RB.024.A Professional Telehealth Services (Medicaid & CHIP)

Original Implementation Date : 08/01/2022
Version [A] Date : 08/01/2022
Last Reviewed Date: December 2024

PRODUCT VARIATIONS

This policy only applies to Health Partners Plans Medicaid & CHIP product lines.

Application of Claim Payment Policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Payment may vary based on individual contract.

POLICY STATEMENT

Professional Telehealth Services are covered and eligible for reimbursement when all the following requirements are met:

- The service is medically necessary and is delivered using any of the following types of communication:
  - Telehealth visit.
  - Telephone based evaluations.
- The member seeking medical care is present at the time of service (i.e., real-time interaction between the member and the healthcare provider).
- Service must be rendered by our Physicians (PCP or Specialist), Nurse Practitioners (NP's), Certified Registered Nurse Anesthetists (CRNA), Physician Assistants (PA's), Registered dietitians, Pharmacists, Nurse -midwives, Clinical Nurse specialist.

Virtual check-ins and E-visits are not eligible for reimbursement consideration. We follow the guidelines listed below for telehealth/telemedicine services.

TYPE OF SERVICE	DESCRIPTION OF SERVICE	CODING	Patient Relationship with Provider	Required Place of Service	Required Modifier	Requires Audiovisual Synchronous Real-time Communication
Telehealth Visits*	A visit with a provider that uses synchronous interactive audio and video telecommunications system.	99202-99205 99212-99215 (office or other outpatient visits)	New or established	02 or 10	GT or 95	Yes
		G0425, G0426, G0427(Telehealth Consultations, emergency department or initial inpatient) G0406, G0407, G0408 (Follow-up inpatient telehealth consultations furnished to individuals in hospitals or SNFs) 98000-98005 (Synchronous audio-video visit for the evaluation and management of a new or established patient)	New or established	02 or 10	GT or 95	Yes
		T1015 (FQHC)	New or established	02, 10 or 50	GT or 95	Yes

TYPE OF SERVICE	DESCRIPTION OF SERVICE	CODING	Patient Relationship with Provider	Required Place of Service	Required Modifier	Requires Audiovisual Synchronous Real-time Communication
Telephone Based Evaluations	Telephone services are non-face-to-face encounters originating from the established patient for evaluation or management of a problem provided by a qualified clinician. For telephone-based services, codes are time-based.	Codes 98008-98016, 98966-98968	Established	02 or 10	--	No

**For telehealth visits* *(synchronous interactive audio and video telecommunications system) providers must report the appropriate Evaluation & Management (E&M) procedure code that would have applied had the service been provided in the office. In addition, providers must use the appropriate telehealth modifier, 95, GT. These types of visits shall be reimbursed in accordance with the provider's contract, Health Partners Plans fee schedules and the member's benefit plan.*

Urgent Care Centers (UCC's) are NOT eligible to receive payment for their case rate code (S9083) when Professional Telehealth Services are performed.

- If an UCC submits a claim with their case rate code when a service is rendered via telehealth, the claim will be denied.
- Only services rendered in person and face to face are eligible for case rate payment (S9083).
- UCC's are eligible for payment of Professional Telehealth Services if the policy criteria are met, and the above Telehealth Visit procedure codes are explicitly included in the provider's contract with us.

Federally Qualified Health Centers (FQHC's) are eligible to receive payment for their case rate code (T1015) when performed in person or virtually through synchronous interactive audio and video telecommunication systems.T1015 must be reported with POS 02, 10 or 50 and modifiers GT or 95.

FQHC's are not eligible to receive payment for telehealth visit codes 99202-99205, 99212-99215, G0425-G0427 and G0406-G0408.

FQHC's are eligible to receive payment for telephone-based evaluations 98008-98016, , 98966-98968). When a FQHC performs a telephone-based evaluation but bills for telephone-based evaluations (98008-98016, , 98966-98968) **and** their case rate code (T1015), the FQHC will only be reimbursed for the telephone-based evaluation.

POLICY GUIDELINES

1. Professional Telehealth Services would typically NOT occur more than once per week for the same episode of care. Providers may be subject to an audit if increased frequency occurs.

2. Authorization is not required for Professional Telehealth Services alone.

3. Providers are expected to report the most appropriate Current Procedural Terminology (CPT®), or Healthcare Common Procedure Coding System (HCPCS) code and applicable modifier for Professional Telehealth Services provided.

Commented [CZ1]: @Sinni, Joe With the new modifier statement, does this statement need to stay or be altered?

4. Professional providers performing telemedicine services must report the appropriate modifier and place-of-service to represent telemedicine services for payment.

4. Telephone codes 98008-98016, 98966-98968 should not be reported when originating from a related E/M service provided within the past seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment. Telephone call codes should not be reported for postop visits.

5. Telephone services may only be utilized in situations where synchronous interactive audio and video telecommunications is not available for the member.

6. Payment of Professional Telehealth Services may be impacted by CCI edits.

7. For providers paid on a capitation basis, services delivered through telehealth are considered included in capitation and are not separately payable.

8. We reserve the right to audit Professional Telehealth Services to evaluate:
    a. Compliance with this policy or related state and federal regulations
    b. Effectiveness and impact to our members
    c. Quality of care

9. Nurse Practitioners (NP's), Certified Registered Nurse Anesthetists (CRNA) Physician Assistants (PA's), Registered dietitians, Nurse -midwives, & Clinical Nurse specialist are required to perform services within the scope of their license.

10. Professional Telehealth Services do not include text messages.

11. Providers must fully document services rendered and identify the telecommunication technology used in the patient's medical record.

12. When providers bill for Professional Telehealth Services in hospital-based clinics, they are not eligible for payment of facility fee component.

13. The policy follows HEDIS guidelines as it relates to quality measures. The policy is subject to change if/when HEDIS guidelines are updated.

CODING

Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.

CPT	Description
99202	Office or other outpatient 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 time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient 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 time for code selection, 30-44 minutes of total time is spent on

	the date of the encounter.
99204	Office or other outpatient 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 time for code selection, 45-59 minutes of total time is spent on the date of the encounter
99205	Office or other outpatient 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 time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
99212	Office or other outpatient 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 time for code selection, 10-19 minutes of total time is spent on the date of the encounter
99213	Office or other outpatient 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 time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient 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 time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient 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 time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
98000	Synchronous audio-video 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.

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98001	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98002	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98003	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98004	Synchronous audio-video 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, 10 minutes must be met or exceeded.
98005	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98008	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98009	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

98010	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98011	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98012	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.
98013	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98014	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98015	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
98016	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 evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion.

98966	Telephone assessment and management service provided by a nonphysician qualified 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 nonphysician qualified 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 nonphysician qualified 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

HCPCS	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 or more communicating with the patient via telehealth.
S0983	Global fee urgent care centers
T1015	Clinic visit/encounter, all-inclusive.

GT Modifier – GT Modifier applies when a visit was a synchronous telehealth service was administered real time through interactive audio and video telecommunication systems.

95 Modifier – 95 Modifier applies to describe a Telehealth session. A Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System. Preferred modifier to be used per Centers for Medicare & Medicaid Services (CMS).

BENEFIT APPLICATION

This Reimbursement Policy does not constitute a description of benefits. Rather, this assists in the administration of the member's benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage.

DESCRIPTION OF SERVICES

- **E-Visits:** An established patient-initiated non-face-to-face communication through an online patient portal.

- **Interactive telecommunications system:** Multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient and distant site physician or practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.

- **Professional Telehealth Services:** Services performed by professional providers using technology to evaluate and communicate with members are limited to telehealth visits, virtual check-ins, telephone based-evaluations, and e-visits.

- **Synchronous interaction:** A real-time interaction between a patient and a health care provider located at a distant site.

- **Telehealth Visits**: A visit with a provider that uses synchronous interactive audio and video telecommunications system.

- **Telephone-based evaluations:** Telephone services are non-face-to-face encounters originating from the established patient for evaluation or management of a problem provided by a qualified clinician.

- **Virtual check-ins:** A brief (5-10-minute) check-in with a provider via telephone or other telecommunications device to determine whether an office visit or other service is needed for an established patient. A remote evaluation of recorded video and/or images submitted by an established patient.

DEFINITIONS

N/A

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making.

Policy Bulletins are developed by us to assist in administering plan benefits and constitute neither offers of coverage nor medical advice.

This Policy Bulletin may be updated and therefore is subject to change.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Date
2024 review. Pharmacists added to the list of eligible providers. Codes 99381-99385, 99391-99395, 99441-99443 were removed. Codes 98000-98005, 98008-98016 were added. Codes 98966-98968 were revised. Telehealth POS and modifier billing statement added. HEDIS statement was added to the guidelines section.	B	TBD
New policy.	A	08/01/2022

REFERENCES

1. Department of Human Services (DHS). Telemedicine Guidelines Related to Covid-19. Provider Quick Tips #229 https://www.dhs.pa.gov/providers/Quick-Tips/Documents/PROMISeQuickTip229.pdf

2. Department of Human Services (DHS). Telemedicine Guidelines Related to Covid-19. Provider Quick Tips #242 https://www.dhs.pa.gov/coronavirus/Pages/OMAP-QTIP242-Telemedicine-Guidelines.aspx

3. Department of Human Services (DHS). Medical Assistance Bulletin. Guidelines for the Delivery of Physical Health Services via Telemedicine. https://www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP/MAB2022050601.pdf

4. Department of Human Services (DHS). Medical Assistance Bulletin #99-23-08 https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/MAB2023080201.pdf

5. State Medicaid and Chip Telehealth Toolkit. https://www.medicaid.gov/medicaid/benefits/downloads/telehealth-toolkt.pdf

6. Department of Human Services (DHS). Medical Assistance Bulletin. Updates to The PROMISe™ Provider Handbook 837 Professional/CMS-1500 Claim Form, Appendix E –

FQHC/RHC Handbook. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/MAB2024030101.pdf

7. The Healthcare Effectiveness Data and Information Set (HEDIS®) https://www.ncqa.org/blog/hedis-my-2025-whats-new-whats-changed-whats-retired/

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