



## **Updated! Expanded Coverage and Reimbursement for Virtual Visits and Telehealth**

**April 13, 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:

HAP has aligned its telehealth billing requirements with the Centers for Medicare and Medicaid Services.

- Non-traditional telehealth services: When billing professional claims for non-traditional telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill 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.
- Traditional telehealth services: Traditional telehealth services professional claims should reflect the designated POS code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site. There is no change to the facility/non-facility payment differential applied based on POS. Claims submitted with POS code 02 will continue to pay at the facility rate.
- Institutional claims: There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

### **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, tablets 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]<sup>1</sup> 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 <https://www.samhsa.gov/sites/default/files/medicare-telemedicine-health-care-fact-sheet.pdf>
- 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](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

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| Medicare resource              | <b>Medicare Telehealth Services List @ <a href="https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes">https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes</a></b> (includes covid-19 updates and the 85 added Telehealth codes) |
| Medicaid resource              | <b>HAP Empowered/Medicaid Members follow the Medicaid fee schedule <a href="https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-159815--,00.html">https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-159815--,00.html</a></b>               |
| Medicaid Covid-19 fee schedule | <b>Michigan Medicaid Covid-19 fee schedule @ <a href="https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-523789--,00.html">https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-523789--,00.html</a></b>                                     |

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

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| 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   |
| 96165 | Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in                       |

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|       | addition to code for primary service)   |
| 96167 | Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes   |
| 96168 | Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)   |
| 99224 | Subsequent Observation Care, Per Day, For The Evaluation And Management Of A Patient, Problem Focused   |
| 99225 | Subsequent Observation Care, Per Day, For The Evaluation And Management Of A Patient, Expanded  |
| 99226 | Subsequent Observation Care, Per Day, For The Evaluation And Management Of A Patient, Detailed  |
| 99407 | Smoking and Tobacco Use Cessation Counseling Visit; Intensive, Greater than 10 Minutes  |
| 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   |

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|       | 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]**

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| 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**

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| ..    | <b>Please note: List is not all inclusive. CMS Temporary Additions for the PHE for the COVID-19 Pandemic are covered but not listed.</b> 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  |

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| 90833 | Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)   |
| 90834 | Psychotherapy, 45 minutes with patient  |
| 90836 | Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)   |
| 90837 | Psychotherapy, 60 minutes with patient  |
| 90838 | Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)   |
| 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 | End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month   |
| 90952 | End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month   |
| 90954 | End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month   |
| 90955 | End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month   |
| 90957 | End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month  |
| 90958 | End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month  |
| 90960 | End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month  |
| 90961 | End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month  |
| 90963 | End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents   |
| 90964 | End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents   |
| 90965 | End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents  |
| 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; for patients younger than 2 years of age   |
| 90968 | End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age   |
| 90969 | End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age  |
| 90970 | End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older   |
| 96116 | 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 |
| 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]   |

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| 96152 | Health & Behavior Intervention, Ea 15 Minutes; Individual [code termed 1/1/2020]  |
| 96153 | Health & Behavior Intervention, Ea 15 Minutes; Group (2+ Patients) [code termed 1/1/2020]   |
| 96154 | Health & Behavior Intervention, Ea 15 Minutes; Family (W/Patient Present) [code termed 1/1/2020]  |
| 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 standardized instrument  |
| 97802 | Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes  |
| 97803 | Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes   |
| 97804 | Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes   |
| 99201 | 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 self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.   |
| 99202 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded 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, 20 minutes are spent face-to-face with the patient and/or family.                       |
| 99203 | Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed 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 presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.  |
| 99204 | 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 moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.                                       |
| 99205 | 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.   |
| 99211 | 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.  |
| 99212 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.                          |
| 99213 | 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, 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. |
| 99214 | 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.                          |
| 99215 | 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

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| 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



**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.
  - Non-traditional telehealth services: When billing professional claims for non-traditional telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill 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.
  - Traditional telehealth services: Traditional telehealth services professional claims should reflect the designated POS code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site. There is no change to the facility/non-facility payment differential applied based on POS. Claims submitted with POS code 02 will continue to pay at the facility rate.
  - Institutional claims: There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

**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.

**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):

| Code  | Description                  | Code  | Description                 | Code  | Description                 | Code  | Description                 |
|-------|------------------------------|-------|-----------------------------|-------|-----------------------------|-------|-----------------------------|
| 77427 | Radiation tx management X5   | 90853 | Group psychotherapy         | 90953 | Esrd serv 1 visit p mo <2yr | 90959 | Esrd serv 1 vst p mo 12-19  |
| 90962 | Esrd serv 1 visit p mo 20+   | 92507 | Speech/hearing therapy      | 92521 | Evaluation of speech fluenc | 92522 | Evaluation of speech fluenc |
| 92523 | Speech sound lang comprehen  | 92524 | Behavral qualit analys voic | 96130 | Psycl tst eval phys/qhp 1st | 96131 | Psycl tst eval phys/qhp ea  |
| 96132 | Nrpsyc tst eval phys/qhp 1st | 96133 | Nrpsyc tst eval phys/qhp ea | 96133 | Nrpsyc tst eval phys/qhp ea | 96136 | Psycl/nrpsyc tst phy/qhp 1s |
| 96137 | Psycl/nrpsyc tst phy/qhp ea  | 96138 | Psycl/nrpsyc tech 1st       | 96139 | Psycl/nrpsyc tst tech ea    | 97110 | Therapeutic exercises       |

|       |                             |       |                             |       |                             |       |                             |
|-------|-----------------------------|-------|-----------------------------|-------|-----------------------------|-------|-----------------------------|
| 97112 | Neuromuscular reeducation   | 97116 | Gait training therapy       | 97161 | PT Eval low complex 20 min  | 97162 | PT Eval mod complex 30 min  |
| 97163 | PT Eval high complex 45 min | 97164 | PT re-eval est plan care    | 97165 | OT eval low complex 30 min  | 97166 | OT eval mod complex 45 min  |
| 97167 | OT eval high complex 60 min | 97168 | OT re-eval est plan care    | 97535 | Self care mngmt training    | 97750 | Physical Performance Test   |
| 97755 | Assistive Technology Assess | 97760 | Orthotic mgmt&traing 1st en | 97761 | Prosthetic traing 1st enc   | 99218 | Initial observation care    |
| 99219 | Initial observation care    | 99220 | Initial observation care    | 99221 | Initial hospital care       | 99222 | Initial hospital care       |
| 99223 | Initial hospital care       | 99234 | Obser/hosp same date        | 99235 | Obser/hosp same date        | 99236 | Obser/hosp same date        |
| 99238 | Hospital discharge day      | 99239 | Hospital discharge day      | 99281 | Emergency dept visit        | 99282 | Emergency dept visit        |
| 99283 | Emergency dept visit        | 99284 | Emergency dept visit        | 99285 | Emergency dept visit        | 99291 | Critical care first hour    |
| 99292 | Critical care addl 30 min   | 99304 | Nursing facility care init  | 99305 | Nursing facility care init  | 99306 | Nursing facility care init  |
| 99315 | Nursing fac discharge day   | 99316 | Nursing fac discharge day   | 99327 | Domicil/r-home visit new pa | 99328 | Domicil/r-home visit new pa |
| 99334 | Domicil/r-home visit est pa | 99335 | Domicil/r-home visit est pa | 99336 | Domicil/r-home visit est pa | 99337 | Domicil/r-home visit est pa |
| 99341 | Home visit new patient      | 99342 | Home visit new patient      | 99343 | Home visit new patient      | 99344 | Home visit new patient      |
| 99345 | Home visit new patient      | 99347 | Home visit est patient      | 99348 | Home visit est patient      | 99349 | Home visit est patient      |
| 99350 | Home visit est patient      | 99468 | Neonate crit care initail   | 99469 | Neonate crit care subsq     | 99471 | Ped critical care initial   |
| 99472 | Ped critical care subsq     | 99473 | Self-meas bp pt educaj/trai | 99475 | Ped crit care age 2-5 init  | 99476 | Ped crit care age 2-5 subsq |
| 99477 | Init day hosp neonate care  | 99478 | lc lbw inf < 1500 gm subsq  | 99479 | lc lbw inf 1500-2500 g subs | 99480 | lc inf pbw 2501-5000 g subs |
| 99483 | Assmt & care pln cog imp    |       |                             |       |                             |       |                             |

## 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: <http://www.mdch.state.mi.us/dch-medicaid/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](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]:
    - 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.
  - MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET: Medicare coverage and payment of virtual services <https://www.samhsa.gov/sites/default/files/medicare-telemedicine-health-care-fact-sheet.pdf>
- Please refer to the CMS guidelines for a current list of the added Telehealth PHE codes.
  - Medicare Telehealth Services List @ <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes> (includes covid-19 updates and the added Telehealth codes)
- 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.

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15. Federal Register. Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. Centers for Medicare & Medicaid Services. 4/6/2020. <https://www.federalregister.gov/documents/2020/04/06/2020-06990/medicare-and-medicaid-programs-policy-and-regulatory-revisions-in-response-to-the-covid-19-public>

#### MEDICAID REFERENCE:

1. MDHHS. General Telemedicine Policy Changes; Updates to Existing Policy; Federally Qualified Health Center and Rural Health Clinic Policy Changes. Michigan Department of Health & Human Services. Bulletin No. MSA 20-09. Issued March 12, 2020. Effective as Indicated. Affected programs: Medicaid, Healthy Michigan Plan, Children Special Health Care Services, Maternity Outpatient Medical Services. [https://www.michigan.gov/documents/mdhhs/MSA\\_20-09\\_683712\\_7.pdf](https://www.michigan.gov/documents/mdhhs/MSA_20-09_683712_7.pdf)
2. MDHHS. COVID-19 Response: Relaxing Face-To-Face Requirement. Michigan Department of Health & Human Services. Bulletin No. MSA-20-12. Issued March 18, 2020. Effective Immediately. Affected programs: Medicaid, Children Special Health Care services, Flint Waiver, Healthy Michigan Plan [https://www.michigan.gov/documents/mdhhs/MSA\\_20-12\\_684250\\_7.pdf](https://www.michigan.gov/documents/mdhhs/MSA_20-12_684250_7.pdf)
3. MDHHS. COVID-19 Response: Telemedicine Policy Expansion; Prepaid InPatient Health Plans (PIHPs)/Community Mental Health services Programs (CMHSPs) Implications. Michigan Department of Health & Human Services. Bulletin No. MSA 20-13. Issued March 20, 2020. Effective March 1, 2020. Affected programs: Medicaid, Healthy Michigan Plan, Children Special Health Care Services, Maternity Outpatient Medical Services. [https://www.michigan.gov/documents/mdhhs/MSA\\_20-13\\_684352\\_7.pdf](https://www.michigan.gov/documents/mdhhs/MSA_20-13_684352_7.pdf)
4. Michigan Medicaid Provider Manual. <http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>
  - 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](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](http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572-,00.html), the Michigan Medicaid Provider Manual will apply.

**EFFECTIVE DATE**

01/01/2015

**REVISED DATE**

04/10/2020

**REVIEWED DATE**

03/18/2020

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