



Behavioral Health Providers and Coverage for Virtual Visits and Telehealth

Behavioral Health providers can use telemedicine as another way to see patients outside the office.

HAP is waiving all member cost share for virtual visits and telehealth from March 15 through April 30. We'll continue to evaluate the effective date of this change as the pandemic response continues to evolve. All virtual visits and telehealth services will have cost share waived whether the service was initiated in response to COVID-19 symptoms or other general health concerns.

Definitions of telehealth and virtual visits

Telehealth is defined as real time audio/visual visit. Virtual visit is defined as a phone visit with provider. CMS guidelines have changed due to COVID-19; therefore, if a provider can do any kind of video or audio call such as FaceTime or Skype, that is considered a telehealth visit.

What HAP members/plans are impacted?

- Medicare (group and individual); individual members; fully insured employer group customers.
- HAP is working with self-insured customers to decide how each group will handle telehealth cost share for their employer-sponsored plans, as well as the effective date for any benefit plan changes.
- Medicaid has extended telehealth benefits to include visits based at home. HAP covers telehealth services for Medicaid members and there is no cost share associated with those services. HAP is working with the Michigan Department of Health and Human Services (MDDHS) to implement a solution for our Medicaid members. Conversations are happening on a daily basis. More information will be provided as soon as possible.

Billing for telehealth and virtual visits

Please see the attached medical policy. It includes covered behavioral health related codes.

HAP is working hard to ensure our members have access to our provider network during these challenging times.

Telemedicine, Telehealth, & Virtual Care Services

DESCRIPTION

Telehealth, telemedicine, virtual care services and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a Member's health. The method of health care delivery is rapidly expanding utilizing computers, cell phones, tablets or other mobile devices to add access and remove barriers to care. Use of telemedicine technology falls into two general categories: synchronous care and asynchronous care. Telemedicine generally involves the application of secure audio/video conferencing for real-time interactive communication. To be considered telemedicine under Michigan State law [Section 500.3476 of THE INSURANCE CODE OF 1956 (EXCERPT), Act 218 of 1956] the health care professional must be able to examine the patient via a real-time, interactive audio or video, or both, telecommunications system and the patient must be able to interact with the off-site health care professional at the time the services are provided

Telemedicine Services

- **Telehealth visit** uses interactive real-time telecommunication technology for office, hospital visits and other services that generally occur in-person. These communications are initiated by the Member.
- **E-visits** are nonface-to-face patient-initiated online evaluation and management services provided via an online patient portal. These services can only be reported when the billing practice has an established relationship with the Member. For E-Visits, the Member must generate the initial inquiry and communications can occur over a 7-day period.
- **Virtual check-in visits** are short patient-initiated communications with a healthcare practitioner via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image. These virtual check-ins are for Members with an established (or existing) relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available). The Member must verbally consent to receive virtual check-in services. The practitioner may respond to the Member's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

Telemedicine Technology:

- **Synchronous telehealth care**– live interaction (audio/video conference) between Member and Provider permitting two-way, real-time communications between an individual at the originating site and the healthcare professional at the distant site. These visits typically are used for office, hospital visits and other services that generally occur in-person. May be used by Members in either an established patient-provider relationship or as a new patient. Examples include:
 - Audio-Video visit:
 - AmWell visit
 - MyChart Mobile Video Visits
 - MyCare On Demand video visit: Member initiates contact and waits for next available provider (not pre-scheduled)
 - Scheduled Video visits – when the video visit is pre-scheduled similar to an office visit
 - Clinic-to-clinic or consultative telehealth visit (visit is between two health professionals with the Member present at the hosting or requesting end)
- **Asynchronous telehealth care** are those communications with a delayed response from the recipient. There is no real-time interaction. Asynchronous telehealth care is known as store and forward messaging involves messaging (including condition driven questionnaires) or data submission (monitoring) that the recipient will respond to within a specified time frame. These communications are used by Members in an established patient-provider relationship.
 - Messaging
 - E-consult
 - Remote monitoring
 - E-home care
 - Tele-radiology readings

COVERED CODES [NOTE: HAP Empowered/Medicaid Members follow the Medicaid fee schedule]

99421 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

- 99422 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
- 99423 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
- 99446 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
- 99447 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review
- 99448 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review
- 99449 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review
- 99451 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
- 99452 Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes
- G0071 Payment for communication technology-based services for 5 minutes or more of a virtual (nonface-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only
- G0406 Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
- G0407 Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
- G0408 Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth
- G0425 Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
- G0426 Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
- G0427 Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
- G0459 Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
- G0508 Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth
- G0509 Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth
- G2010 Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment

G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
G2061	Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes
G2062	Qualified nonphysician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes
G2063	Qualified nonphysician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes
G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month
G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)

ADDITIONAL COVERED CODES for Commercial Plan Members [per State of Michigan telehealth regulations, NOTE: HAP Empowered/Medicaid Members follow the Medicaid fee schedule]

98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

- 99442 Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
- 99443 Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
- 98970 Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- 98971 Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
- 98972 Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

SERVICES THAT MAY BE COVERED when identified as Telehealth and included on the Medicare Telehealth Services List

- . Medicare Telehealth Services List @ <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>
- 90785 Interactive Complexity (List Separately In Addition To The Code For Primary Procedure)
- 90791 Psychiatric Diagnostic Evaluation
- 90792 Psychiatric Diagnostic Evaluation With Medical Services
- 90832 Psychotherapy, 30 Minutes With Patient And/Or Family Member
- 90833 Psychotherapy, 30 Minutes With Patient And/Or Family Member When Performed With An Evaluation And Management Service
- 90834 Psychotherapy, 45 Minutes With Patient And/Or Family Member
- 90836 Psychotherapy, 45 Minutes With Patient And/Or Family Member When Performed With An Evaluation And Management Service
- 90837 Psychotherapy, 60 minutes with patient
- 90838 Psychotherapy, 60 Minutes With Patient And/Or Family Member When Performed With An Evaluation And Management Service
- 90839 Psychotherapy For Crisis; First 60 Minutes
- 90840 Psychotherapy For Crisis; Each Additional 30 Minutes (List Separately In Addition To Code For Primary Service)
- 90845 Psychoanalysis
- 90846 Family psychotherapy (without the patient present), 50 minutes
- 90847 Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
- 90951 Monthly ESRD Services, for Patients Younger Than 2 Years of Age; with 4 or More Face-To-Face Physician Visits Per Month
- 90952 Monthly ESRD Services, for Patients Younger Than 2 Years of Age; with 2-3 Face-To-Face Physician Visits Per Month
- 90954 Monthly ESRD Services, for Patients 2-11 Years of Age; with 4 or More Face-To-Face Physician Visits Per Month

90955 Monthly ESRD Services, for Patients 2-11 Years of Age; with 2-3 Face-To-Face Physician Visits Per Month

90957 Monthly ESRD Services, for Patients 12-19 Years of Age; with 4 or More Face-To-Face Physician Visits Per Month

90958 Monthly ESRD Services, for Patients 12-19 Years of Age; with 2-3 Face-To-Face Physician Visits Per Month

90960 Monthly ESRD Services, for Patients 20 Years of Age and Older; with 4 or More Face-To-Face Physician Visits Per Month

90961 Monthly ESRD Services, for Patients 20 Years of Age and Older; with 2-3 Face-To-Face Physician Visits Per Month

90963 End-Stage Renal Disease (ESRD) Related Services for Home Dialysis Per Full Month, for Patients Younger Than 2 Yrs of Age

90964 End-Stage Renal Disease (ESRD) Related Services for Home Dialysis Per Full Month, for Patients 2-11 Years of Age

90965 End-Stage Renal Disease (ESRD) Related Services for Home Dialysis Per Full Month, for Patients 12-19 Years of Age

90966 End-Stage Renal Disease (ESRD) Related Services for Home Dialysis Per Full Month, for Patients 20 Years of Age and Older

90967 End-Stage Renal Disease (ESRD) Related Services for Dialysis Less Than A Full Month of Service, Per Day; Pt < 2 Yrs

90968 End-Stage Renal Disease (ESRD) Related Services for Dialysis Less Than A Full Month of Service, Per Day; Pt 2-11 Yrs

90969 End-Stage Renal Disease (ESRD) Related Services for Dialysis Less Than A Full Month of Service, Per Day; Pt 12-19 Yrs

90970 ESRD Related Services for Dialysis Less Than A Full Month of Service, Per Day; Pt 20 Yrs of Age and Older

96116 Neurobehavioral status exam, per hr psychologist/physician time, patient time and interpretation/report time

96150 Health & Behavior Assessment, Ea 15 Minutes; Initial Assessment

96151 Health & Behavior Assessment, Ea 15 Minutes; Re-Assessment

96152 Health & Behavior Intervention, Ea 15 Minutes; Individual

96153 Health & Behavior Intervention, Ea 15 Minutes; Group (2+ Patients)

96154 Health & Behavior Intervention, Ea 15 Minutes; Family (W/Patient Present)

96160 Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument

96161 Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardiz

97802 Medical Nutrition Therapy; Initial Assessment & Intervention, Face-To-Face W/Pt, 15 Min

97803 Medical Nutrition Therapy; Re-Assessment & Intervention, Face-To-Face W/Pt, Each 15 Min

97804 Medical Nutrition Therapy; Group (2 Or More Ind),Each 30 Min

99201 Office/Op Visit, New Pt, 3 Key Components: Prob Focus Hx; Prob Focus Exam; Strtfrwd Med Decision

99202 Office/Op Visit, New Pt, 3 Key Components: Expand Prob Focus Hx; Expand Prob Focus Exam; Strtfrwd Dec

99203 Office/Op Visit, New Pt, 3 Key Components: Detailed Hx; Detailed Exam; Med Decision Low Complexity

99204 Office/Op Visit, New Pt, 3 Key Components:Comprehensive Hx;Comprehensive Exam;Med Decisn Mod Complex

99205 Office/Op Visit, New Pt, 3 Key Components:Comprehensive Hx;Comprehensiv Exam;Med Decisn High Complex

99211	Office/Op Visit, Est Pt, Not Requiring Physician Presence, Typically 5 Min
99212	Office/Op Visit, Est Pt, 2 Key Components: Prob Focus Hx; Prob Focus Exam; Strtfwd Med Decision
99213	Office/Op Visit, Est Pt, 2 Key Components: Expand Prob Hx; Expand Prob Exam;Med Decision Low Complex
99214	Office/Op Visit, Est Pt, 2 Key Components: Detailed Hx; Detailed Exam; Med Decision Mod Complexity
99215	Office/Op Visit, Est Pt, 2 Key Components:Comprehensive Hx;Comprehensiv Exam;Med Decisn High Complex
99231	Subsequent Hosp Care 2+ Key Components:Prob Focus Int Hx;Prob Focus Exam;Med Dec Strtfwd/Low Complex
99232	Subsequent Hosp Care 2+ Key Components:Expand Prob Focus Int Hx;Expand Prob Exam;Med Dec Mod Complex
99233	Subsequent Hosp Care 2+ Key Components: Detailed Intervl Hx; Detailed Exam;Med Decision High Complex
99307	Subsequent nursing facility care, per day, 2 of: problem focus history; problem focus exam; straightfwd decision making
99308	Subsequent nursing facility care, per day, 2 of: expdd problem focus hx; expdd problem focus exam; low decision making
99309	Subsequent nursing facility care, per day, 2 of: detailed history; detailed exam; moderate medical decision making
99310	Subsequent nursing facility care, per day, 2 of: comp history; comp exam; medical decision making of high complexity
99354	Prolonged Physician Service, Office/Op W/Direct Contact; 1st Hr
99355	Prolonged Physician Service, Office/Op W/Direct Contact; Add'l 30 Min
99356	Prolonged Physician Service, Inpt W/Direct Contact; 1st Hr
99357	Prolonged Physician Service, Inpt W/Direct Contact; Add'l 30 Min
99406	Smoking and Tobacco Use Cessation Counseling Visit; Intermediate, Greater than 3 Minutes up to 10 Minutes
99495	Transitional Care Management Services, Moderate Complexity, Within 14 Calendar Days Of Discharge
99496	Transitional Care Management Services, High Complexity, Within 7 Calendar Days Of Discharge
99497	Advance care plan incl explanation & discussion of advance directives such as standard forms by the physician; first 30 mins, face-to-face w/patient, family mem(s) & surrogate
99498	Advance care plan incl explanation & discussion of advance directives such as standard forms by physician; each addl 30 mins (List in addition to code for primary procedure)
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes outpatient self-management training services, group session (two or more), per 30 minutes
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes
G0296	Counseling visit to discuss need for lung cancer screening (ldct) using low dose ct scan (service is for eligibility determination and shared decision making)
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes

G0420	Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per 1 hour
G0421	Face-to-face educational services related to the care of chronic kidney disease; group, per session, per 1 hour
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit
G0442	Annual alcohol misuse screening, 15 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
G0444	Annual depression screening, 15 minutes
G0445	Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes
G0447	Face-to-face behavioral counseling for obesity, 15 minutes
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)
G0513	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)
G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service)

NON-COVERED HCPCS CODES

S9110	Telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month
T1014	Telehealth transmission, per minute, professional services bill separately

Modifier [inclusion on this list does not imply coverage]

G0	Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (informational modifier)
GQ	Via Asynchronous Telecommunications systems.
GT	Service via interactive audio and video telecommunication systems [critical access hospitals]
95	Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System

Place of Service

02	Telehealth: The location where health services and health related services are provided or received, through a telecommunication system.
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COVERAGE CRITERIA

NOTE: During the Medicare-defined covid-19 pandemic time frame, coverage will follow Medicare guidelines for broadened access to telemedicine services.

1. **Telehealth visit:** Evaluation, management and consultation services using synchronous (real-time, interactive) telehealth technologies are covered for HAP/AHL Members when ALL of the following are met:
 - a. The Member and provider must be present at the time of the consultation.
 - b. The provider must be HAP contracted.
 - c. The consultation must take place via an interactive audio and/or video HIPAA compliant telecommunication system (provider equipment). Medicare Members must follow Medicare guidelines.
 - i. **Acceptable Equipment:** Common Skype is not acceptable for telehealth purposes; however, professional Skype-like products are available with technology that meets compliance. Health Insurance Portability and Accountability Act (HIPAA) guidelines require that any software transmitting protected personal health information meet a 128-bit level of encryption, at a minimum, need auditing, archival and backup capabilities. State laws must also be followed.
2. **E-visits or Online digital evaluation and management service:** Members may have non-face-to-face patient-initiated communications with their doctors without going to the doctor's office by using online patient portals. These services can only be reported when the billing practice has an established relationship with the Member. The Member must verbally consent to receive virtual check-in services.
 - a. For these E-Visits, the Member must generate the initial inquiry and communications can occur over a 7-day period.
 - b. Medicare Advantage plan Members: The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable.
 - c. Commercial plan Members: The services may be billed using CPT codes 99421-99423 and CPT codes 98970 - 98972, as applicable.
3. **Virtual check-ins:** Virtual check-ins are for Members with an established (or existing) relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available). The Member must verbally consent to receive virtual check-in services.
 - a. Virtual check in services may be furnished through several communication technology modalities, such as telephone (G2012). The practitioner may respond to the Member's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.
 - b. In addition, separate from these virtual check-in services, captured video or images can be sent to a physician (G2010).
4. For ANY form of telemedicine service:
 - a. A permanent record of the telemedicine communications must be maintained as part of the Member's medical record.
 - b. The provider must be a health care professional who is licensed, registered or otherwise authorized to provide health care in the state where the Member is located at the time the telemedicine service is rendered.
 - i. Provider specialties eligible to provide telehealth services include:
 - A. Physicians
 - B. Nurse Practitioners (NPs)
 - C. Physician Assistants (PAs)
 - D. Certified Nurse-Midwives (CNMs)
 - E. Clinical Nurse Specialists (CNSs)
 - F. Certified Registered Nurse Anesthetists (CRNAs)
 - G. Clinical Psychologists (CPs)
 - H. Clinical Social Workers (CSWs)
 - I. Registered Dietitians (RDs) or Medical Nutritional Professionals (MNTs)
 - c. Appropriate informed consent which includes a description of potential risks, consequences, and benefits of telemedicine is obtained.
 - d. All services provided are medically necessary and appropriate for the Member.
5. Coverage of services is based on the Member's subscriber documents. Please refer to those resources for information regarding eligibility for coverage, network or provider requirements. If the Member has coverage for the services discussed in this policy, then the medical criteria applies.
 - a. HAP has contracted with AmWell to provide telemedicine services for urgent care services. AmWell does not provide urgent care services for Behavioral Health indications for HAP/AHL Members.
6. Medicaid Providers should refer to:
 - a. The Michigan Medicaid Provider Manual for coverage criteria, located at: <http://www.mdch.state.mi.us/dch-medicare/manuals/MedicaidProviderManual.pdf>
 - b. The Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--00.html

LIMITATIONS

1. Telemedicine services are subject to all terms and conditions of the Member's HAP/AHL subscriber contract, including, but not limited to, required copayments, coinsurances, deductibles, and approved amounts.
2. Any claims for Member reimbursement for telemedicine services must include standard claim data including provider NPI, billing address and procedure /service codes.
3. Provider Type and Telemedicine services: 99441-99443; 98970 - 98972
 - a. The communication should be performed through HIPAA-compliant platforms, like an electronic health record portal or secure email.
 - i. Nonevaluative electronic communication of test results does not qualify for this type of code.
 - b. Qualified health care professional [physician]:
 - i. New AMA CPT® guidelines indicate certain codes are appropriate when a patient initiates a service performed by a physician or other qualified healthcare professional (QHP).
 - ii. The codes all begin with the same phrasing, which sets out the basic requirements: "Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days." They are time-based:
 - A. 99421: 5-10 minutes
 - B. 99422: 11-20 minutes
 - C. 99423: 21 or more minutes
 - c. Non-qualified health care professional [non-physician]: There are alternative codes (98970-98972) that are almost identical to 99421-99423. The difference is that the descriptors for 98970-98972 state that a "Qualified nonphysician health care professional" performs the service.
 - i. This provider type would include speech-language pathologists, physical therapists, occupational therapists, social workers, and dietitians.
 - ii. The codes all begin with the same phrasing, which sets out the basic requirements: "online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days". They are time-based:
 - A. 98970: 5-10 minutes
 - B. 98971: 11-20 minutes
 - C. 98972: 21 or more minutes

EXCLUSIONS

1. The following services are not covered as telemedicine services:
 - a. Evaluation, management and consultation services using asynchronous technology (i.e., connecting at each other's own convenience and own schedule), such as e-mail.
 - b. Installation or maintenance of any telecommunication devices or systems.
 - c. Facsimile transmissions.
 - d. Software or other applications for management of acute or chronic disease.
 - e. Appointment scheduling.
 - f. Refilling or renewing existing prescriptions without substantial change in clinical situation.
 - g. Scheduling diagnostic tests.
 - h. Reporting normal test results.
 - i. Updating patient demographic information.
 - j. Providing educational materials.
 - k. Services that would not typically be charged during a regular office visit.
 - l. Requests for referrals.
 - m. Provider initiated e-mail.
 - n. Clarification of simple instructions.
 - o. Formal imaging interpretation by a radiologist.
 - p. Provider-to-provider consultations when the member is not present.
 - q. Brief follow-up after a medical procedure to confirm stability of the patient's condition without indication of complication or new condition including, but not limited to, routine global surgical follow-up.
 - r. Brief discussion to confirm stability of a Member's chronic condition without change in current treatment.
 - s. Advising a patient to seek face to face care within 48 hours when further evaluation is needed.
 - t. Telemedicine services that occurs the same day as a face to face visit, when performed by the same provider and for the same condition.
 - u. Online medical evaluations occurring more than once within 7 days for the same episode of care and rendered by the same health care provider.
 - v. Online medical evaluations that occur within 7 days after a face to face evaluation and management service performed by the same provider for the same condition, whether provider requested or unsolicited patient follow-up.
2. Telemedicine services are not covered for HAP/AHL Members who:
 - a. Are unwilling or refuse the service.
 - b. Are unable to self-actuate or have no caregiver available who is able to assist.

- c. Are enrolled in hospice care.
 - d. Receive clinical interventions at a high frequency (greater than three times per week).
3. Telemedicine services are not covered when billed by a non-HAP/AHL contracted or affiliated provider and/or company.

REFERENCE:

1. State of Michigan. THE INSURANCE CODE OF 1956 (EXCERPT) Act 218 of 1956. Section 500.3476. State of Michigan Legislature. © 2020 Legislative Council, State of Michigan. [http://www.legislature.mi.gov/\(S\(hckc2ukqarspavr5wqqwunu1\)\)/mileg.aspx?page=GetObject&objectname=mcl-500-3476](http://www.legislature.mi.gov/(S(hckc2ukqarspavr5wqqwunu1))/mileg.aspx?page=GetObject&objectname=mcl-500-3476)

MEDICARE REFERENCE:

1. MLN Matters MM9726. New Place of Service (POS) Code for Telehealth and Distant Site Payment Policy. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9726.pdf>
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- a. Billing & Reimbursement for Institutional Providers
 - i. SECTION 6 – HOSPITAL CLAIM COMPLETION – INPATIENT
 - A. 6.5 TELEMEDICINE
 - ii. SECTION 7 – HOSPITAL CLAIM COMPLETION – OUTPATIENT
 - A. 7.27 TELEMEDICINE
 - iii. SECTION 8 - REMITTANCE ADVICE
 - A. 8.14 OTHER SERVICE REVENUE CODES
- b. Behavioral Health and Intellectual and Developmental Disability Supports and Services
 - i. SECTION 3 – COVERED SERVICES
 - A. 3.26 TELEMEDICINE
 - ii. SECTION 4 – TELEMEDICINE
 - iii. SECTION 18 – BEHAVIORAL HEALTH TREATMENT SERVICES/APPLIED BEHAVIOR ANALYSIS
 - A. 18.9.D. TELEPRACTICE FOR BHT SERVICES
- c. Children’s Special Health Care Services
 - i. SECTION 9 – BENEFITS
 - A. 2.3 TELEMEDICINE
- d. Federally Qualified Health Centers and Tribal Health Centers
 - i. 7.4 COVERED SERVICES
- e. Home and Community Based Services
- f. Home Health
 - i. SECTION 1 – GENERAL INFORMATION
 - A. 1.1 FACE-TO-FACE ENCOUNTER
- g. Hospital
 - i. SECTION 3 – COVERED SERVICES
 - A. 3.33 TELEMEDICINE
- h. Nursing Facility Coverages
 - i. 10.35 TELEMEDICINE
- i. Practitioner
 - i. SECTION 17 – TELEMEDICINE
- j. RURAL HEALTH CLINICS
 - i. SECTION 3 – BENEFITS
 - A. 3.3 TELEMEDICINE
- k. School Based Services
 - i. 2.4.C. TELEPRACTICE FOR SPEECH, LANGUAGE AND HEARING SERVICES
- l. Tribal Health Centers
 - i. SECTION 3 – BENEFITS

This Benefit policy discusses the medical criteria for covered services. Coverage of services for Members is based on the Member’s subscriber documents and are subject to all terms and conditions including specific exclusions and limitations. This type of document includes the following: Subscriber contract and associated riders; Member Benefit Guide; or an Evidence of Coverage document (for Medicare Advantage Members).

HAP HMO/POS and AHL EPO/PPO Members:

If there is a discrepancy between this policy and coverage described in the subscriber documents, the Member’s subscriber documents will apply.

ASO Members:

Coverage as discussed in this policy may not apply to employer groups that are self-funded (referred to as an ASO group [Administrative Services Only]). Each ASO group determines the coverage available to their members which is found in the ASO Benefit Guide and associated riders. If a member has coverage for the type of service covered by this policy, then the medical criteria as discussed in this policy applies to those services.

Medicare Advantage Plan Members:

Coverage is based on Medicare (CMS) regulations and guidelines which include the NCDs (National Coverage Decision) and LCDs (Local Coverage Decision) for our area. When no coverage determination has been made by CMS, then this policy will apply.

Medicaid Plan Members:

For Medicaid/Healthy Michigan Plan members coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will apply.