific line of business or variation is noted:

1. HIPAA violation penalties against providers using everyday communication technologies were waived by the HHS Office for Civil Rights during the PHE. The requirement for HIPAA compliance resumes on May 12, 2023. ^{58, 59, 60}

However, the HHS Office for Civil Rights has announced a 90-day transition period (or grace period) during which the OCR will continue to not impose penalties on covered health care providers for noncompliance with the HIPAA Rules that occurs in connection with the good faith provision of telehealth. [This grace period ends on August 9, 2023.](#) ⁶⁶

2. Place of Service (POS) codes:
 - a. For Commercial and Medicare Advantage plans:

For all telehealth services performed on 3/1/2020 through the end of the PHE, do not use POS 02 or 10, but instead:

 - i. Bill with the Place of Service (POS) equal to what it would have been in the absence of a PHE.
 - ii. Append modifier 95 (which CMS does not otherwise accept).
 - iii. This will indicate that the service rendered was performed via telehealth during the PHE. ¹⁸
 - iv. Beginning May 12, 2023, report telehealth services with POS 02 or 10 (whichever is appropriate based on the patient’s location).
 - b. For Medicaid plans, continue to bill using telehealth POS as before the PHE:
 - i. Note: On Thursday, December 16, 2021 the Oregon Health Authority (OHA) notified us that OHP Medicaid will not be utilizing POS 10 at this time. Continue to use POS 02 for all Medicaid claims for services delivered using a telehealth modality until further notice from OHA.
 - ii. Bill with modifiers GT, GQ, and 95. Refer to [RPM052, “Telehealth and Telemedicine Services”](#) for information.
 - iii. For members with Medicare as primary, bill according to CMS guidelines. As secondary will process based on Medicare paid amounts, telemedicine coding doesn’t have to match OHP claims coding to pay secondary in MMIS per OAR 410-120-1280.

3. Modifier “CR” was required during the PHE for some services, but was only voluntary, not required, on telehealth services. Discontinue use of modifier CR on date of service May 12, 2023.⁴⁹
4. Modifier “CS” was required during the PHE for medical visits (telehealth or non-telehealth) related to COVID-19 testing. Discontinue use of modifier CS on date of service May 12, 2023.⁴
5. Condition code “DR” was required on facility claims during the PHE for some services. Discontinue use of condition code DR on date of service May 12, 2023.⁴⁹
6. During the PHE, cost-sharing did not apply for COVID-19 testing-related services (both telehealth and non-telehealth), including the visit when COVID-19 testing is performed or ordered.

For detailed information about what qualifies a visit to be related to COVID-19 testing, see 2020-04-07-MLNC-SE.¹⁹

7. When the COVID-19 PHE ends, Medicare payment for virtual communication services (G0071) will no longer include online digital evaluation and management services and these services may only be provided to established patients.⁵⁶ For Commercial plans and Oregon Medicaid plans, G0071 is for reporting-only and not eligible for separate reimbursement.
8. E-visits (online digital evaluation services, 99421-99423, 98970-98972, G2061-G2063). E-visit procedure code descriptions state “established patients” but during the COVID-19 PHE these codes could be used for new patient visits also.¹⁷
 - a. Medicare Advantage plans:

Beginning on May 12, 2023, e-visits are only eligible to be used for established patients, consistent with the procedure code descriptions.^{51, 57} Note: E-visits are not considered telehealth by CMS; they are covered by Medicare separately from the telehealth rules.

 - i. E-visits do not have rural location requirements.
 - ii. Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits and report them using HCPCS codes G2061-G2063.
 - b. Medicaid plans: Beginning on May 12, 2023, e-visits are only eligible to be used for established patients, consistent with the procedure code descriptions.
 - c. Commercial plans:

Prior to the PHE, online digital evaluation services (E-visits) using non-real-time technologies, such as email, provider portal communication, and instant messaging were not covered benefits on standard Commercial plans or were considered included in the reimbursement for any related face-to-face services performed before or after the contact. Telehealth services were expanded during the PHE to include communication methods that were not real-time and/or do not include audio-visual communication.

On May 12, 2023, these services will no longer be separately covered for Commercial plans, unless the member is on a non-standard plan with specific coverage language for online digital communication (email, portal communications, messaging, etc.).
9. Telehealth allowed to fulfill many face-to-face visit requirements for clinicians to see their patients in inpatient rehabilitation facilities and hospice.^{54, 55}
10. Hospital Outpatient Services in Provider-Based Departments (PBDs) may no longer provide services at home via telehealth and bill originating site fee Q3014. When the PHE ends, hospitals and CAHs will be required to provide services to patients within their hospital departments.⁵⁷

11. Remote patient monitoring (a/k/a remote physiologic monitoring) is closely related to telehealth. Sometimes it is considered a different method of care and treatment which pairs well with telehealth,³² and other times it is considered a third technology method of telehealth.⁴⁷
 - a. Established patient relationship requirement – Beginning May 12, 2023, clinicians must once again have an established relationship with the patient prior to providing RPM services.⁶²
 - b. Duration of services requirement – During the PHE, if the patient was diagnosed with, or was suspected of having, COVID-19 and all other requirements were met, clinicians were allowed to bill CPT codes 99453 and 99454 when as few as two days of data were collected. Beginning on May 12, 2023, clinicians must return to only billing for these services when at least 16 days of data have been collected (these are monthly codes and services must be performed for more than half of the month for billing).

D. Ended on August 9, 2023.

The requirement for [telehealth HIPAA compliance resumes on May 12, 2023](#).^{58, 59, 60} The OCR transition period (grace period) ends on August 9, 2023. On August 10, 2023, providers are subject to penalties for noncompliance with HIPAA rules in connection with telehealth technology and services.⁶⁶

E. Ended on December 31, 2023.

The following expanded PHE provisions and telehealth waivers will end on December 31, 2023 for all plans and lines of business, unless a specific line of business or variation is noted:

Physicians may supervise their clinical staff using virtual technologies when appropriate, instead of requiring in-person presence.^{16, 32}

F. Ended on December 31, 2024.

The following expanded PHE provisions and telehealth waivers will end on December 31, 2024 for all plans and lines of business, unless a specific line of business or variation is noted:

1. Certain telehealth visits stipulated by CMS (see CMS list of telehealth-approved codes) can be delivered audio-only (such as a telephone) if someone is unable to use both audio and video, such as a smartphone or computer.^{32, 61} (Note that this flexibility is being permanently adopted in a broader context due to changes contained in the Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule.^{68, 69}) Keep in mind that aside from telephone calls, the telehealth requirement for HIPAA compliance resumes on May 12, 2023 and penalties for HIPAA violations resume August 10, 2023.^{58, 59, 66, 60, 34}
2. Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services can be paid for as Medicare telehealth services. Specific procedure codes were added to the CMS telehealth procedure code list.^{36, 48}
 - a. Physical Therapy Evaluations 97161-97164.
 - b. Physical Therapy Procedures 97110, 97112, 97116, 97150, 97530, 97535, 97537, 97542, 97750, 97755, and 97763.
 - c. Biofeedback training, 90901.
 - d. Patient self-management, 98960, 98961, and 98962.
 - e. Occupational therapy, 97165, 97166, 97167, 97168.
 - f. Speech therapy, 92522 and 92523.
3. Virtual check-in services may continue to be used for established patients from May 12, 2023 through December 31, 2024.¹⁶ Note: Virtual check-ins (G2010, G2012) are not considered telehealth services by CMS; they are covered by Medicare separately from the telehealth rules.^{51, 39}
 - a. Virtual check-ins do not have a rural location requirement.
 - b. Virtual check-ins do not have specific originating site limitation.

4. The required face-to-face encounter for home health can be conducted via telehealth when the patient is at home.⁵⁶

G. Ending on September 30, 2025.

The following expanded PHE provisions and telehealth waivers will end on September 30, 2025 for all plans and lines of business, unless a specific line of business or variation is noted:

1. The patient does not have to reside in a rural location to receive telehealth services.^{1, 2, 34, 73}
2. The patient can receive telehealth services in their home or any setting of care.^{1, 2, 34, 73}

H. Ending on December 31, 2025.

The following expanded PHE provisions and telehealth waivers will end on December 31, 2025 for all plans and lines of business, unless a specific line of business or variation is noted:

Providers may furnish telehealth services from any location, including the provider's home.^{11, 34, 67, 68}

I. Not changing or ending.

The following telehealth guidelines will not change or be affected by the end of the PHE. These apply for all plans and lines of business, unless a specific line of business or variation is noted:

1. The use of telehealth services was strongly encouraged during the PHE to contain the spread of this new virus and the COVID-19 outbreak. After May 11, 2023, when the PHE is declared over, telehealth services should continue to be used as clinically appropriate under standard (non-PHE) telehealth coverage guidelines.
2. Modifiers for telehealth services:
 - a. Continue to use modifiers GQ and G0 when required by current Medicare rules for traditional telehealth services:
 - i. Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier.
 - ii. Furnished for diagnosis and treatment of an acute stroke, use G0 modifier.
 - b. Critical access hospital method II claims should continue to bill with modifier GT.¹⁸
3. Continue to use place of service codes 02 and 10 to designate telehealth for Medicare and Commercial claims, and place of service 02 for Medicaid claims. No additional telehealth modifier will be needed when real-time audio + visual HIPAA-secure technology is used (unless a specific guideline exists).
4. List of procedure codes and services allowed to be performed as telehealth:
 - a. Medicare Advantage:

As part of the PHE flexibilities, Medicare expanded the list of procedure codes covered as telehealth services, retroactive to date of service March 1, 2020. (CMS¹⁶) Medicare updates the list annually. Should the expanded coverage of some of those specific procedure codes come to an end, they will no longer appear on the list of Medicare telehealth procedure codes. This list can be found at: <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>.
 - b. Medicaid:
 - i. Medicaid allows all of the Medicare-approved telehealth procedure codes as well as additional codes and services specified under the CCO coverage lists and on the OHA fee schedules as eligible for modifier GT.
 - ii. For Medicaid telehealth consultations for emergency and inpatient services, refer to the current or applicable for date of service [Prioritized List of Health Services](#), Ancillary Guideline A5, Telehealth, Teleconsultations and Online/Telephonic Services.

- iii. For members with Medicare as primary, bill according to CMS guidelines. As secondary will process based on Medicare paid amounts, telemedicine coding doesn't have to match OHP claims coding to pay secondary in MMIS per OAR 410-120-1280.
 - c. Commercial plans:
Commercial plans allow all the Medicare-approved telehealth procedure codes as well as additional codes and services covered under the plan which can safely and effectively be performed via telehealth.
5. Telehealth cost-sharing is never more than if the service was performed in person.
 6. Modifier 93 was added on 1/1/2022 to indicate telehealth services provided using audio-only technology (e.g., telephone, provider portal audio-only). Modifier 93 does not need to be appended to procedure codes with "telephone" in the code description, such as 99441 – 99443.
 5. For dates of service 1/1/2025 and after, if the distant site physician or practitioner is technically capable of using an interactive telecommunications system, but the patient is not capable of, or does not consent to, the use of video technology, then any telehealth service (not restricted to a specific code list) may be delivered by two-way, real-time audio-only communication technology (such as phone calls).^{74, 75} Keep in mind that aside from telephone calls, the telehealth requirement for HIPAA compliance resumed on May 12, 2023 and penalties for HIPAA violations resumed August 10, 2023.^{58, 59, 66, 60, 34}

Definitions

Acronyms/Abbreviations

Acronym	Definition
AMA	American Medical Association
CAE 2025	Full-Year Continuing Appropriations and Extensions Act, 2025 ⁷³
CCA 2023	Consolidated Appropriations Act, 2023 ³³⁻³⁹
CDC	Centers for Disease Control
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
FQHC	Federally Qualified Health Center
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HHS	The U.S. Department of Health and Human Services (HHS)
HIPAA	Health Insurance Portability and Accountability Act
ICD-10-CM	International Classification of Diseases, Tenth Edition, Clinical Modification
OCR	Office of Civil Rights (branch of HHS that enforces HIPAA)
OHA	Oregon Health Authority
OHP	Oregon Health Plan (aka Oregon Medicaid)
PHE	Public Health Emergency
PHEIC	Public Health Emergency of International Concern
RHC	Rural Health Clinic
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RPM	Remote Physiologic Monitoring (also known as/see also Remote Patient Monitoring)
WHO	World Health Organization

Definition of Terms

Term	Definition
Pandemic	A global outbreak of disease.
Public Health Emergency	An extraordinary event which is determined to constitute a public health risk through the spread of disease and requires a coordinated response.
Public Health Emergency of International Concern (PHEIC)	A formal declaration by the World Health Organization (WHO) of a public health emergency of international scale. ¹⁰
Remote Patient Monitoring (RPM) Remote Physiologic Monitoring (RPM)	Remote patient/physiologic monitoring (RPM) is using technology to enable monitoring of patients outside of conventional clinical settings (e.g., monitoring the patient in the home instead of in the clinic or the hospital). The monitoring involves the collection and analysis of patient physiologic data (e.g., heart rate, blood pressure, weight, temperature, glucose level, etc.) that are used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. ⁶⁴ Remote patient monitoring may be part of Home Health Agency services or may be handled directly by a physician/clinic.

Procedure codes (CPT & HCPCS):

- For a list of telehealth services covered under each type of plan, see “[Telehealth And Telemedicine Services](#),” Moda Health Reimbursement Policy Manual, RPM052.
- See [here for a list of key PHE telehealth coding changes for Commercial plans](#) (effective for dates of service March 6, 2020 to May 11, 2023).

Modifiers

Modifier	Modifier Description & Definition
CR	Catastrophe/disaster related
CS	Cost-sharing waived for specified COVID-19 testing-related services that result in an order for, or administration of, a COVID-19 test and/or used for cost-sharing waived preventive services furnished via telehealth in Rural Health Clinics and Federally Qualified Health Centers during the COVID-19 public health emergency

Diagnosis Codes (ICD-10)

Code	Code Description
B97.21	SARS-associated coronavirus as the cause of diseases classified elsewhere
B97.29	Other coronavirus as the cause of diseases classified elsewhere (Comment: For confirmed cases of COVID-19 for DOS 3/31/2020 and earlier)
U07.1	COVID-19 [acute respiratory disease] (Comment: Effective for DOS 4/1/2020 and following ¹⁵)
Z03.818	Encounter for observation for suspected exposure to other biological agents ruled out
Z20.828	Contact with and (suspected) exposure to other viral communicable diseases

Place of Service Codes

Note: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service. ³

Code	Short Description	Place of Service Code Long Description
02	Telehealth	The location where health services and health related services are provided or received, through telecommunication technology. (Does not apply to originating site facilities billing a facility fee.) (Effective for claims submitted 1/1/2017 – 12/31/2021, regardless of date of service.)
02	Telehealth Provided Other than in Patient’s Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology. (Description change effective January 1, 2022, and applicable for Medicare April 1, 2022.)
10	Telehealth Provided in Patient’s Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology. (This code is effective January 1, 2022, and available to Medicare April 1, 2022.)

Condition Code

Condition Code	Condition Code Description
DR	Disaster Related

Related Policies

- A. [“Moda Health Reimbursement Policy Overview.”](#) Moda Health Reimbursement Policy Manual, RPM001.
- B. [“Telehealth and Telemedicine Services.”](#) Moda Health Reimbursement Policy Manual, RPM052.

Resources

1. CMS. “Medicare Telehealth Frequently Asked Questions (FAQs).” Last updated January 7, 2021; Last accessed March 13, 2023. <https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf> . [3/13/23: Info not current. No mention of PHE ending.]
2. CMS. “Medicare Telemedicine Health Care Provider Fact Sheet.” March 17, 2020; Last accessed March 13, 2023. <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet> . [3/13/23: Info not current. No mention of PHE ending.]
3. OHA. “Health Evidence Review Commission (HERC) guideline Note A5.” March 20, 2020; Last accessed March 25, 2020. <https://www.oregon.gov/oha/HPA/DSI-HERC/SearchablePLdocuments/Prioritized-List-GN-A005.docx> . [3/13/23: This link now goes to the 2023 list, so the 2020 list is no longer available that I know of.]
4. OHA. “Public Notice, OHA State Plan Amendment.” March 20, 2020; Last accessed March 25, 2020. <https://www.oregon.gov/oha/HSD/OHP/Announcements/Public%20notice%20->

[%20State%20Plan%20Amendment%20to%20expand%20Medicaid%20coverage%20of%20telehealth%20services.pdf?fbclid=IwAR2um1xHr-lLP96FlbzM9OTYuO1Bl8SxJN-42y4jqK9nTMstxwtgrAEIu8](#) .

5. WHO. "Naming the coronavirus disease (COVID-19) and the virus that causes it." Last accessed March 23, 2020. [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it) .
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7. WHO. "Rolling updates on coronavirus disease (COVID-19) – Summary." Last updated July 31, 2020; Last accessed: March 13, 2023. <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen> . [3/23/23: Info not current. No mention of PHE ending.]
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9. OHA. "Oregon Health Authority | COVID-19 Updates | Situation in the U.S. and Globally." Last updated March 24, 2020; Last accessed March 25, 2020. <https://govstatus.egov.com/OR-OHA-COVID-19> . [3/13/23: Subtopic of Situation in the U.S. and Globally no longer exists on this page.]
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20. CMS. "New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)." MLN Matters Number: SE20016 Revised. <https://www.cms.gov/files/document/se20016-new-expanded-flexibilities-rhcs-fqhcs-during-covid-19-phe.pdf> . April 30, 2020; Last accessed March 6, 2023.
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22. CMS. "COVID-19: Non-Physician Practitioner Billing for Audio Services." MLNConnects, 2020-11-12-MLNC. November 12, 2020; Last accessed March 6, 2023. https://www.cms.gov/outreach-and-education/outreachffsprovpartprogprovider-partnership-email-archive/2020-11-12-mlnc#_Toc55891815 .
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Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
4/9/2025	Updated for CAE 2025. ⁷³ Acronyms & Resources updated. Formatting updates.
11/13/2024	Updated for extension/CMS adoption of two flexibilities scheduled to end 12/31/2024. Updated Cross References and References & Resources. Formatting updates.
2/14/2024	Clarified to use modifier 93 (audio-only) for telephone call visits. Updated References & Resources. Formatting updates.
5/2/2023	Complete overhaul of policy and revised policy title resulting from announced end of PHE on May 11, 2023 & related information from CMS, HHS, & other relevant sources.
12/14/2022	Formatting updates.
3/26/2020	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
3/6/2020	Original Effective Date (with or without formal documentation). Policy based on CMS policy & individual state legislative requirements.