Updated! Expanded Coverage and Reimbursement for Virtual Visits and Telehealth

May 7, 2020

We've updated our Telemedicine, Telehealth, & Virtual Care Services medical policy. A copy is attached.

Please be sure to refer to the section Telehealth coverage during Public Health Emergency (PHE) and note the following changes:

- We added an asterisk (*) next to codes that CMS identified as meeting audio only criteria.
- We updated the billing information.
  When billing professional claims for telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill as ONE of the following:
  - With the Place of Service (POS) equal to what it would have been in the absence of a PHE, along with a modifier 95, indicating that the service rendered was actually performed via telehealth
  - With the designated POS code 02-Telehealth, indicating the billed service was furnished as a professional telehealth service from a distant site.

Reminder!
Only one POS may be submitted on the same claim. Please be sure to submit appropriate COVID-19 treatment and testing codes.

Remember, you can find the most up-to-date policy when you log in at hap.org and select Benefit Admin Manual under More.
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, tables or other mobile devices to add access and remove barriers to care. Telemedicine technology falls into two general categories: synchronous care and asynchronous care. Telemedicine typically 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]¹ the health care professional must be able to examine the patient via a real-time, interactive audio or video, or both, telecommunication system and the patient must be able to interact with the off-site health care professional at the time the services are provided.

COVID-19 RESPONSE:

- During the Medicare-defined covid-19 pandemic time frame, coverage for Medicare Advantage Plan Members will follow Medicare guidelines for broadened access to telemedicine services.
  - MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET: Medicare coverage and payment of virtual services
  - HAP Empowered/Medicaid Members will follow the State of Michigan MDHHS guidelines for COVID-19 Response.
    - Michigan Medicaid policy bulletins: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42553-87513--,00.html
  - HAP/AHL Commercial and Individual product Members are covered following the Medicare telehealth guidelines in effect for the Covid-19 pandemic time frame.

EXPANDED TELEMEDICINE SERVICES:

- To support social distancing recommendations during this time, the telemedicine adjustments apply to all diagnosis and conditions, not just COVID-19 related concerns.
  - Applies to all Medicare Advantage, HAP/AHL Commercial & Individual product Members.
  - HAP Empowered/Medicaid Members continue to follow MDHHS directives.
- All Members may make the call for telehealth services from their home.
- All Members may utilize audio-only interactive technology if audio/video technology is not available or inaccessible.
- It is expected that codes selected for claims will accurately reflect the services rendered.
- Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services are covered as telehealth services.
  - Applies to all Medicare Advantage, HAP/AHL Commercial & Individual product Members.
  - HAP Empowered/Medicaid Members continue to follow MDHHS directives.
- Autism Spectrum Evaluation & Treatment: Covered via audio and/or audio-video telemedicine access for HAP/AHL Commercial & Individual product Members during this time frame. Please refer to the Benefit Administration Manual policy: Autism Spectrum Disorders, Evaluation and Treatment for coverage criteria.

COVERED CODES - resources

Medicare resource Medicare Telehealth Services List @ https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes (includes covid-19 updates and the expanded temporary PHE-Telehealth codes)

Medicaid resource HAP Empowered/Medicaid Members follow the Medicaid fee schedule
https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-159815--,00.html

Medicaid Covid-19 fee schedule Michigan Medicaid Covid-19 fee schedule @ https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-523789--,00.html

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

96156 * Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
96159 * Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96164 * Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
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

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.
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, 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

Please note: List is not all inclusive. CMS Temporary Additions for the PHE for the COVID-19 Pandemic are covered but not listed. Standard billing guidelines apply to these services. Service components for each code must be met or exceeded for the level of service selected.

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
Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour

96116 *

96150
Health & Behavior Assessment, Ea 15 Minutes; Initial Assessment [code termed 1/1/2020]

96151
Health & Behavior Assessment, Ea 15 Minutes; Re-Assessment [code termed 1/1/2020]
Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 10 minutes are spent face-to-face with the patient and/or family.

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, other agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least
2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family

99231 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.

99232 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.

99233 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

99307 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.

99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.

99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.

99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.

99354 * Prolonged evaluation and management or psychotherapy 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 hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)

99355 * Prolonged evaluation and management or psychotherapy 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 for prolonged service)

99356 * Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)

99357 * Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)

99406 * Smoking and Tobacco Use Cessation Counseling Visit; Intermediate, Greater than 3 Minutes up to 10 Minutes

99495 Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision
making of at least moderate complexity during the service period. Face-to-face visit, within 14 calendar days of discharge.

99496  Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge. Medical decision making of high complexity during the service period. Face-to-face visit, within 7 calendar days of discharge.

99497 *  Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.

99498 *  Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately 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.

**Telehealth Modifiers** [inclusion on this list does not imply coverage]

95  Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System.

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].

**Place of Service**
**Telehealth** is the location where health services and health-related services are provided or received, through a telecommunication system.

### COVERAGE CRITERIA

**Telehealth coverage during Public Health Emergency (PHE):**

- Health Alliance Plan (HAP) continues to cover telehealth (telemedicine) and, like Medicare, has expanded its telehealth coverage during the COVID-19 pandemic.
- Medicare telehealth guidelines apply to all HAP/AHL Commercial and individual product members and Medicare Advantage members.
- HAP Empowered/Medicaid Members will follow the State of Michigan MDHHS guidelines for COVID-19 Response.

**Billing:**

- HAP reimburses all providers for telemedicine
- Office/outpatient E/M level selection for services when furnished via telehealth can be based on MDM or time.
- HAP expects that codes selected for claims accurately reflect the services rendered.
- Documentation requirements follow CMS policy and provide additional flexibility during this PHE.
- HAP has aligned its telehealth billing requirements with the Centers for Medicare and Medicaid Services.
  - When billing professional claims for telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill as ONE of the following:
    - With the Place of Service (POS) equal to what it would have been in the absence of a PHE, along with a modifier 95, indicating that the service rendered was actually performed via telehealth
    - With the designated POS code 02-Telehealth, indicating the billed service was furnished as a professional telehealth service from a distant site.

**Audio only/audio and visual:**

- Audio-only interactive technology may be used if audio/video technology is not available or inaccessible. For audio-only access, HAP is in agreement with the following CMS decision.
  - In the context of the PHE for the COVID-19 pandemic, especially in the case that two-way, audio/video technology might not be available, CMS concedes that there are many circumstances where prolonged, audio-only communication between the practitioner and the patient could be clinically appropriate. CMS notes that existing telephone E/M codes, in both description and valuation, are the best way to recognize the relative resource costs of these kinds of services. Therefore, CMS is finalizing on an interim basis for the COVID-19 public health emergency, separate payment for CPT codes 98966-98968 and CPT codes 99441-99443.
- It remains our expectation that practitioners will document E/M visits as necessary to ensure quality and continuity of care.
- CMS has identified some services that meet audio only criteria, they are identified with an * in any code section.

**Providers:**

- Telehealth services are covered for providers including physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, nutritionists, licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology.

**Autism Spectrum Evaluation & Treatment:**

- Autism Spectrum evaluation and treatment is covered. Please refer to the Benefit Administrative Manual policy: Autism Spectrum Disorders, Evaluation & Treatment for coverage criteria.

**Medicare temporary additions for PHE telemedicine services are covered for HAP commercial, individual and Medicare Members (list may not be all-inclusive):**

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Telemedicine Services

- **Telehealth visits** use 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 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 consists of live interaction (audio/video conference) between Member and Provider permitting two-way, real-time communications between the Member 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: 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, also known as store and forward messaging, involves messaging (including condition-driven questionnaires) or data submission (monitoring) that the provider 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

COVERAGE CRITERIA:

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).

For ANY form of telemedicine service:

1. A permanent record of the telemedicine communications must be maintained as part of the Member’s medical record.
2. 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.

   a. Provider specialties eligible to provide telemedicine services include:
      i. Physicians
      ii. Nurse Practitioners (NPs)
      iii. Physician Assistants (PAs)
      iv. Certified Nurse-Midwives (CNMs)
      v. Clinical Nurse Specialists (CNSs)
      vi. Certified Registered Nurse Anesthetists (CRNAs)
      vii. Clinical Psychologists (CPs)
      viii. Clinical Social Workers (CSWs)
ix. Registered Dietitians (RDs) or Medical Nutritional Professionals (MNTs)
b. Appropriate informed consent which includes a description of potential risks, consequences, and benefits of telemedicine is obtained.
c. All services provided are medically necessary and appropriate for the Member.

3. 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.

4. Medicaid Providers should refer to:
   a. The Michigan Medicaid Provider Manual for coverage criteria, located at: [link]
   b. The Michigan Medicaid Fee Schedule located at: [link]

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. Nonevalutative 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]:
      i. 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.
      ii. This provider type would include speech-language pathologists, physical therapists, occupational therapists, social workers, and dietitians.
      iii. 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

Telehealth coverage exclusions during Public Health Emergency (PHE):

- Some concessions have been made to address the current PHE when billed with CMS telehealth CPT/HCPCS codes.
  - [link]
- Please refer to the CMS guidelines for a current list of the added Telehealth PHE codes.
  - Medicare Telehealth Services List @ [link]
- HAP/AHL Medicare, Commercial and Individual product Members are covered following the Medicare telehealth guidelines in effect for the Covid-19 pandemic time frame. These guidelines have expanded the services available by telemedicine and now include options for E&M and office evaluation services. The preventive medicine service codes [99381-99387; 99391-99397] are not included in those guidelines, therefore preventive services described by codes: 99381-99387; 99391-99397 are not covered for HAP/AHL Members as a telemedicine service.
1. The following services are not covered as telehealth services:
   a. E-mail or text only communication
   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. Request for medication refill.
   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. Reminders for healthcare related issues.
   r. Brief follow-up after a medical procedure to confirm stability of the Member’s condition without indication of complication or new condition including, but not limited to, routine global surgical follow-up because the service is included in the global reimbursement.
   s. Telehealth services where information is exchanged and further evaluation is required such that the Member is subsequently advised to seek face to face care by the same provider within 48 hours.
   t. 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. Telehealth 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. Telehealth services are not covered when billed by a non-HAP/AHL contracted or affiliated provider and/or company.

REFERENCE:


MEDICARE REFERENCE:

2. DEPARTMENT OF HEALTH AND HUMAN SERVICES. Centers for Medicare & Medicaid Services, Telehealth Services. ICN 901705


17. WPS. Telehealth Modifier Fact Sheet. Center for Medicare & Medicaid Services. Last updated May 7, 2019. https://www.wpsgha.com/wps/portal/mac/site/claims/guides-and-resources/modifier-telehealth/utp/z0/fczRCslgFIDhJ5lJFgxvKwgqJsdFFOG9C8kwPmQS1PX97gi5_-PjBgaaT7Je8bZSTjVtPZnjepBxkJh47RXne3V-7E5ipIh7Bxcw_8F26Is6Kg9msS0wSnMG7VdyWJINjhwseS0vrKA_2dFMWFDiAFTbAGWt5i-Y1TSIQ!!/

MEDICAID REFERENCE:


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.

EFFECTIVE DATE
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