Expanded Coverage and Reimbursement for Virtual Visits and Telehealth

HAP is waiving all member cost share for virtual visits and telehealth from March 15 through April 30. We'll continue to evaluate the effective date of this change as the pandemic response continues to evolve.

All virtual visits and telehealth services will have cost share waived whether the service was initiated in response to COVID-19 symptoms or other general health concerns. This includes primary care, specialty care and behavioral health.

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

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

What we're advising members about telehealth and virtual visits
We're advising members to contact their doctor's office first for virtual visits or telehealth services. We understand some providers have limited ability to support telehealth and virtual visits. Therefore, HAP is advising members to use Amwell®, our contracted telehealth vendor. Members are also given instructions on how to use Amwell.

Note: Amwell providers are not currently enrolled in Medicaid. HAP continues to work with the State to determine if there is pathway to making Amwell available to Medicaid members.

Billing for telehealth and virtual visits
Please see the attached medical policy.

HAP is working our hard to ensure our members have access to our provider network during these challenging times.
Telemedicine, Telehealth, & Virtual Care Services

DESCRIPTION

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

Telemedicine Services

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

Telemedicine Technology:

- **Synchronous telehealth care**—live interaction (audio/video conference) between Member and Provider permitting two-way, real-time communications between an individual at the originating site and the healthcare professional at the distant site. These visits typically are used for office, hospital visits and other services that generally occur in-person. May be used by Members in either an established patient-provider relationship or as a new patient. Examples include:
  - Audio-Video visit:
    - AmWell visit
    - MyChart Mobile Video Visits
      - MyCare On Demand video visit: Member initiates contact and waits for next available provider (not pre-scheduled)
      - Scheduled Video visits – when the video visit is pre-scheduled similar to an office visit
  - Clinic-to-clinic or consultative telehealth visit (visit is between two health professionals with the Member present at the hosting or requesting end)

- **Asynchronous telehealth care** are those communications with a delayed response from the recipient. There is no real-time interaction. Asynchronous telehealth care is known as store and forward messaging involves messaging (including condition driven questionnaires) or data submission (monitoring) that the recipient will respond to within a specified time frame. These communications are used by Members in an established patient-provider relationship.
  - Messaging
  - E-consult
  - Remote monitoring
    - E-home care
    - Tele-radiology readings

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

99421 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes

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

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

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

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

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

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

Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes

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

Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth

Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth

Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth

Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth

Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth

Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth

Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy

Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth

Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth

Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
G2012  Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

G2061  Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes

G2062  Qualified nonphysician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes

G2063  Qualified nonphysician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes

G2086  Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month

G2087  Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month

G2088  Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)

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

98966  Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

98967  Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

98968  Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion

99441  Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442  Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

99443  Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion

98970  Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

98971  Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes

98972  Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

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

- Medicare Telehealth Services List @ https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

90785  Interactive Complexity (List Separately In Addition To The Code For Primary Procedure)

90791  Psychiatric Diagnostic Evaluation

90792  Psychiatric Diagnostic Evaluation With Medical Services

90832  Psychotherapy, 30 Minutes With Patient And/Or Family Member

90833  Psychotherapy, 30 Minutes With Patient And/Or Family Member When Performed With An Evaluation And Management Service

90834  Psychotherapy, 45 Minutes With Patient And/Or Family Member

90836  Psychotherapy, 45 Minutes With Patient And/Or Family Member When Performed With An Evaluation And Management Service

90837  Psychotherapy, 60 minutes with patient

90838  Psychotherapy, 60 Minutes With Patient And/Or Family Member When Performed With An Evaluation And Management Service

90839  Psychotherapy For Crisis; First 60 Minutes

90840  Psychotherapy For Crisis; Each Additional 30 Minutes (List Separately In Addition To Code For Primary Service)

90845  Psychoanalysis

90846  Family psychotherapy (without the patient present), 50 minutes

90847  Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes

90951  Monthly ESRD Services, for Patients Younger Than 2 Years of Age; with 4 or More Face-To-Face Physician Visits Per Month

90952  Monthly ESRD Services, for Patients Younger Than 2 Years of Age; with 2-3 Face-To-Face Physician Visits Per Month

90954  Monthly ESRD Services, for Patients 2-11 Years of Age; with 4 or More Face-To-Face Physician Visits Per Month
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>90955</td>
<td>Monthly ESRD Services, for Patients 2-11 Years of Age; with 2-3 Face-To-Face Physician Visits Per Month</td>
</tr>
<tr>
<td>90957</td>
<td>Monthly ESRD Services, for Patients 12-19 Years of Age; with 4 or More Face-To-Face Physician Visits Per Month</td>
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<tr>
<td>90958</td>
<td>Monthly ESRD Services, for Patients 12-19 Years of Age; with 2-3 Face-To-Face Physician Visits Per Month</td>
</tr>
<tr>
<td>90960</td>
<td>Monthly ESRD Services, for Patients 20 Years of Age and Older; with 4 or More Face-To-Face Physician Visits Per Month</td>
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<tr>
<td>90961</td>
<td>Monthly ESRD Services, for Patients 20 Years of Age and Older; with 2-3 Face-To-Face Physician Visits Per Month</td>
</tr>
<tr>
<td>90963</td>
<td>End-Stage Renal Disease (ESRD) Related Services for Home Dialysis Per Full Month, for Patients Younger Than 2 Yrs of Age</td>
</tr>
<tr>
<td>90964</td>
<td>End-Stage Renal Disease (ESRD) Related Services for Home Dialysis Per Full Month, for Patients 2-11 Years of Age</td>
</tr>
<tr>
<td>90965</td>
<td>End-Stage Renal Disease (ESRD) Related Services for Home Dialysis Per Full Month, for Patients 12-19 Years of Age</td>
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<tr>
<td>90966</td>
<td>End-Stage Renal Disease (ESRD) Related Services for Home Dialysis Per Full Month, for Patients 20 Years of Age and Older</td>
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<tr>
<td>90967</td>
<td>End-Stage Renal Disease (ESRD) Related Services for Dialysis Less Than A Full Month of Service, Per Day; Pt &lt; 2 Yrs</td>
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<tr>
<td>90968</td>
<td>End-Stage Renal Disease (ESRD) Related Services for Dialysis Less Than A Full Month of Service, Per Day; Pt 2-11 Yrs</td>
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<tr>
<td>90969</td>
<td>End-Stage Renal Disease (ESRD) Related Services for Dialysis Less Than A Full Month of Service, Per Day; Pt 12-19 Yrs</td>
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<tr>
<td>90970</td>
<td>ESRD Related Services for Dialysis Less Than A Full Month of Service, Per Day; Pt 20 Yrs of Age and Older</td>
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<tr>
<td>96116</td>
<td>Neurobehavioral status exam, per hr psychologist/physician time, patient time and interpretation/report time</td>
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<tr>
<td>96150</td>
<td>Health &amp; Behavior Assessment, Ea 15 Minutes; Initial Assessment</td>
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<tr>
<td>96151</td>
<td>Health &amp; Behavior Assessment, Ea 15 Minutes; Re-Assessment</td>
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<tr>
<td>96152</td>
<td>Health &amp; Behavior Intervention, Ea 15 Minutes; Individual</td>
</tr>
<tr>
<td>96153</td>
<td>Health &amp; Behavior Intervention, Ea 15 Minutes; Group (2+ Patients)</td>
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<tr>
<td>96154</td>
<td>Health &amp; Behavior Intervention, Ea 15 Minutes; Family (W/Patient Present)</td>
</tr>
<tr>
<td>96160</td>
<td>Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument</td>
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<tr>
<td>96161</td>
<td>Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardiz</td>
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<tr>
<td>97802</td>
<td>Medical Nutrition Therapy; Initial Assessment &amp; Intervention, Face-To-Face W/Pt, 15 Min</td>
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<tr>
<td>97803</td>
<td>Medical Nutrition Therapy; Re-Assessment &amp; Intervention, Face-To-Face W/Pt, Each 15 Min</td>
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<tr>
<td>97804</td>
<td>Medical Nutrition Therapy; Group (2 Or More Ind),Each 30 Min</td>
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<tr>
<td>99201</td>
<td>Office/Op Visit, New Pt, 3 Key Components: Prob Focus Hx; Prob Focus Exam; Strtfwd Med Decision</td>
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<tr>
<td>99202</td>
<td>Office/Op Visit, New Pt, 3 Key Components: Expand Prob Focus Hx; Expand Prob Focus Exam; Strtfwd Dec</td>
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<tr>
<td>99203</td>
<td>Office/Op Visit, New Pt, 3 Key Components: Detailed Hx; Detailed Exam; Med Decision Low Complexity</td>
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<tr>
<td>99204</td>
<td>Office/Op Visit, New Pt, 3 Key Components:Comprehensive Hx;Comprehensive Exam;Med Decisn Mod Complex</td>
</tr>
<tr>
<td>99205</td>
<td>Office/Op Visit, New Pt, 3 Key Components:Comprehensive Hx;Comprehensiv Exam;Med Decisn High Complex</td>
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</tbody>
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99211 Office/Op Visit, Est Pt, Not Requiring Physician Presence, Typically 5 Min
99212 Office/Op Visit, Est Pt, 2 Key Components: Prob Focus Hx; Prob Focus Exam; Strtfwd Med Decision
99213 Office/Op Visit, Est Pt, 2 Key Components: Expand Prob Hx; Expand Prob Exam; Med Decision Low Complex
99214 Office/Op Visit, Est Pt, 2 Key Components: Detailed Hx; Detailed Exam; Med Decision Mod Complexity
99215 Office/Op Visit, Est Pt, 2 Key Components: Comprehensive Hx; Comprehensive Exam; Med Decisn High Complex
99231 Subsequent Hosp Care 2+ Key Components: Prob Focus Int Hx; Prob Focus Exam; Med Dec Strtfwd/Low Complex
99232 Subsequent Hosp Care 2+ Key Components: Expand Prob Focus Int Hx; Expand Prob Exam; Med Dec Mod Complex
99233 Subsequent Hosp Care 2+ Key Components: Detailed Intervl Hx; Detailed Exam; Med Decision High Complex
99307 Subsequent nursing facility care, per day, 2 of: problem focus history; problem focus exam; straightfwd decision making
99308 Subsequent nursing facility care, per day, 2 of: expdd problem focus hx; expdd problem focus exam; low decision making
99309 Subsequent nursing facility care, per day, 2 of: detailed history; detailed exam; moderate medical decision making
99310 Subsequent nursing facility care, per day, 2 of: comp history; comp exam; medical decision making of high complexity
99354 Prolonged Physician Service, Office/Op W/Direct Contact; 1st Hr
99355 Prolonged Physician Service, Office/Op W/Direct Contact; Add'l 30 Min
99356 Prolonged Physician Service, Inpt W/Direct Contact; 1st Hr
99357 Prolonged Physician Service, Inpt W/Direct Contact; Add'l 30 Min
99406 Smoking and Tobacco Use Cessation Counseling Visit; Intermediate, Greater than 3 Minutes up to 10 Minutes
99495 Transitional Care Management Services, Moderate Complexity, Within 14 Calendar Days Of Discharge
99496 Transitional Care Management Services, High Complexity, Within 7 Calendar Days Of Discharge
99497 Advance care plan incl explanation & discussion of advance directives such as standard forms by the physician; first 30 mins, face-to-face w/patient, family mem(s) & surrogate
99498 Advance care plan incl explanation & discussion of advance directives such as standard forms by physician; each addl 30 mins (List in addition to code for primary procedure)
G0108 Diabetes outpatient self-management training services, individual, per 30 minutes
G0109 Diabetes outpatient self-management training services, group session (two or more), per 30 minutes
G0270 Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes
G0296 Counseling visit to discuss need for lung cancer screening (ldct) using low dose ct scan (service is for eligibility determination and shared decision making)
G0396 Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes
G0397 Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes
<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
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<tbody>
<tr>
<td>G0420</td>
<td>Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per 1 hour</td>
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<tr>
<td>G0421</td>
<td>Face-to-face educational services related to the care of chronic kidney disease; group, per session, per 1 hour</td>
</tr>
<tr>
<td>G0438</td>
<td>Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit</td>
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<tr>
<td>G0439</td>
<td>Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit</td>
</tr>
<tr>
<td>G0442</td>
<td>Annual alcohol misuse screening, 15 minutes</td>
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<tr>
<td>G0443</td>
<td>Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes</td>
</tr>
<tr>
<td>G0444</td>
<td>Depression screening, 15 minutes</td>
</tr>
<tr>
<td>G0445</td>
<td>Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training &amp; guidance on how to change sexual behavior</td>
</tr>
<tr>
<td>G0446</td>
<td>Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes</td>
</tr>
<tr>
<td>G0447</td>
<td>Face-to-face behavioral counseling for obesity, 15 minutes</td>
</tr>
<tr>
<td>G0506</td>
<td>Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)</td>
</tr>
<tr>
<td>G0513</td>
<td>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)</td>
</tr>
<tr>
<td>G0514</td>
<td>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)</td>
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</table>

**NON-COVERED HCPCS CODES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
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<tbody>
<tr>
<td>S9110</td>
<td>Telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month</td>
</tr>
<tr>
<td>T1014</td>
<td>Telehealth transmission, per minute, professional services bill separately</td>
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</table>

**Modifier [inclusion on this list does not imply coverage]**

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

**Place of Service**

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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>02</td>
<td>Telehealth: The location where health services and health related services are provided or received, through a telecommunication system.</td>
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</tbody>
</table>

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

1. **Telehealth visit:** Evaluation, management and consultation services using synchronous (real-time, interactive) telehealth technologies are covered for HAP/AHL Members when ALL of the following are met:
   a. The Member and provider must be present at the time of the consultation.
   b. The provider must be HAP contracted.
   c. The consultation must take place via an interactive audio and/or video HIPAA compliant telecommunication system (provider equipment). Medicare Members must follow Medicare guidelines.
      i. **Acceptable Equipment:** Common Skype is not acceptable for telehealth purposes; however, professional Skype-like products are available with technology that meets compliance. Health Insurance Portability and Accountability Act (HiPAA) guidelines require that any software transmitting protected personal health information meet a 128-bit level of encryption, at a minimum, need auditing, archival and backup capabilities. State laws must also be followed.

2. **E-visits or Online digital evaluation and management service:** Members may have non-face-to-face patient-initiated communications with their doctors without going to the doctor’s office by using online patient portals. These services can only be reported when the billing practice has an established relationship with the Member. The Member must verbally consent to receive virtual check-in services.
   a. For these E-Visits, the Member must generate the initial inquiry and communications can occur over a 7-day period.
   b. Medicare Advantage plan Members: The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable.
   c. Commercial plan Members: The services may be billed using CPT codes 99421-99423 and CPT codes 98970 - 98972, as applicable.

3. **Virtual check-ins:** Virtual check-ins are for Members with an established (or existing) relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available). The Member must verbally consent to receive virtual check-in services.
   a. Virtual check-in services may be furnished through several communication technology modalities, such as telephone (G2012). The practitioner may respond to the Member’s concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.
   b. In addition, separate from these virtual check-in services, captured video or images can be sent to a physician (G2010).

4. For ANY form of telemedicine service:
   a. A permanent record of the telemedicine communications must be maintained as part of the Member’s medical record.
   b. The provider must be a health care professional who is licensed, registered or otherwise authorized to provide health care in the state where the Member is located at the time the telemedicine service is rendered.
      i. Provider specialties eligible to provide telehealth services include:
         A. Physicians
         B. Nurse Practitioners (NPs)
         C. Physician Assistants (PAs)
         D. Certified Nurse-Midwives (CNMs)
         E. Clinical Nurse Specialists (CNSs)
         F. Certified Registered Nurse Anesthetists (CRNAs)
         G. Clinical Psychologists (CPs)
         H. Clinical Social Workers (CSWs)
         I. Registered Dietitians (RDs) or Medical Nutritional Professionals (MNTs)
   c. Appropriate informed consent which includes a description of potential risks, consequences, and benefits of telemedicine is obtained.
   d. All services provided are medically necessary and appropriate for the Member.

5. **Coverage of telemedicine services:** Coverage of services discussed in this policy, then the medical criteria applies.
   a. HAP has contracted with AmWell to provide telemedicine services for urgent care services. AmWell does not provide urgent care services for Behavioral Health indications for HAP/AHL Members.

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

**EXCLUSIONS**

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

3. Telemedicine services are not covered when billed by a non-HAP/AHL contracted or affiliated provider and/or company.

REFERENCE:

tename=mcl-500-3476

MEDITCARE REFERENCE:


MEDICAID REFERENCE:

1. MDHHS. Implant is placed just under the skin along with the electrode array, which consists of 22 active electrodes that follow the natural curve of your child’s cochlea and stimulate the hearing nerve. Medical services Administration Bulletin. MSA 20-09. Issued March 12, 2020. https://content.govdelivery.com/attachments/MDHHS/2020/03/12/file_attachments/1399761/MSA%2020-09.pdf
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/0,1607,7-132-2945-42542-42543-42546-42351-159815--00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945-42542-42543-42546-42351-159815--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.