PROVIDER REIMBURSEMENT GUIDANCE			
Telehealth/ Telemedicine Policy			
Original Date Approved	Effective Date SCO/ICO	Effective Date Medicare Advantage*	Revision Date
03/13/2020	04/23/2022	04/23/2022	05/10/2023

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options MA	☒ Medicare Premier – (PPO) MA**
☒ One Care MA	☒ CCA Medicare Preferred – (PPO) RI
☒ CCA Medicare Preferred – (PPO) MA	☒ CCA Medicare Value - (PPO) RI
☒ CCA Medicare Value - (PPO) MA	☒ Medicare Maximum – (HMO D-SNP) RI

PAYMENT POLICY SUMMARY:

Telehealth is the use of electronic communication and information technologies to provide or support clinical care at a distance. Telehealth is defined for payment purposes as the use of services via audio and video equipment permitting two-way, real time interactive communication between the CCA member and the distant site physician or practitioner. While telemedicine usually refers to clinical components or care of telehealth, telehealth and telemedicine are used interchangeably in this policy due to the terms being preferred differently by governing bodies.

For services furnished for the purposes of diagnosis, evaluation, or treatment of a behavioral/mental health disorder to a member in their home, interactive telecommunications may also include two-way, real-time audio-only communication technology if the member is not capable of or does not consent to the use of video technology.

Through December 31, 2024, members with Medicare can receive telehealth services in their home (i.e., not a medical office or facility) and even by audio only for some non-behavioral/ mental telehealth services as allowed in the current calendar year Centers for Medicare & Medicaid Services (CMS) Medicare Physician Fee Schedule.

Massachusetts and Rhode Island also recognize telehealth as (a) remote patient monitoring and (b) online adaptive interviews for the purpose of evaluating, consulting, prescribing, treating, or monitoring of a member's health. Additionally, for members in Rhode Island, store-and-forward technology as an avenue for telemedicine is available, but this does not include: (1) an email message, (2) facsimile (fax) transmission between the provider and member, or (3) an automated computer program used to diagnose and/or treat ocular or refractive conditions. Additionally, for members with Massachusetts Medicaid, provider-to-provider asynchronous e-consults are available as of April 1, 2023.

Unless stated otherwise, CCA aligns with the Centers for Medicare & Medicaid Services (CMS) guidance for telehealth coverage. Services delivered via telehealth should meet medical necessity and be clinically appropriate to deliver via the mode of telehealth used. Reimbursement guidance & billing guidance (including place of service, codes, and modifiers) should be accurately documented for telehealth services provided to CCA members. While CCA allows reimbursement for some services via telehealth, it is not a requirement to provide services in this manner.

AUTHORIZATION REQUIREMENTS:

CCA does not have telehealth-specific authorization requirements, but other CCA notification and authorization policies and procedures apply. For more information on prior authorizations, please refer to the Prior Authorization Requirements in the plan specific Provider Manual.

REIMBURSEMENT GUIDELINES:

The following telehealth-related reimbursement guidelines are addressed in this payment policy:

A. Eligible Providers
B. HIPAA Compliance
C. In-Person Requirements
D. Obtaining Consent
E. Documentation
F. Best Practices
G. Written Referrals/ Prescriptions for Service
H. Reimbursement
I. Geographic Restrictions & Originating Site
J. Opioid Treatment Programs

A. Eligible Providers

Providers eligible to perform telehealth services are the following: physician, nurse practitioner, physician assistant, nurse-midwife, clinical nurse specialist, clinical psychologist, clinical social worker, and registered dietician or nutrition professional.

- Additionally, telehealth services can be provided by a physical therapist, occupational therapist, speech language pathologist, or audiologist through December 31, 2024.
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) can serve as a telehealth provider for behavioral/ mental health services.
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) may also provide telehealth services for non-behavioral/ mental health through December 31, 2024.

Eligibility for certified registered nurse anesthetists to conduct telehealth visits varies by state and product. Certified registered nurse anesthetists are covered by Medicare so are eligible providers for Medicare Advantage members and dual-eligible members (i.e., Senior Care Options, OneCare, Medicare Maximum) for Medicare covered services. For dual-eligible members receiving a service not covered by Medicare, coverage would depend on Medicaid coverage and allowances. For example, Massachusetts Medicaid does not cover services by certified registered nurse anesthetists via telehealth.

Only contracted providers who perform and bill telehealth services and

(a) are within the scope of their practice to perform the service, and

(b) are licensed within their respective state(s) based on the member's location at the time of the service,

will be reimbursed for the performance of telehealth services.

B. HIPAA Compliance

Providers are responsible for ensuring telehealth services in any format (including web-online or web-based scheduling) are compliant with federal, including HIPAA (Health Insurance Portability and Accountability Act) requirements, and state privacy laws so that members rights to confidentiality and security are protected.

- During the COVID-19 nationwide public health emergency, the Office of Civil Rights (OCR) has exercised its enforcement discretion to not impose penalties for non-compliance with HIPAA rules in connection with the good faith provision of non-public telehealth use. However, the COVID-19 Federal Public Health Emergency will end May 11, 2023, at which time - barring other waivers or allowances - telehealth modes need align with HIPAA requirements.
- Telehealth must follow the HIPAA Privacy Rule including, but not limited to, (1) applying reasonable safeguards to protect the member's privacy, and (2) verifying the identity of the member.
- When allowed, audio-only services may be conducted via (1) a standard telephone landline or (2) other electronic technologies such as (a) communication applications (apps), (b) VoIP technologies, (c) technologies that electronically record and transcribe, (d) messaging services that store audio messaging.
    - HIPAA's Security Rule applies when electronic technologies (i.e., not a standard telephone landline) are used to protect a member's electronic protected health information (ePHI).

C. In-Person Requirements

All in-person, same location requirements for Medicare and Medicaid services, as applicable, should be followed.

- An in-person visit within six (6) months of an initial behavioral/mental health telehealth service, and annually thereafter, is not required through December 31, 2024.
- Following the end of the COVID-19 Federal Public Health Emergency on May 11, 2023, the Drug Enforcement Administration (DEA) has issued the following temporary flexibilities:
    - Extending the full set of telemedicine flexibilities regarding prescription of controlled medications as were in place during the PHE through November 11, 2023.
    - For any practitioner-patient telemedicine relationships that have been established on or before November 11, 2023, the full set of telemedicine flexibilities regarding prescription of controlled medications as were in place during the PHE will continue to be permitted through November 11, 2024.

D. Obtaining Consent

Members should be provided with information in plain language to support them in making an informed decision about whether to participate in telehealth services. Information should be

provided in the member's preferred method of delivery and documented in the member's record. The provider should provide the member with a statement explaining at least:

- What a telehealth visit entails.
- What is expected from the member and the therapy provider.
- Any relevant privacy considerations; and
- That the member may take back their consent for telehealth services at any time.

At least verbal consent must be obtained before starting telehealth and consent, whether verbal or written, should be documented in the member's record.

For Virtual Check-In services, annual consent can be obtained at the same time as the services are furnished for both new and established patients. After May 11, 2023, Virtual Check-ins may only be furnished to established patients.

Members have the right to decline to receive services via telehealth and instead opt for in-person care. State rules, such as in Rhode Island for e-mail and text-based conversations, around informed telehealth consent should be followed.

E. Documentation

Documentation must support the service performed and must be retained in the member's permanent medical record. Documentation should comply with applicable state and federal requirements and be at least on par with documentation of in-person visits (including but not limited to verifying the member's identify, disclose the providers identify and credentials, etc.). Written policies should exist for electronic communications including topics such as privacy, process, storage, best practices, and quality oversight.

For Massachusetts Senior Care Options and OneCare Members, documentation must also include:

- That the service was provided via telehealth; and
- A description of the rationale for service via telehealth.

F. Best Practices

The following are best practices when delivering services via telehealth:

1. Before each member appointment, the provider must ensure that the provider is able to deliver the service to the same standard of care and in compliance with licensure regulations and requirements, programmatic regulations, and performance specifications related to the service (e.g., accessibility and communication access) using telehealth as is applicable to the delivery of the services in person. For example, hands-on care is not required. If the provider cannot meet this standard of care or other requirements, the provider must direct the member to seek in-person care.
2. Providers must inform members of the location of the provider rendering services via telehealth (i.e., distant site) and obtain the location of the member (i.e., originating site).
3. The provider must inform the member of how the member can see a clinician in-person in the event of an emergency or as otherwise needed.

G. Written Referral/ Prescription for services (Massachusetts Senior Care Options and OneCare Only)

Beginning May 12, 2023, initial and ongoing prescriptions (as required for the service) for services or referrals will be required in a written format versus an oral format for therapy services.

H. Reimbursement (Massachusetts Senior Care Options and OneCare Only)

For Senior Care Options and OneCare Massachusetts members, telehealth-eligible covered services via a telehealth modality will be reimbursed at parity with its in-person counterpart. Likewise, through September 30, 2023, an eligible distant-site provider delivering covered services via telehealth in accordance with this bulletin may bill CCA a facility fee if such a fee is permitted under the provider's governing regulations or contracts. Also rates of payment for therapist services delivered via telehealth will be the same as rates of payment for therapist services delivered via traditional (e.g., in-person) methods identified in 101CMR 339.00: Rates for Restorative Services.

I. Geographic Restrictions & Originating Site

There are no geographic restrictions for originating site for telehealth services for mental/behavioral health services.

There are no geographic restrictions for originating site for telehealth services for non-mental/behavioral health services until December 31, 2024.

The home is allowed to be an originating site for Home Health Agency (HHA) services through December 31, 2024.

Rural hospital emergency departments are allowed as an originating site permanently.

J. Opioid Treatment Programs

Patient counseling and therapy services as well as periodic assessments can be provided by telephone in cases where two-way interactive audio-video communication technology is not available. After December 31, 2023, periodic assessments must have a video/audio interaction.

After May 11, 2023, when the Federal Public Health Emergency ends, the following temporary waivers are scheduled to expire:

- Flexibility allowing practitioners delivering OUD care via an Opioid Treatment Program (OTP) the option to initiate and support patients on buprenorphine treatment via telehealth (audio-video or audio-only) without the need for an in- person exam.
- Flexibility allowing practitioners delivering OUD care via an OTP the option to support patients on methadone treatment via audio-video telehealth, including counseling and therapy services delivered via audio-only telehealth, where needed, to ensure care continuity.

The Substance Abuse & Mental Health Services Administration (SAMHSA) has a proposed rule to extend this flexibility or provide an interim solution to address the above in some capacity.

Until May 11, 2024, a year after the end of the COVID-19 Federal Public Health Emergency, the Substance Abuse & Mental Health Services Administration (SAMHSA) will allow flexibility for Opioid Treatment Programs to dispense take-home and split doses of methadone, where clinically appropriate.

BILLING AND CODING GUIDELINES:

The following telehealth-related billing and coding guidelines are addressed in this payment policy:

A. Place of Service
B. Modifiers
    a. For Professional Services
    b. For Institutional Claims
C. All Eligible Codes & Services
D. Specialty Telehealth Codes
    a. Audio Only Specific Codes
    b. Virtual Check-ins
    c. E-Visits
    d. Audio Only Services
    e. Provider-to-Provider e-Consultation
    f. Remote Patient Monitoring/ Remote Physiological Monitoring

A. Place of Service

The Place of Service (POS), aligning with CMS Place of Service descriptions, attests to the accurate location of the member:

Place of Service Code	Place of Service Name	Place of Service Description
02	Telehealth Provided Other than in a Patient's home	The location where health services and health related services are provided or received, through telecommunication technology. 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.

B. Modifiers

For claims containing POS 02 or POS 10, modifiers signaling telehealth services must be used.

a. **For professional claims**, providers must include the following when appropriate:

Modifier	Description
95	Counseling and therapy services rendered via audio-video telecommunications
93	Services rendered via audio-only telehealth
FQ	Counseling and therapy services provided using audio-only telecommunications
FR	Supervising practitioner was present through a real-time two-way, audio and video communication technology
GQ	Via asynchronous telemedicine

Therapy providers and rehabilitation centers must include modifier “GT” when submitting claims for services delivered via telehealth.

b. **For institutional claims**, providers are to use the following modifiers:

Modifier	Description
95	Counseling and therapy services rendered via audio-video telecommunications
93	Services rendered via audio-only telehealth
GT	Services rendered via interactive audio and video telecommunications systems * Modifier GT is required on the institutional claim, for the distant-site provider, when there is an accompanying professional claim containing Place of Service (POS) 02 or 10.
FQ	Counseling and therapy services provided using audio-only telecommunications
FR	Supervising practitioner was present through a real-time two-way, audio and video communication technology
GQ	Via asynchronous telemedicine

Professional and institutional claims with the aforementioned modifiers must also meet the following requirements:

- modifier 93 is to be allowed only for codes listed in Appendix T of the CPT coding book; and
- modifier 95 is to be allowed only with codes listed in Appendix P of the CPT coding book.

c. Therapy providers, speech and hearing therapists, and rehabilitation centers must include modifier "GT" when submitting claims for services delivered via telehealth.

C. All Eligible Codes & Services

The most current CMS Medicare Physician Fee Schedule[1] outlines which codes are allowed by CMS & CCA for telehealth audio-video services, and which are allowed for audio-only services. States may provide coding guidance; however, Rhode Island does not have additional guidance around coding at the time of this update (April 2023). Claims must include appropriate modifiers and places of service codes as noted in the reimbursement guidelines section of this document in order to accurately reflect the service provided.

Federally, the following guidance is provided regarding covered or non-covered services:

- **Home Health Agencies (HHAs)** can permanently provide more services to beneficiaries using telecommunications technology within the 30-day period of care, as long as it is part of the patient's plan of care and does not replace needed in-person visits as ordered on the plan of care. CMS acknowledges that the use of such technology may result in changes to the frequency or types of in-person visits outlined on existing or new plans of care. Telecommunications technology can include, for example: remote patient monitoring; telephone calls (audio only and TTY); and two-way audio-video technology that allows for real-time interaction between the clinician and patient.
- **Acute Hospital Care at Home Initiative** will not be allowed, barring further regulatory flexibilities/ allowances, after December 31, 2024.
- After May 11, 2023, Medicare patients with **end-stage renal disease (ESRD)** who are on home dialysis must receive face-to-face visits without the use of telehealth, at least monthly in the case of the initial there months of home dialysis and at least once every three consecutive months after the initial three months.
- After May 11, 2023, the waivers to use a telehealth mode for **National Coverage Determination (NCD) or Local Coverage Determination (LCD) evaluations and assessments** previously requiring an in-person, face-to-face visit will expire.
- After May 11, 2023, the waivers for **frequency restrictions** for codes furnished by telehealth expired. The following will once again take effect:
    - A subsequent inpatient visit could be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233).
    - A subsequent skilled nursing facility visit could be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 14 days (CPT codes 99307- 99310).
    - Critical care consult codes could be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation (HCPCS codes G0508-G0509).
- Prior to December 31, 2023, the regulatory definition of **direct supervision**, which requires the supervising physician or practitioner to be "immediately available" to furnish assistance and direction during the service, to include "virtual presence" of the

[1] As of April 2023, the 2023 CMS Physician Fee Schedule is available at: https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1770-f and the general Physician Fee Schedule website is: https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched

supervising clinician through the use of real-time audio and video technology. After December 31, 2023 (the end of the calendar year that the COVID-19 Federal Public Health Emergency ends), this flexibility of the regulatory definition will return to not include telehealth.

- After May 11, 2023, the **Hospitals and Critical Access Hospitals (CAH)** waiver which made it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off-site hospital will expire.
- **Mental/ Behavioral Health Services**: Video-audio may be used to furnish services for the purposes of diagnosis, evaluation, or treatment of a behavioral/mental health disorder to a member in their home. Interactive telecommunications may also include two-way, real-time audio-only communication technology if the member is not capable of or does not consent to the use of video technology.
- Certain **Hospital-Only Remote Outpatient Therapy and Education Services** were allowed via a waiver during the Federal Public Health Emergency. However, after May 11, 2023, flexibilities via telehealth will not be allowed when the member is at home, except for behavioral health services furnished remotely by clinical staff of hospital outpatient departments.

For Massachusetts Senior Care Options and OneCare Members

- The following services are not be eligible for coverage of telehealth services under Massachusetts Medicaid: Ambulance Services, Ambulatory Surgery Services, Anesthesia Services, Certified Registered Nurse Anesthetist Services, Chiropractic Services, Hearing Aid Services, Inpatient Hospital Services (though not hospital-at-home services), Laboratory Services, Nursing Facility Services, Orthotic Services, Personal Care Services, Prosthetic Services, Renal Dialysis Clinic Services, Surgery Services, Transportation Services, or X-Ray/Radiology Services.
- In alignment with 42 CRF 440.70, providers may permanently use the mode of video/audio telehealth for face-to-face meetings for **Durable Medical Equipment** (DME) and **Oxygen and Respiratory Therapy**.
- Effective May 12, 2023,
    - **Continuous Skilled Nursing Services** are no longer allowed via telehealth.
    - **Day Habilitation Services** are no longer allowed via telehealth
    - **Independent Nurses**: The flexibility to allow a complex care member's Comprehensive Needs Assessment to be conducted by an Independent Nurse via telehealth will no longer be allowed. Instead, complex care members will receive in-person Comprehensive Needs Assessments. This applies to members seeking Community Case Management (CCM) services and for members requiring reevaluation for CCM services.
    - **Personal Care Management**
        - Initial clinical evaluations and re-evaluations including reassessments based on significant change must be conducted in-person not via telehealth.
        - Functional skills training sessions may be conducted in-person or by video conference, as appropriate 1) at the discretion of the provider, and 2) with the consent by the member. Note that if the provider deems video conference appropriate, with consent by the member, but the member lacks video conference technology or otherwise requests a telephonic session, the provider may conduct the session telephonically.

- **Adult Foster Care and Group Adult Foster Care**: Telehealth (including telephone or live video) is allowed for most services, except
  - Caregiver or direct care aide assistance with activities of daily living or instrumental activities of daily living, including cueing and supervising such activities; and
  - Initial evaluations and reassessments, including reassessments based on significant change.
- **Hospice (Third Benefit Period)**: Consistent with the federal Consolidated Appropriations Act of 2023, MassHealth will continue to cover the face-to-face visit required for members entering their third hospice benefit period when appropriately provided via telehealth. Under the Consolidated Appropriations Act, the face-to-face visit may only be conducted via two-way audio-video telecommunications technology that allows for real-time interaction.
- **Rehabilitation Center**: Consistent with the federal Consolidated Appropriations Act of 2023, Rehabilitation Services are covered via telehealth services until December 31, 2024, unless specified earlier. Comprehensive evaluations or reevaluations conducted via telehealth must be via live video/audio modes. Live video is preferred for follow-up visits, but telephone is allowed if allowed by the code being used for the service.
- **Speech and Hearing**: Consistent with the federal Consolidated Appropriations Act of 2023, Speech and Hearing Services are covered via telehealth services until December 31, 2024, unless specified earlier. Comprehensive evaluations or reevaluations conducted via telehealth must be via live video/audio modes. Live video is preferred for follow-up visits, but telephone is allowed if allowed by the code being used for the service.

D. Specialty Telehealth Services

a. Telehealth-Specific Codes

The following G codes (included in CMS's Physician Fee Schedule) are specific to telehealth and not billable by non-physician behavioral health providers:

Procedure Codes	Description
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth
G0425	Telehealth consultation, emergency department or initial inpatient, typically, 30 minutes communicating with the patient via telehealth
G0426	Telehealth consultation, emergency department or initial inpatient, typically, 50 minutes communicating with the patient via telehealth
G0427	Telehealth consultation, emergency department or initial inpatient, typically, 70 minutes communicating with the patient via telehealth
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
G0508	Telehealth consultation, critical care, initial, physicians typically spend

	60 minutes communicating with the patient and providers via telehealth
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth

b. Virtual Check In's

Virtual check-ins, or Communication Technology-based Services (CTBS) must be initiated by the member and have consent obtained for the service:

Code	Description	Modality
G2010	Remote evaluation of recorded video and/or image(s) submitted by an established patient (e.g., store and forward) including interpretation with follow up with the patient within 24 business hours or soonest available appointment, not originating from a visit within the previous 7 days	Recorded video and/or image(s)
G2012	Brief communication technology-based service (e.g., virtual check-in) by a physician, or other qualified health care professional who can report evaluation & management services, provided to an established patient, not related to a service within the previous seven days and not resulting in a visit within 24 hours. 5-10 minutes of medical discussion	Telephone, Audio/Video, Secure Text Messaging, Email, or Patient Portal.
G2251	Brief communication technology-based service, e.g., virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of clinical discussion	
G2252	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: 11–20 minutes of medical discussion	
G0071	Payment for communication technology-based services for 5 minutes or more of a virtual (nonface-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit;	Recorded video and/or image(s) **During covid-19 PHE (Public Health Emergency) this also includes*

	RHC or FQHC only	*99421-99423**

During the COVID-19 Federal Public Health Emergency (FPHE), these services were allowed for both new and established patients. After May 11, 2023, these are only allowed for established patients.

c. **E-Visits**

Established members have the ability to engage in non-face-to-face member-initiated communications with their doctors without traveling to their provider's office and communicating with their provider via Patient Portal. The member must initiate and consent to the discussion, and communication may occur over a 7-day period.

During the COVID-19 Federal Public Health Emergency (FPHE), these services were allowed for both new and established patients. After May 11, 2023, these are only allowed for established patients.

Code	Description
99421	Online digital evaluation & management service, for an established patient, for up to 7 days cumulative time during the 7 days; 5-10 minutes
99422	Online digital evaluation & management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11-20 minutes
99423	Online digital evaluation & management service, for an established patient, for up to 7 days cumulative time during the 7 days; 21 or more minutes

Clinicians who may not bill independently evaluation & management services (ex: Physical Therapists, Occupational Therapists, Speech Language Pathologists, Clinical Psychologists) may report the following codes for E-Visits:

Code	Description
98970	Qualified nonphysician health care professional online digital assessment and management, 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 assessment and management, 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 assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

d. Audio Only Services

Audio Only Services are defined by CPT as non-face-to-face Evaluation & Management (E&M) services provided to a patient using the telephone provided by a physician or other qualified health care professional, who may report E&M services.

Established patients can engage in non-face-to-face patient-initiated communications with their provider if the telephone service does not end with the patient being seen within the next 24 hours or next available urgent care appointment. If the telephone service is in reference to a service performed within the previous 7 days (either

requested or unsolicited patient follow up) or within the post-operative period of a previously completed procedure, then the service is considered part of that procedure and not reported separately.

Below are the coding/billing guidelines for Audio Only Services through December 31, 2024, via the Consolidated Appropriations Act, 2023:

Code	Description
99441	Telephone E&M services by a physician, or other qualified health care professional who can report evaluation & management services, provided to an established patient, not related to a service within the previous seven days and not resulting in a visit within 24 hours or soonest available appointment. 5-10 minutes of medical discussion.
99442	Telephone E&M services by a physician, or other qualified health care professional who can report evaluation & management services, provided to an established patient, not related to a service within the previous seven days and not resulting in a visit within 24 hours or soonest available appointment. 11-20 minutes of medical discussion.
99443	Telephone E&M services by a physician, or other qualified health care professional who can report evaluation & management services, provided to an established patient, not related to a service within the previous seven days and not resulting in a visit within 24 hours or soonest available appointment. 21-30 minutes of medical discussion.

Additionally, some services are allowed via audio-only through December 31, 2023, as noted in the Physician Fee Schedule.

FQHC's/RHC's should bill T1015 in addition to the qualifying visit 99441-99443 and 98966-98968. G2025 should be used for Distant Site Telehealth fees for FQHC's/RHC's.

Code	Description
98966	Telephone assessment and management services by a qualified non-physician professional provided to an established patient, not related to a service within the previous seven days and not resulting in an assessment and management service or procedure within 24 hours or soonest available appointment. 5-10 minutes of medical discussion
98967	Telephone assessment and management services by a qualified non-physician professional provided to an established patient, not related to a service within the previous seven days and not resulting in an assessment and management service or procedure within 24 hours or soonest available appointment. 11-20 minutes of medical discussion
98968	Telephone assessment and management services by a qualified non-physician professional provided to an established patient, not related to a service within the previous seven days and not resulting in an assessment and management service or procedure within 24 hours or soonest available appointment. 21-30 minutes of medical discussion

e. Provider-to-Provider e-Consultation (Massachusetts Senior Care Options and OneCare Only)

The following CPT codes may be billed for provider-to-provider e-consultations provided via telehealth (and in the case of 99446-99449, for live consultations as well):

Procedure Codes	Description
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional; 5 minutes or more of medical consultative time
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional; 30 minutes
99446	Interprofessional telephone/Internet/electronic health assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
99447	Interprofessional telephone/Internet/electronic health assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review
99448	Interprofessional telephone/Internet/electronic health assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review
99449	Interprofessional telephone/Internet/electronic health 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

In order to bill for the initial provider-to-provider e-consult, CPT code 99452 must be used (both to create the consult and respond to the member) for instances requiring at least 30 minutes of the requesting provider's time. Note that 99452 will only be paid one time for each member in a 14-day period even if billed for multiple instances.

Providers acting in a primary care capacity or providing evaluation and management (E/M) services may bill 99452. Providers must be seeking specialty guidance from a specialist with whom the member does not already have an established relationship. (For example, a primary care or urgent care provider may initiate an e-consult via 99452 to a pulmonologist

when a lung nodule is found on a patient's x-ray and the member has no prior relationship with a pulmonologist. However, if a member is already established with a pulmonologist, e-consultation codes should not be used. Instead, medical record gateway communication and other similar communication channels should be used.)

CPT codes 99451, 99446, 99447, 99448, or 99449 may be used to answer a provider-to-provider e-consult (including to review the request and medical records, make recommendations, and report back to the requester) that requires five minutes or more of medical consultative time. Note that 99451, 99446, 99447, 99448, or 99449 will only be paid one time for each member in a seven-day period even if billed for multiple instances. 99451, 99446, 99447, 99448, or 99449 will also not be paid if a visit occurs with the same type of provider as that which was e-consulted within 14 days of the e-consult. (For example, if an e-consult is billed by a cardiologist and the member has also seen a cardiologist within the same 14-day period, the e-consult will not be paid.)

Providers acting in a specialty care and consultative function to bill codes 99451, 99446, 99447, 99448, or 99449. Providers providing specialty guidance must be from a specialty type with whom the member does not already have an established relationship. (For example, a pulmonologist may answer an e-consult via 99451, 99446, 99447, 99448, or 99449 when a lung nodule is found on a patient's x-ray and the member has no prior relationship with a pulmonologist. However, if a member is already established with a pulmonologist, these e-consultation codes should not be used to provide an answer from another pulmonologist. Instead, medical record gateway communication and other similar communication channels should be used without billing of these codes.)

Parties mutually answering an individual e-consult with a pairing of codes 99451, 99446, 99447, 99448, or 99449 with 99452 need not be part of the same health system but must use secure electronic mediums to discuss and hold patient records.

E-consult codes are to be billed on professional claims only. Providers may not bill CCA a facility claim for these e-consult codes.

Modifiers for POS 02, POS 10, or modifier 95 are not required and will not be accepted for e-consult codes 99446, 99447, 99448, 99449, 99451, or 99452.

E-consults may be billed for the same date of service as an office (e.g., E/M) visit.

f. Remote Patient Monitoring & Remote Physiologic Monitoring

After May 11, 2023, clinicians must have an established relationship with the patient prior to providing Remote Physiologic Monitoring (RPM) services. CMS will continue to allow RPM services to be furnished to patients with acute and chronic conditions. These services must only be billed when at least 16 days of data have been collected.

Procedure Codes	Description
99453	Staff service: initial set up of device; bill after 16 days of monitoring
99454	Staff or facility service covers initial device payment; bill after 16 days of receipt of and monitoring readings, bill every 30 days
99457	QHP service; 20 minutes of Non F2F and F2F time spent in analysis and via synchronous communication with patient the findings or care

	plan
99458	Add-on code: full additional 20 minutes for services described in 99457

AUDIT and DICLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Please refer to CPT/HCPCS for complete and updated list of codes. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies, procedures, and claims editing logic. CCA has the right to conduct audits on any contracted provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

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POLICY TIMELINES DETAILS:

1. Drafted October 2019
2. Approved March 2020
3. Revised March 17th, 2020, to reference COVID-19 temporary Telemedicine regulation changes
4. Revised April 9th, 2020, to include further language to clarify Behavioral Health services
5. Revised April 13th, 2020, due to the release of new COVID-19 regulations
6. Revised April 17th, 2020, due to the release of new COVID-19 regulations
7. Revised April 20th, 2020, due to the release of new COVID-19 regulations
8. Revised April 27th, 2020, due to the release of new COVID-19 regulations
9. Revised June 2nd, 2020, to include FQHC/RHC codes
10. Revised November 15, 2021
11. Revised March 2022, revised POS codes 02 & 10
12. Revision: April 2023, add Medicare Premier – (PPO) MA* product