Public Health Emergency Unwind

In January, the Biden Administration announced its intent to end the national emergency and public health emergency (PHE) related to the COVID-19 pandemic on May 11, 2023. We will follow guidelines from the Centers for Medicare & Medicaid Services (CMS) and the Michigan Department of Health and Human Services (MDHHS) unless otherwise noted. Below is a high-level overview of changes effective May 11, 2023.

COVID-19 Testing

Member	Guidelines
HAP Commercial HAP Medicare Advantage	• Apply cost share for COVID-19 testing. • At home test kits not covered
HAP Empowered Medicaid HAP Empowered MI Health Link	• No cost share for COVID-19 testing until Sept. 30, 2024 • Cover at home test kits through Sept. 30, 2024. Kit must be: – FDA approved or granted FDA Emergency Use Authorization (EUA) when dispensed by a Medicaid-enrolled pharmacy – Ordered by an authorized prescriber and up to one test per day

Telehealth and virtual visits including billing guidelines

Member	Guidelines
HAP Commercial HAP Medicare Advantage	Follow *HAP's Telemedicine, Telehealth & Virtual Care Services* benefit policy which is aligned with CMS guidelines. See attached copy. You can always find the most up-to-date copy when you log in at **hap.org** and select *Benefit Admin Manual* under *More*.
HAP Empowered Medicaid HAP Empowered MI Health Link	• Follow MDHHS guidelines (MMP 23-10) • Maternal Infant Health Providers follow MDHHS guidelines (MMP 23-17)

Prior authorization and referrals

Member	Guidelines
HAP Commercial HAP Medicare Advantage	Return to processes in place prior to PHE. Providers should always check to see if prior authorization is required. Members are expected to go to contracted providers. However, requests for services at non-contracted providers are reviewed on a case-by-case basis.
HAP Empowered Medicaid HAP Empowered MI Health Link	

Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies Flexibilities

Member	Guidelines
HAP Commercial HAP Medicare Advantage	Follow CMS guidelines
HAP Empowered Medicaid HAP Empowered MI Health Link	Follow MDHHS guidelines (MMP 23-27)

COVID-19 Vaccine Administration

Member	Guidelines
HAP Commercial HAP Medicare Advantage	Cover with no cost share at an in-network provider. For more information, refer to *Immunizations & Vaccines (includes Monoclonal Antibodies for Pre-exposure Prevention of COVID-19)* benefit policy.
HAP Empowered Medicaid HAP Empowered MI Health Link	Cover with no cost share through Sept. 30, 2024. Note: May 12, 2023 through Sept. 30, 2024, FQHCs, RHCs, Tribal FQHCs, and THCs will be reimbursed for COVID-19 vaccine administration services when no other eligible qualifying clinic visit is provided on the same date of service. For more information, refer to MMP 23-26.

Appeals

- Return to normal timeframes.

Telemedicine, Telehealth & Virtual Care Services - Post PHE

DESCRIPTION

EFFECTIVE FOR SERVICES RENDERED ON or AFTER 5/12/2023

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. To be considered telemedicine under Michigan State law [Section 500.3476 of the Insurance Code of 1956 (excerpt), Act 218 of 1956][1] and later amended in 2020 "Telemedicine" means the use of an electronic media to link patients with health care professionals in different locations. The health care professional must be able to examine the patient via a health insurance portability and accountability act of 1996, Public Law 104-191 compliant, secure interactive audio or video, telecommunications system, or through the use of store and forward online messaging". [11,12]

FEE SCHEDULE RESOURCES:

- **Medicare Telehealth Service Codes @ https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes**
- **Medicaid Telemedicine Service Codes**: **https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/telemedicine**

Please Note:
Any specific products/tests referenced in this policy are just examples and are intended for illustrative purposes only. It is not intended to be a recommendation of one product over another and is not intended to represent a complete listing of all products available. These examples are contained in a "such as" or "e.g." statement in parentheses.
The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

RELEVANT CODES - Acceptable as EITHER "Audio Only" OR "Audio-Visual" Telehealth service

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
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
90853	Group Psychotherapy (Other Than, Multiple-Family Group)
92507	Speech/Hearing/Voice/Communication Therapy; Individual
92508	Speech/Hearing/Voice/Communication Therapy; Group, 2+ Individuals

92521	Evaluation of speech fluency (eg, stuttering, cluttering)
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive an
92524	Behavioral and qualitative analysis of voice and resonance
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
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and v
96127	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder scale), with scoring and documentation, per standardized instrument
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test
96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized
96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to co
96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardiz
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 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)
97535	Self Care/Home Management Training, Direct Contact, Each 15 Min
97802	Medical Nutrition Therapy; Initial Assessment & Intervention, Face-To-Face W/Pt, 15 Min
97803	Medical Nutrition Therapy; Re-Assessment & Intervention, Face-To-Face W/Pt, Each 15 Min
97804	Medical Nutrition Therapy; Group (2 Or More Ind),Each 30 Min
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
99406	Smoking and Tobacco Use Cessation Counseling Visit; Intermediate, Greater than 3 Minutes up to 10 Minutes
99407	Smoking and Tobacco Use Cessation Counseling Visit; Intensive, Greater than 10 Minutes
99441	Telephone Evaluation and Management Service Provided by a Physician; 5-10 Minutes of Medical Discussion
99442	Telephone Evaluation and Management Service Provided by a Physician; 11-20 Minutes of Medical Discussion
99443	Telephone Evaluation and Management Service Provided by a Physician; 21-30 Minutes of Medical Discussion
99497	Advance care plan incl explanation & discussion of advance directives such as standard forms by the physician; first 30 mins, face-to-face w/patient, family mem(s) & surrogate
99498	Advance care plan incl explanation & discussion of advance directives such as standard forms by physician; each addl 30 mins (List in addition to code for primary procedure)
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes outpatient self-management training services, group session (two or more), per 30 minutes
G0270	Medical Nutrition Therapy; Reassessment And Subsequent Intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes
G0296	Counseling visit to discuss need for lung cancer screening (ldct) using low dose ct scan (service is for eligibility determination and shared decision making)
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes
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
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
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
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

G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
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 t
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 t
G2086	Office-based treatment for opioid use disorder, incl development of treatment plan, care coordination, individual therapy & group therapy & counseling; at least 70 minutes in
G2087	Office-based treatment for opioid use disorder, incl care coordination, individual therapy & group therapy & counseling; at least 60 minutes in a subsequent calendar month
G2088	Office-based treatment for opioid use disorder, incl care coordination, individual therapy & group therapy & counseling; each add'l 30 minutes beyond the first 120 minutes (li
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient evaluation and management services.) (Do not report G2212 on the same date of service as codes 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)

RELEVANT CODES - Acceptable ONLY as "Audio-Visual" Telehealth service

0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.
0363T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.
59430	Postpartum Care Only (Sep Proc)
77427	Radiation Treatment Management, 5 Treatments
90875	Individual Psychophysiological Therapy W/Biofeeback Training; Approximately 20-30 Min
90901	Biofeedback Training, Any Modality
90951	Monthly ESRD Services, for Patients Younger Than 2 Years of Age; with 4 or More Face-To-Face Physician Visits Per Month
90952	Monthly ESRD Services, for Patients Younger Than 2 Years of Age; with 2-3 Face-To-Face Physician Visits Per Month
90953	Monthly ESRD Services, for Patients Younger Than 2 Years of Age; with 1 Face-To-Face Physician Visit Per Month
90954	Monthly ESRD Services, for Patients 2-11 Years of Age; with 4 or More Face-To-Face Physician Visits Per Month
90955	Monthly ESRD Services, for Patients 2-11 Years of Age; with 2-3 Face-To-Face Physician Visits Per Month
90956	Monthly ESRD Services, for Patients 2-11 Years of Age; with 1 Face-To-Face Physician Visit Per Month
90957	Monthly ESRD Services, for Patients 12-19 Years of Age; with 4 or More Face-To-Face Physician Visits Per Month
90958	Monthly ESRD Services, for Patients 12-19 Years of Age; with 2-3 Face-To-Face Physician Visits Per Month

90959	Monthly ESRD Services, for Patients 12-19 Years of Age; with 1 Face-To-Face Physician Visit Per Month
90960	Monthly ESRD Services, for Patients 20 Years of Age and Older; with 4 or More Face-To-Face Physician Visits Per Month
90961	Monthly ESRD Services, for Patients 20 Years of Age and Older; with 2-3 Face-To-Face Physician Visits Per Month
90962	Monthly ESRD Services, for Patients 20 Years of Age and Older; with 1 Face-To-Face Physician Visit Per Month
90963	End-Stage Renal Disease (ESRD) Related Services for Home Dialysis Per Full Month, for Patients Younger Than 2 Yrs of Age
90964	End-Stage Renal Disease (ESRD) Related Services for Home Dialysis Per Full Month, for Patients 2-11 Years of Age
90965	End-Stage Renal Disease (ESRD) Related Services for Home Dialysis Per Full Month, for Patients 12-19 Years of Age
90966	End-Stage Renal Disease (ESRD) Related Services for Home Dialysis Per Full Month, for Patients 20 Years of Age and Older
90967	End-Stage Renal Disease (ESRD) Related Services for Dialysis Less Than A Full Month of Service, Per Day; Pt < 2 Yrs
90968	End-Stage Renal Disease (ESRD) Related Services for Dialysis Less Than A Full Month of Service, Per Day; Pt 2-11 Yrs
90969	End-Stage Renal Disease (ESRD) Related Services for Dialysis Less Than A Full Month of Service, Per Day; Pt 12-19 Yrs
90970	ESRD Related Services for Dialysis Less Than A Full Month of Service, Per Day; Pt 20 Yrs of Age and Older
92002	Ophthalmological Medical Exam & Eval; Intermediate, New Patient
92004	Ophthalmological Medical Exam & Eval; Comprehensive, New Patient, 1+ Visits
92012	Ophthalmological Medical Exam & Eval; Intermediate, Established Patient
92014	Ophthalmological Medical Exam & Eval; Comprehensive, Established Patient, 1+ Visits
92526	Treatment, Swallowing Dysfunction &/Or Oral Function, Feeding
92550	Tympanometry and Reflex Threshold Measurements
92552	Pure Tone Audiometry (Threshold); Air Only
92553	Pure Tone Audiometry (Threshold); Air & Bone
92555	Speech Audiometry Threshold
92556	Speech Audiometry Threshold; W/Speech Recognition
92557	Comprehensive Audiometry Threshold Eval & Speech Recognition
92563	Tone Decay Test
92565	Stenger Test, Pure Tone
92567	Tympanometry (Impedance Testing)
92568	Acoustic Reflex Testing
92570	Acoustic Immittance Testing
92587	Evoked Otoacoustic Emissions; Limited
92588	Evoked Otoacoustic Emissions; Comprehensive/Dx
92601	Dx Analysis Cochlear Implant, Patient <7 Yrs; W/Programming
92602	Dx Analysis Cochlear Implant, Patient <7 Yrs; Reprogramming
92603	Dx Analysis Cochlear Implant, Patient >7 Yrs; W/Programming
92604	Dx Analysis Cochlear Implant, Patient >7 Yrs; Reprogramming
92607	Eval, Prescription, Speech-Generating Augmentative & Alternative Communication Device; 1st Hr
92608	Eval, Prescrip, Speech-Generating Augmentative & Alternative Communication Device; Ea Add'l 30 Min
92609	Therapeutic Services, Non-Speech Generative Device Use, W/Programming & Modification
92610	Eval, Oral & Pharyngeal Swallow Function
92625	Assessment Of Tinnitus (Includes Pitch, Loudness Matching, And Masking)
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour

92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (List sepa
93750	Interrogation of Ventricular Assist Device (VAD), In Person, with Physician Analysis
93797	Cardiac Rehab, Outpt, Physician Services; W/O Cont Ecg Monitor, Per Session
93798	Cardiac Rehab, Outpt, Physician Services; W/Cont Ecg Monitor, Per Session
94002	Ventilation Assist and Management, Initiation of Pressure or Volume Preset Ventilators; Hospital, Initial Day
94003	Ventilation Assist and Management, Initiation of Pressure or Volume Preset Ventilators; Hospital, Each Subsequent Day
94004	Ventilation Assist and Management, Initiation of Pressure or Volume Preset Ventilators; Nursing Facility, Per Day
94005	Home Ventilator Mgmt Care Plan Oversgt of a Patient (Not Present) In Home/Domicil/Rest Home, In Calendar Month, 30 Min/>
94625	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)
94626	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)
94664	Demonstrate &/Or Eval, Pt Use, Aerosol Generator/Nebulizer/Inhaler/Ippb Device
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming
95971	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
95972	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
95983	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional
95984	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)
96040	Medical Genetics and Genetic Counseling Services, Each 30 Minutes Face-To-Face with Patient/Family
96105	Assessment, Aphasia, Interpretation & Report, Per Hr
96110	Developmental Testing; Limited, W/Interpretation & Report, Per Hr
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized develo
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized develo
96125	Standardized Cognitive Performance Testing per Hour, Face-To-Face Time and Interpreting Results and Preparing Report
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes

96171	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
97110	Therapeutic Proc, 1+ Areas, Each 15 Min; Therapeutic Exercises
97112	Therapeutic Proc, 1+ Areas, Each 15 Min; Neuromuscular Reeducation
97116	Therapeutic Proc, 1+ Areas, Each 15 Min; Gait Training (W/Stair Climbing)
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensato
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensato
97150	Therapeutic Proc(S), Group, (2+ Individuals)
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patie
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of tech
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with gua
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face w
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination o
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the pla
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan
97530	Therapeutic Actvities, Direct Patient Contact, Each 15 Min
97537	Community/Work Reintegration Training, Direct Contact, Each 15 Min
97542	Wheelchair Management/Propulsion Train, Each 15 Min
97750	Physical Performance Test, W/Written Report, Each 15 Min
97755	Assistive Technology Assessment, Direct One-On-One Contact By Provider, with Written Report, Each 15 Minutes
97760	Orthotic(s) management and training, upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
98960	Education and training for patient self-management by nonphysician, face-to-face with the patient, ea 30 min; individ pt

98961	Education and training for patient self-management by nonphysician, face-to-face with the patient, ea 30 min; 2-4 pts
98962	Education and training for patient self-management by nonphysician, face-to-face with the patient, ea 30 min; 5-8 pts
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
99221	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

99222	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded
99223	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
99231	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
99232	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99233	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
99234	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99235	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.
99236	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.
99238	Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter
99239	Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter
99281	Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional
99282	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making
99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99315	Nursing facility discharge management; 30 minutes or less total time on the date of the encounter
99316	Nursing facility discharge management; more than 30 minutes total time on the date of the encounter
99341	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99342	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99344	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99345	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
99347	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99348	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99349	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99350	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99468	Initial Neonatal Critical Care, Per Day, Critically Ill Neonate, 28 Days of Age or Less
99469	Subsequent Neonatal Critical Care, Per Day, Critically Ill Neonate, 28 Days of Age or Less
99471	Initial Pediatric Critical Care, Per Day, Critically Ill Infant or Young Child, 29 Days Through 24 Months of Age
99472	Subsequent Pediatric Critical Care, Per Day, Critically Ill Infant or Young Child, 29 Days Through 24 Months of Age
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
99475	Initial Pediatric Critical Care, Per Day, Critically Ill Infant or Young Child, 2 Through 5 Years of Age
99476	Subsequent Pediatric Critical Care, Per Day, Critically Ill Infant or Young Child, 2 Through 5 Years of Age
99477	Initial Hospital Care, Per Day, Neonate, Who Requires Frequent Interventions and Other Intensive Care Services
99478	Subsequent Intensive Care, Per Day,Recovering Very Low Birth Weight Infant (Present Body Weight Less Than 1500 Grams)
99479	Subsequent Intensive Care, Per Day, Recovering Low Birth Weight Infant (Present Body Weight of 1500-2500 Grams)

99480	Subsequent Intensive Care, Per Day, Recovering Infant (Present Body Weight of 2501-5000 Grams)
99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (eg, home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 60 minutes of total time is spent on the date of the encounter.
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, At least moderate level of medical decision making 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, High level of medical decision making during the service period, Face-to-face visit, within 7 calendar days of discharge
G0316	Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minute
G0317	Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional
G0318	Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact
G0410	Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes
G0422	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session
G0423	Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session
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
G3002	Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary beha
G3003	Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for G3002.
G9685	Physician service or other qualified health care professional for the evaluation and management of a beneficiary's acute change in condition in a nursing facility. this servic
S9152	Speech therapy, re-eval

ON-LINE DIGITAL EVALUATION & MANAGEMENT SERVICES

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
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 day; 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

NON-COVERED SERVICES

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 guarantee coverage]

93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System • Should only be appended to approved audio-only telehealth codes.
95	Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System • Should only be appended to approved telehealth codes. • The place of service code should reflect where the services were rendered had they been conducted in person.
GT	Service via interactive audio and video telecommunication systems [critical access hospitals] • The GT modifier is only allowed on institutional claims billed by CAH Method II providers
GQ	Service via Asynchronous Telecommunications systems
G0	Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (informational modifier)

PLACE OF SERVICE IDENTIFIERS

02	Telehealth: The location where health services and health related services are provided or received, through a telecommunication system. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
10	Telehealth Provided in Patient's Home: The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology

DEFINITIONS or DESCRIPTION OF SERVICE

Telemedicine Technology:
Consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), HAP covers telehealth/telemedicine services when delivered by a compliant real-time interactive system (allowing instantaneous interaction between the Member and the care provider via telecommunication system) at both the originating and distant sites. The technology used must meet the needs for audio and visual compliance in accordance with state & federal standards. Providers must ensure the privacy of the Member and the security of any information shared via telehealth interactions.

- **Synchronous telehealth care** consists of live interaction (audio-only or audio/video conference) between Member and Provider permitting two-way, instantaneous 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.
    - **Telehealth visits** use interactive synchronous telecommunication technology for office, hospital visits and other services that generally occur in-person. These communications are initiated by the Member. Examples include:
        - **Audio-only** or **Audio-Video visit**:
            - Contracted Telehealth vendor using remote access technology such as a smartphone, laptop or tablet to connect virtually with a provider instantly.

        - **Video Visits** in patient home (or non-clinical originating site)
            - **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
        - **Facilitated video visit or consultative telehealth visit** (visit is between two health professionals with the Member present at the hosting clinical originating site or requesting end)
- **Asynchronous telehealth care** are those communications with a delayed response from the recipient. Asynchronous telehealth care, also known as store and forward messaging, involves messaging (including condition-driven questionnaires or provider-to-provider consultation) 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. Examples include:
    - **E-visits or Online digital evaluation and management services** 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.
    - **Messaging**
    - **E-consult**
    - **Remote monitoring**

COVERAGE CRITERIA

1. **Telehealth visit**:
    a. Evaluation, management and consultation services using synchronous interactive telehealth technologies are covered for HAP/AHL Members when ALL of the following are met:
        i. The Member and provider must be present at the time of the consultation.
        ii. The provider must be HAP contracted.
        iii. Member consents to service provided via telehealth modality.
        iv. The consultation must take place via an interactive audio and/or video HIPAA compliant telecommunication system (provider equipment).
    b. Medicare Members must follow Medicare guidelines and covered services.
    c. Acceptable Equipment: 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**:
    a. 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.
    b. The Member must consent to receive asynchronous on-line services.
    c. For these E-Visits, the Member must generate the initial inquiry and communications can occur over a 7-day period.
    d. Applicable CPT codes: 99421, 99422, 99423 and 98970, 98971, 98972
3. **Virtual check-in communication**:
    a. 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).
    b. The Member must verbally consent to receive virtual check-in services.
    c. Virtual check in services may be furnished through several communication technology modalities, such as telephone (The practitioner may respond to the Member's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal).
        i. In addition, separate from these virtual check-in services, captured video or images can be sent to a physician).
4. **Mental Health Services**:
    a. If the Member doesn't have the technical capacity or the availability of real-time audio and visual interactive telecommunications, or they don't consent to the use of real-time video technology, HAP will cover audio-only communication for telehealth mental health services to Members located in their homes.
        i. NOTE: Services provided via text messaging are not a billable service.
    b. Coverage of services specific to the treatment of Autism Spectrum Disorders is addressed in a different Benefit Administration Manual policy. Please refer to: Autism Spectrum Disorders, Evaluation and Treatment.
5. **Place of Service**:

a. Consistent with Medicare billing rules, HAP will continue to accept telehealth services using the place of service it would have been provided when billed with the corresponding location modifier (such as POS 11 = office) instead of POS 02 (clinical originating site) or 10 (home originating site) when billed with an appropriate telehealth modifier (93 or 95 or GT).
    i. POS guidelines apply to Medicare Advantage plan Members as well as Members other than Medicare Advantage.

6. **Billing for Telehealth Services**:
    a. Forms:
        i. Medicare Advantage plan Members follow Medicare billing rules. Professional claims (1500 form) are appropriate.
        ii. Members other than Medicare Advantage Members: HAP will accept either a professional claims form (1500) or an institutional invoice (UB04).
            A. NOTE: An institutional invoice (UB04) is only acceptable when there is no associated professional form submitted for the service.
    b. Revenue codes:
        i. For services submitted on the institutional invoice, the appropriate National Uniform Billing Committee (NUBC) revenue code, along with the appropriate telemedicine Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) procedure code and a telehealth modifier (such as 95 or 93), must be used.

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.
    a. Appropriate informed consent which includes a description of potential risks, consequences, and benefits of telemedicine is obtained.
    b. All services provided are medically necessary and appropriate for the Member.
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 (list may not be all-inclusive):
        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. Physical/Occupational/Speech therapists
        x. Registered Dietitians (RDs) or Medical Nutritional Professionals (MNTs)
    b. NOTE: Through the end of CY 2023, PT, OT, SLP, DSMT, MNT providers should continue to bill for these services when furnished remotely in the same way they have been during the PHE.
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. NOTE: Any clinical criteria or contractual limitations for a service apply regardless of mode of service delivery.
4. Services must be provided by a HAP/AHL contracted or affiliated provider.
5. Medicare Advantage plan Members follow fee-for service Medicare billing guidelines and covered services.
    a. **Medicare Telehealth Service Codes @ https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes**
6. Medicaid Providers should refer to:
    a. **Medicaid Telemedicine Service Codes**: **https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/telemedicine**
    b. The Michigan Medicaid Provider Manual for coverage criteria, located at: **https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf**
    c. MDHHS - Health & Human Services. **PHE Unwind Policy Crosswalk. https://www.michigan.gov/mdhhs/end-phe/medicaid-benefit-changes/phe-unwind-policy-crosswalk**
    d. The Michigan Medicaid Fee Schedule located at: **https://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. Online digital evaluation and management services: 99421-99423; 98970 – 98972
    a. The communication should be performed through HIPAA-compliant platforms, like an electronic health record portal or secure email.
        i. Non-evaluative electronic communication of test results do not qualify for this type of code.
    b. Physician or Qualified health care professional:
        i. 99421-99423: CPT® guidelines indicate certain codes are appropriate when originating from the established patient to the physician or other qualified health care professional for evaluation or management of a problem utilizing internet resources.
        ii. The codes begin with the same phrasing: “Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days.”
    c. Qualified non-physician health care professional:
        i. 98970 – 98972 These are alternative codes (98970-98972) that are almost identical to 99421-99423. The difference is the provider type.
        ii. These codes are used by providers such as: speech-language pathologists, physical therapists, occupational therapists, social workers, and dietitians.
        iii. The codes begin with the same phrasing: "online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days".

EXCLUSIONS

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. Reminders for healthcare related issues.
    q. 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.
    r. 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.
    s. 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.
    t. Urgent care
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.
4. Counseling for mental health indications provided by text messaging is not covered for HAP/AHL Members because It is considered investigational, or unproven due to a lack of long-term outcome evidence that there is health outcome improvement for the Member.

REFERENCE:

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    a. Billing & Reimbursement for Institutional Providers
        i. SECTION 6 – HOSPITAL CLAIM COMPLETION – INPATIENT
            A. 6.5 TELEMEDICINE
        ii. SECTION 7 – HOSPITAL CLAIM COMPLETION – OUTPATIENT
            A. 7.27 TELEMEDICINE
        iii. SECTION 8 - REMITTANCE ADVICE
            A. 8.14 OTHER SERVICE REVENUE CODES
    b. Behavioral Health and Intellectual and Developmental Disability Supports and Services
        i. SECTION 3 – COVERED SERVICES
            A. 3.26 TELEMEDICINE
        ii. SECTION 4 – TELEMEDICINE
        iii. SECTION 18 – BEHAVIORAL HEALTH TREATMENT SERVICES/APPLIED BEHAVIOR ANALYSIS
            A. 18.9.D. TELEPRACTICE FOR BHT SERVICES
    c. Children's Special Health Care Services
        i. SECTION 9 – BENEFITS
            A. 2.3 TELEMEDICINE
    d. Federally Qualified Health Centers and Tribal Health Centers
        i. 7.4 COVERED SERVICES
    e. Home and Community Based Services
    f. Home Health
        i. SECTION 1 – GENERAL INFORMATION
            A. 1.1 FACE-TO-FACE ENCOUNTER
    g. Hospital
        i. SECTION 3 – COVERED SERVICES
            A. 3.33 TELEMEDICINE
    h. Nursing Facility Coverages
        i. 10.35 TELEMEDICINE
    i. Practitioner
        i. SECTION 17 – TELEMEDICINE
    j. RURAL HEALTH CLINICS
        i. SECTION 3 – BENEFITS
            A. 3.3 TELEMEDICINE
    k. School Based Services
        i. 2.4.C. TELEPRACTICE FOR SPEECH, LANGUAGE AND HEARING SERVICES
    l. Tribal Health Centers
        i. SECTION 3 – BENEFITS

Benefit Administration Manual Policies are developed to provide guidance to Members and Providers. This Policy relates only to the services or supplies described in it. The existence of a Benefit Administration Manual Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Policy. Coverage of services for Members is based on the Member's subscriber documents and is 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: **https://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: **https://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html**, the Michigan Medicaid Provider Manual will apply.

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