Telemedicine Payment Policy

Policy

This payment policy applies to coverage and reimbursement for telemedicine (telehealth) services provided by contracted (in-network) providers during the COVID-19 State of Emergency, issued by Governor Baker on March 10, 2020. On March 15, 2020, Governor Baker issued an "Order Expanding Access to Telehealth Services and to Protect Health Care Providers." Governor Baker's Emergency Order is effective March 16, 2020 and applies to commercial health insurers in Massachusetts. Similar guidance has been issued by the Centers for Medicare & Medicaid Services[1] informing Medicare Advantage plans of their obligations and permissible flexibilities related to telehealth services during the COVID-19 public health emergency, and by the Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid regarding coverage and reimbursement for telehealth services related to COVID-19 for MassHealth ACO members. MassHealth Provider Bulletins are available at: https://www.mass.gov/masshealth-provider-bulletins.

Fallon Health covers medically necessary telemedicine (telehealth) services provided by contracted (in-network) providers. During the State of Emergency, Fallon Health will cover medically necessary telehealth services provided by non-contracted providers in accordance with guidance issued by the Massachusetts Division of Insurance for commercial plan members, the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage plan members and the Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid for MassHealth ACO members.

In addition to directly covering telehealth services, Fallon Health and Beacon Health Options have entered into relationships with national telehealth vendors to augment telehealth services to plan members. This policy does not apply to telehealth services rendered by Teladoc (Fallon Health's national telehealth vendor). Instead, please refer to the following website for information on Teladoc services for medical telehealth services: https://member.teladoc.com/fallon. Please refer to Beacon Health Options website at: https://www.beaconhealthoptions.com/ for information on behavioral health telehealth services.

Telehealth services are covered for commercial, MassHealth ACO, Medicare Advantage, NaviCare, Summit ElderCare and Fallon Health Weinberg PACE plan members.

Definitions

According to Massachusetts General Law, Chapter 175, Section 47BB, **t**elemedicine (telehealth), is as it pertains to the delivery of health care services, is the use of interactive audio and video (i.e., live video) for the purpose of diagnosis, consultation or treatment. Telemedicine does not include the use of audio-only telephone, fax machine, or email.

Telemedicine (telehealth) permits real-time live video communication between the physician or other qualified health care professional and the plan member.

For the purposes of this payment policy, telemedicine and telehealth are used interchangeably.

For the duration of the Governor's Emergency Order or until the State of Emergency is lifted, whichever happens first, telemedicine (telehealth), as it pertains to the delivery of health care services to commercial, MassHealth ACO and NaviCare plan members, will include live video and audio-only (i.e., telephone).

[1] HPMS Memo "Information Related to Coronavirus Disease 2019 - COVID-19," Date: March 10, 2020.

Medicare requires the use of an interactive audio and video telecommunications system that permits real-time communication between the provider at the distant site and the plan member at the originating site. For the duration of the COVID-19 public health emergency, Medicare is permitting audio-only for **certain** services identified in the List of Telehealth Services available on the CMS website at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes. Providers should familiarize themselves with the Medicare requirements for Telehealth Services and the flexibilities provided during the COVID-19 public health emergency in CMS-1744-IFC and CMS-1544-IFC.

Telemedicine (telehealth) services must be delivered via a secure and private data connection. All transactions and data communication must comply with the Health Insurance Portability and Accountability Act (HIPAA). However, for the duration of the national public health emergency, the Office for Civil Rights at the Department of Health and Human Services will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. A covered health care provider that wants to provide telehealth services during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients, including (but not limited to): Apple FaceTime, Google Hangouts video, Facebook Messenger video chat, Zoom or Skype. Fallon Health does not endorse, require, or recommend one platform over another.

Referral/notification/prior authorization requirements

For the duration of the Governor's Order or until the State of Emergency due to COVID-19 is lifted, whichever happens first, Fallon Health is waiving referral and prior authorization requirements for medically necessary COVID-19 and non-COVID-19 treatment delivered via telemedicine (telehealth) by contracted (in-network) providers.

See ICD-10-CM diagnosis coding for COVID-19 under **Billing/coding/reimbursement guidelines** for the ICD-10-CM diagnosis codes that will document encounters related to COVID-19.

Billing/coding/reimbursement guidelines

Documentation requirements – All telemedicine (telehealth) services require the same documentation as would be required if the service was provided in-person. When an Evaluation & Management (E/M) service is billed, documentation in the medical record must support the level of E/M billed. In addition, for all telemedicine (telehealth) services, providers must document whether the service was provided via telephone or live video, the location of the provider at the time the service was provided (distant site) and the location of the member at the time the service was provided (originating site). Medical records may be requested to ensure appropriate documentation of services rendered and accuracy of coding.

Guidelines for medication management and prescribing via telehealth – Providers must follow all applicable federal and state statutes and regulations governing medication management and prescribing via telehealth. If prescribing services via telehealth or telephone, providers must (1) maintain policies for providing patients with timely and accurate prescriptions by mail, phone, e-prescribing and/or fax, and (2) document prescriptions in the patient's medical record consistent with in-person care.

Standards in the Delivery of Telehealth Services – In accordance with Bulletin 2020-04 issued by the Massachusetts Division of Insurance on March 16, 2020, Fallon Health is required to instruct in-network providers to comply with the following Standards in the Delivery of Telehealth Services:

- For an initial appointment with a new patient, the provider must review the patient's relevant medical history and any relevant medical records with the patient before the delivery of any service.
- For existing provider-patient relationships, the provider must review the patient's medical history and any available medical records with the patient during the service.
- Prior to each patient appointment, the provider must ensure that the provider is able to deliver the services to the same standard as in-person care and in compliance with the provider's licensure regulations and requirements, programmatic regulations, and performance specifications related to the service (e.g., accessibility and communication access).
- If the provider cannot meet appropriate standard of care or other requirements for providing requested care via telehealth, then the provider must make this determination prior to the delivery of treatment, notify the patient of this, and advise the patient to instead seek appropriate in-person care.
- To the extent feasible, providers must ensure the same rights to confidentiality and security as provided in face-to-face services and must inform members of any relevant privacy considerations prior to providing services via telehealth.
- Providers must follow consent and patient information protocols consistent with those followed during in-person visits.
- Providers must inform patients of the location of the provider rendering services via telehealth (distant site) and obtain the location of the patient (originating site).
- Providers must inform the patient of how the patient can see a clinician in-person in case of an emergency or otherwise.

Telehealth Originating Site Facility Fee – HCPCS Code Q3014 describes the telehealth originating sites facility fee. The telehealth originating site facility fee is not covered by Fallon Health. Claims for Q3014 will deny vendor liable (members cannot be billed).

Eligible Providers* – The following providers may furnish Telehealth Services (in accordance with 42 CFR § 410.78 (b)(2) and subject to State law):
- Physicians
- Nurse practitioners
- Physician assistants
- Nurse-midwives
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinical psychologists and clinical social workers
- Registered dieticians or nutrition professionals

* Pursuant to authority granted under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that broadens the waiver authority under section 1135 of the Social Security Act, the Secretary has authorized additional telehealth waivers. CMS is waiving the requirements of section 1834(m)(4)(E) of the Act and 42 CFR § 410.78 (b)(2) which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site effective date of March 1, 2020 through the end of the emergency declaration. The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.

For the duration of the Governor's Order or until the State of Emergency is lifted, whichever happens first, Fallon Health will cover clinically appropriate, medically necessary services delivered via telehealth when furnished by the following ancillary providers:

- Podiatrists
- Optometrists
- Physical therapists
- Occupational therapists
- Speech-language pathologists
- Early Intervention providers (see Early Intervention Payment Policy for additional information)

In addition, LTSS providers may furnish services via telehealth for MassHealth ACO and NaviCare plan members consistent with **MassHealth LTSS Provider Information: Updates Related to the Coronavirus Disease 2019 (COVID-19)**. For additional information please refer to the payment policy specific for that provider.

Reimbursement for Telehealth Services for the duration of the Governor's Order or until the State of Emergency is lifted, whichever happens first – Effective for dates of service retroactive to March 16, 2020, Fallon Health will reimburse contracted (in-network) providers for covered Telehealth Services (COVID-19 and non-COVID 19 related) provided to commercial plan members, at same rate of reimbursement that Fallon Health would reimburse for the same service provided in-person. Effective for dates of service retroactive to March 12, 2020, Fallon Health will reimburse contracted (in-network) providers for covered Telehealth Services (COVID-19 and non-COVID 19 related) provided to MassHealth ACO plan members, at same rate of reimbursement that Fallon Health would reimburse for the same service provided in-person.

Reimbursement for covered telehealth services independently-provided by mid-level practitioners is 85% of the applicable physician fee schedule amount.

Member cost-sharing for Telehealth Services for the duration of the Governor's Order or until the State of Emergency is lifted, whichever happens first – Effective for dates of service retroactive to March 16, 2020, Fallon Health is waiving cost-sharing (copayments, coinsurance and deductibles) for medically necessary COVID-19 delivered by contracted (in-network) providers.

ICD-10-CM diagnosis coding for COVID-19 – On April 1, 2020, the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), issued updated Coding and Reporting Guidelines for COVID-19 effective for discharges and encounters with dates of service April 1, 2020 to September 30, 2020. This updated Guidance is available at: https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf. For discharges and encounters with dates of service prior to April 1, 2020, refer to Interim Guidance available at: https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf.

Coding for discharges and encounters with dates of service prior to April 1, 2020:

- For pneumonia confirmed as due to COVID-19, assign codes J12.89, Other viral pneumonia, and B97.29, Other coronavirus as the cause of diseases classified elsewhere.
- For acute bronchitis confirmed as due to COVID-19, assign codes J20.8, Acute bronchitis due to other specified organisms, and B97.29, Other coronavirus as the cause of diseases classified elsewhere.
- For bronchitis NOS confirmed as due to COVID-19, assign codes J40, Bronchitis, not specified as acute or chronic, and B97.29 Other coronavirus as the cause of diseases classified elsewhere.
- For lower respiratory infection NOS or acute respiratory infection NOS, confirmed as due to COVID-19, assign codes J22, Unspecified acute lower respiratory infection, and code B97.29, Other coronavirus as the cause of diseases classified elsewhere.

- For respiratory infection, NOS, confirmed as due to COVID-19, assign codes J98.8, Other specified respiratory disorders, and code B97.29 Other coronavirus as the cause of diseases classified elsewhere.
- For acute respiratory distress syndrome (ARDS) confirmed due to COVID-19, assign codes J80, Acute respiratory distress syndrome, and B97.29 Other coronavirus as the cause of diseases classified elsewhere.

Coding for discharges and encounters with dates of service on or after April 1, 2020 to September 30, 2020:
For plan members with a confirmed COVID-19 diagnosis, use ICD-10-CM code U07.1, 2019-nCoV acute respiratory disease, as the primary diagnosis on claims for discharges and encounters with dates of services on or after April 1, 2020, followed by the appropriate codes for associated manifestations, except in the case of obstetrics patients (codes from Chapter 15: Pregnancy, Childbirth, and the Puerperium always take sequencing priority). A diagnosis of COVID-19 is considered confirmed when documented by the provider, or with documentation of a positive or a presumptive positive COVID-19 test result.

- For pneumonia confirmed as due to COVID-19, assign codes U07.1, COVID-19, and J12.89, Other viral pneumonia.
- For acute bronchitis confirmed as due to COVID-19, assign codes U07.01, COVID-19, and J20.8, Acute bronchitis due to other specified organisms.
- For bronchitis NOS confirmed as due to COVID-19, assign codes U07.01, COVID-19, and J40, Bronchitis, not specified as acute or chronic.
- For lower respiratory infection NOS or acute respiratory infection NOS, confirmed as due to COVID-19, assign codes U07.01, COVID-19, and J22, Unspecified acute lower respiratory infection.
- For respiratory infection, NOS, confirmed as due to COVID-19, assign codes U07.01, COVID-19, and J98.8, Other specified respiratory disorders.
- For acute respiratory distress syndrome (ARDS) confirmed due to COVID-19, assign codes U07.01, COVID-19, and J80, Acute respiratory distress syndrome.
- For plan members with COVID-19 in pregnancy, childbirth and the puerperium, assign codes O98.5, Other viral diseases complicating pregnancy, childbirth and the puerperium, followed by U07.01, COVID-19, and the appropriate codes for associated manifestations.

Coding for encounters where there is concern about a possible or actual exposure to COVID-19:
- For cases where there is concern about a possible exposure to COVID-19, but it is ruled out after evaluation, it would be appropriate to assign code Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out.
- For cases where there is an actual exposure to someone who is confirmed to have COVID-19, it would be appropriate to assign code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

Expansion of Telehealth Services for the duration of the Governor's Order or until the State of Emergency is lifted, whichever happens first – The services listed in the table below may be delivered via telemedicine (telehealth) when clinically appropriate and medically necessary for the plan member. The performance and delivery of health care services via (telemedicine) telehealth must be clearly documented in the member's record. See **Documentation Requirements** above.

When billing professional claims (CMS-1500) for services delivered via telehealth, please use Place of Service Code 02.
Modifier 95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunication system) may be appended per Appendix P of the Current Procedural Terminology (CPT®) Manual.

When billing facility claims (UB-04) for services delivered via telehealth, please bill the appropriate revenue code and CPT/HCPCS code with telehealth modifier 95, GO, GQ, or GT.

Coverage of Preventive Visits via Telehealth - Preventive Medicine Services are comprehensive in nature, and reflect age and gender appropriate history and examination, counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of laboratory or diagnostic procedures. Additional services such as immunization administration (CPT 90460, 90461, or 90471-90474), visual acuity screening (CPT 99173), developmental screening (CPT 96110), behavioral/emotional assessments (CPT 96127) and administration of patient/caregiver health risk assessments (CPT 96160, 96161) may be reported in addition to a Preventive Medicine Service.

Preventive visits are critical to ensuring the health and well-being of plan members. During the COVID-19 State of Emergency, Fallon Health will reimburse plan providers for a preventive visit delivered via telehealth when a preventive visit is clinically appropriate for the plan member (i.e., the physical examination can be deferred) and the plan member has consented to the telehealth visit. Documentation must include a plan for follow-up for any components of the preventive visit deferred due to telehealth. Claims for Preventive Medicine Services and any additional services reported in addition to the Preventive Medicine Service delivered via telehealth, must be submitted with Place of Service 02.

For those preventive visits delivered via telehealth, there are components of a Preventive Medicine Service that cannot be completed via telehealth. These components should be completed as soon as possible. When a Preventive Medicine Service has been delivered via telehealth and reimbursed by Fallon Health:

- For MassHealth ACO, NaviCare and Summit ElderCare plan members: Fallon Health will reimburse one in-person follow-up Evaluation & Management (E/M) Service to complete the components of the Preventive Medicine Service not performed on the day of the Preventive Medicine Service. The follow-up E/M Service can be billed with CPT code 99211, 99212 or 99213, depending on the complexity of the visit. Additional services, such as immunization administration and visual acuity screening, that are separately reimbursed with a Preventive Medicine Service, may be reported with the E/M Service.
- For commercial and Medicare Advantage plan members: Fallon Health will not reimburse an additional Preventive Medicine Service or E/M Service to complete the components of the Preventive Medicine Service that were not performed via telehealth. Additional services, such as immunization administration and visual acuity screening, that are separately reimbursed with a Preventive Medicine Service, will be separately reimbursed.

Telehealth Services

Code	Descriptor
96110	Developmental screening, per instrument, scoring and documentation
96127	Brief emotional/behavioral assessment (eg, depression inventory) with scoring and documentation, per standardized instrument
96160	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.
96161	Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.

97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient each 15 minutes.
97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes.
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service. **(Covered for MassHealth ACO, NaviCare and Summit ElderCare members only** per MassHealth guidance: CPT 99050 can be billed with a Telehealth Service provided after hours for urgent care only**.)**
99201	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99211	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 10 minutes are spent face to face with patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99221	Initial Hospital Care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity
99222	Initial Hospital Care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.
99223	Initial Hospital Care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.
99231	Subsequent Hospital Care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused

	interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity.
99232	Subsequent Hospital Care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity.
99233	Subsequent Hospital Care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity.
99238	Hospital discharge day management; 30 min.
99239	Hospital Discharge Day Management Services; more than 30 minutes
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)

99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older
99401	Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual; approximately 15 minutes
99402	Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual; approximately 30 minutes
99403	Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual; approximately 45 minutes
99404	Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual; approximately 60 minutes
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes.
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes.
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
99411	Preventive medicine counseling or risk factor reduction intervention(s) provided to individuals in a group setting; approximately 30 minutes
99412	Preventive medicine counseling or risk factor reduction intervention(s) provided to individuals in a group setting; approximately 60 minutes

99495	Transitional care management; communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; Medical decision-making of at least moderate complexity during the service period; face-to-face visit within 14 calendar days of discharge.
99496	Transitional care management; communication (direct contact, telephone, electronic) with patient and/or caregiver within two business days of discharge; Medical decision-making of high complexity during the service period, face-to-face visit within seven calendar days of discharge.
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure).
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes.
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.
G0270	Medical Nutrition therapy; reassessment and subsequent intervention(s) for change in diagnosis, individual, 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).
G0442	Annual alcohol misuse screening, 15 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
G0444	Annual depression screening, 15 minutes.
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).
S0302	Completed early periodic screening diagnosis and treatment (EPSDT) service (list in addition to code for appropriate evaluation and management service)
S3005	Performance measurement, evaluation of patient self-assessment, depression **(Covered for MassHealth ACO and NaviCare members only)**
T1015	Clinic, visit/encounter, all-inclusive. **(Covered for commercial, MassHealth ACO and NaviCare members only)**

Physical Therapy, Occupational Therapy and Speech Therapy Telehealth Services

The performance and delivery of therapy services via telehealth must be clearly documented in the member's record. See **Documentation Requirements** above.

Please submit CMS 1500 claims for services delivered via telehealth with Place of Service Code 02.

UB-04 claims for services delivered via telehealth should be submitted with the appropriate revenue code and CPT/HCPCS code with telehealth modifier 95, GO, GQ, or GT.

Commercial plan members: The physical therapy, occupational therapy and speech therapy services listed in the table below are covered for commercial plan members, effective March 16, 2020.

MassHealth ACO and NaviCare plan members**:** Per MassHealth guidance **(MassHealth LTSS Provider Information: Updates Related to the Coronavirus Disease 2019 (COVID-19)**, updated as of April 7, 2020), effective March 12, 2020, therapy providers may conduct required in-person activities via telehealth (including telephone and live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-providers#provider-bulletins-), as determined necessary by the Therapy Provider.

- Please refer to Fallon Health's Physical and Occupational Therapy (PT/OT) Payment Policy and Speech Therapy Payment Policy for information on prior authorization extensions and flexibilities related to physician referrals.
- Therapy providers should bill the same procedure codes for services delivered via telehealth as appropriate for services delivered face-to-face.

Medicare Advantage plan members: Medicare Advantage plan members have coverage for CPT codes 97161- 97168; CPT codes 97110, 97112, 97116, 97530, 97535, 97750, 97755, 97760, 97761, 92507, 92508, 92521- 92524 delivered via telehealth, effective March 1, 2020. For the COVID-19 public health emergency, Medicare is permitting audio-only for CPT codes: 92507, 92508, 92521-92524 and 97535. Providers should familiarize themselves with the Medicare requirements for Telehealth Services and the flexibilities provided during the COVID-19 public health emergency in CMS-1744-IFC and CMS-1544-IFC. Although CMS has issued interim guidance (CMS-1744-IFC) permitting the use of modifier 95 on fee-for-service claims for telehealth services, please submit CMS 1500 claims for services delivered via telehealth for Medicare Advantage members to Fallon Health with Place of Service Code 02.

Telehealth Services - Physical Therapy, Occupational Therapy and Speech Therapy

Code	Descriptor
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing).
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with

	stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg,

	physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes.
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual.
92521	Evaluation of speech fluency (eg, stuttering, cluttering).
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria).
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language).
92524	Behavioral and qualitative analysis of voice and resonance.

Telephone Services (CPT 99441-99443 and 98966-98968)

Effective March 1, 2020 and for the duration of the State of Emergency in Massachusetts, Fallon Health is covering telephone services (CPT 99441-99443 and 98966-98968) provided by contracted (in-network) providers for all plan members. These codes are reported for medical evaluation/assessment and management by physicians or other health qualified health care providers and should not be used for administrative or other non-medical discussions.

- Telephone Services (CPT 99441-99443) are non-face-to-face evaluation and management (E/M) services provided to established patients by a physician or other qualified health care professional who may independently bill for E/M services.

- Telephone Services (CPT 98966-98968) are non-face-to-face assessment and management services provided to established patients. The following providers may report telephone services using CPT codes 98966-98968:
  - Clinical psychologists and clinical social workers
  - Registered dietitians or nutrition professionals
  - Physical therapists, occupational therapists, and speech language pathologists
- While the code descriptors refer to “an established patient,” for the duration of the COVID-19 public health emergency, Medicare is exercising enforcement discretion on an interim basis to relax enforcement of this aspect of the descriptors and is extending telephone services (CPT 99441-99443 and 98966-98968) to new and established patients, accordingly, Fallon Health will allow telephone services for new and established Medicare Advantage plan members. Fallon Health will also extend telephone services to new and established commercial, MassHealth ACO and NaviCare plan members.
  - Telephone services (CPT codes 99441-99443 and 98966-98968) are not telehealth services and should not be submitted with Place of Service Code 02, with the exception of telephone services (CPT 99441-99443) for Medicare Advantage, NaviCare, Summit ElderCare and Fallon Health Weinberg PACE plan members, because on April 30, 2020, CMS added telephone services (CPT 99441-99443) to the List of Telehealth Services. This change is retroactive to March 1, 2020. As a result, please submit claims for telephone services (CPT 99441-99443) for Medicare Advantage, NaviCare, Summit ElderCare and Fallon Health Weinberg PACE plan members to Fallon Health with Place of Service Code 02.
- Telephone Services are time-based codes. The length of the telephone encounter must be documented, in addition to the nature of the service and other pertinent information, in the medical record.
  - If the telephone encounter relates to and takes place within a postoperative period, the service is considered part of the procedure and not separately reimbursable.
  - The telephone encounter cannot be related to an E/M service (including a telehealth service) performed and reported by the physician or qualified health care professional within the previous seven (7) days.
  - If the telephone encounter ends with a decision to see the patient (including via telehealth) within 24 hours or the next available urgent appointment, the telephone encounter is considered part of the pre-service work of the subsequent E/M service, procedure and visit.

Telephone Services

Code	Descriptor
99441	Telephone evaluation and management service provided 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 provided 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 provided 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.
98966	Telephone assessment and management service provided by a qualified non-physician 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 non-physician 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 non-physician 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.

Telehealth Services for Medicare Advantage, NaviCare, Summit ElderCare and Fallon Health Weinberg PACE plan members:

Medicare Advantage, NaviCare, Summit ElderCare, and Fallon Health Weinberg PACE plan members have coverage for the Telehealth Services listed on the CMS website at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

The performance and delivery of health care services via telehealth must be clearly documented in the member's record. See **Documentation Requirements** above.

Please submit professional claims for services delivered via telehealth to Fallon Health with Place of Service Code 02. UB-04 claims for services delivered via telehealth should be submitted with the appropriate revenue code and CPT/HCPCS code with telehealth modifier 95, GO, GQ, or GT.

Medicare List of Telehealth Services Effective March 1, 2020 (Includes temporary services for the public health emergency); updated 04/30/2020**:**

- Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
- Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217- 99220; CPT codes 99224- 99226; CPT codes 99234- 99236)
- Initial and subsequent hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99231-99233, CPT codes 99238- 99239)
- Initial and subsequent nursing facility visits, all levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT 99307-99310, CPT codes 99315-99316, HCPCS G9683)
- Critical Care Services (CPT codes 99291-99292)
- Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99324-99326, 99327- 99328, CPT codes 99334-99337)

- Home Visits, New and Established Patient, All levels (CPT codes 99341- 99345; CPT codes 99347- 99350)
- Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT codes 99468-99473; CPT codes 99475- 99476)
- Initial and Continuing Intensive Care Services (CPT codes 99477- 994780)
- Care Planning for Patients with Cognitive Impairment (CPT code 99483)
- Transitional Care Management Services (CPT codes 99495, 99496)
- Advanced Care Planning services (CPT 99497, 99498)
- Psychological and Neuropsychological Testing (CPT code 96110, CPT codes 96112 (non-covered service), 96113, CPT code 96116, CPT code 96121, CPT code 96127, CPT codes 96130- 96133; CPT codes 96136- 96139)
- Therapy Services, Physical, Occupational and Speech Therapy (CPT codes 97161- 97168; CPT codes 97110, 97112, 97116, 97530, 97535, 97750, 97755, 97760, 97761, 92507, 92508, 92521- 92524, HCPCS code S9152 (not valid for Medicare purposes))
- Radiation Treatment Management Services (CPT code 77427)
- Psychiatric diagnostic evaluations, psychotherapy (CPT codes 90785, 90781, 90782, CPT codes 90832-90838, CPT codes 90839-90840, CPT codes 90845, CPT codes 90846, 90847, CPT code 90853, CPT code 90875 (non-covered service), HCPCS code G0410 (statutory exclusion))
- End-stage renal disease (CPT codes 90951--90970)
- Health and Behavior Assessment (CPT 96156,96158, 96159, 96164, 96165, 96167, 96168)
- Health and Behavior Intervention (CPT codes 96170 (non-covered service), 96171 (non-covered service))
- Health Risk Assessment (CPT codes 96160, 96161)
- Adaptive Behavior Assessment Procedures and Adaptive Behavior Treatment Procedures (CPT code 97151, 97152; CPT codes 97153-97158, CPT code 0362T, CPT code 0373T)
- Medical Nutrition Therapy (CPT codes 97802-97804, HCPCS codes G0270)
- Office//Outpatient Visits (CPT codes 99201-99205, CPT codes 99211-99215)
- Telephone Evaluation and Management Services (CPT codes 99441-99443)
- Prolonged service in the office or other outpatient setting (CPT codes 99354, 99355)
- Prolonged service in the inpatient or observation setting (CPT codes 99356, 99357)
- Smoking cessation services (CPT 99406, 99407, HCPCS codes G0436, G0437)
- Annual Wellness Visits, Initial and Subsequent (HCPCS codes G0438, G0439)
- Diabetes self-management training services (HCPCS codes G0108, G0109)
- Counseling visit to discuss need for lung cancer screening using low dose CT scan (HCPCS G0296)
- Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services (HCPCS codes G0396, G0397)
- Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs (HCPCS codes G0406-G0408)
- Kidney disease education services
- Telehealth consultations, emergency department or initial inpatient (HCPCS codes G0425-G0427)
- Annual alcohol misuse screening (HCPCS code G0442)

- Brief face-to-face behavioral counseling for alcohol misuse (HCPCS code G0443)
- Annual depression screening (HCPCS code G0444)
- High-intensity behavioral counseling to prevent sexually transmitted infection (HCPCS code G0445)
- Annual, face-to-face intensive behavioral therapy for cardiovascular disease (HCPCS code G0446)
- Face-to-face behavioral counseling for obesity (HCPCS code G0447)
- Telehealth Pharmacologic Management (HCPCS code G0459)
- Comprehensive assessment of and care planning for patients requiring chronic care management (HCPCS code G0506)
- Telehealth Consultation, Critical Care, initial and subsequent (HCPCS codes G0508, G0509)
- Prolonged preventive services (HCOCS codes G0513, G0514)
- Office-based treatment for opioid use disorder (HCPCS codes G0286-G0288)
- Ophthalmological Services, General and Diagnostic (CPT codes 92002, 92004, 92012, 92014)
- Post-operative analysis, fitting, and adjustments of a cochlear implant (CPT codes 92601-92604)
- Respiratory Care (CPT codes 93003-94005 (bundled code), CPT code 94664)

Virtual check-ins for Medicare Advantage, NaviCare, Summit ElderCare and Fallon Health Weinberg PACE Members:

Medically necessary virtual check-ins (HCPCS code G2012) and remote evaluations of recorded video and/or images (HCPCS code G2010) are covered for Medicare Advantage, NaviCare, Summit ElderCare and Fallon Health Weinberg PACE members only.

Virtual check-ins (HCPCS code G2012) are patient-initiated communications with a physician or other qualified health care professional to assess whether the patient's condition necessitates an office visit. The provider may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal. In instances when the virtual check-in service originates from or leads to an evaluation and management (E/M) service with the same physician or other qualified health care professional, this service would be considered bundled into the associated E/M service, and therefore, would not be separately reimbursable.

Pre-recorded video or images can be sent to a physician or other qualified health care professional by a plan member for remote evaluation of the plan member's condition (HCPCS code G2010). This service involves store-and-forward communication technology (asynchronous transmission of recorded video or images). Like virtual check-ins, this is a patient-initiated communication that would be used to determine whether or not an office visit or other service is warranted. When remote evaluation of pre-recorded patient-submitted image or video originates from or results in an E/M service with the same physician or qualified health care professional, this service is considered bundled into that E/M service and therefore not separately reimbursable.

- Consent is required for non-face-to-face services and must be documented in the medical record. Consent must be obtained at least annually. During the COVID-19 Emergency, consent may be obtained at the time a service is furnished.
- Virtual check-ins and remote evaluations are only reportable by providers who can furnish E/M services. These services require direct interaction between the patient and the billing provider.

- Virtual check-ins and remote evaluations are not telehealth services. Please do not submit claims for these services with Place of Service Code 02.
- While the code descriptors refer to “an established patient,” for the duration of the COVID-19 public health emergency, Medicare is exercising discretion on an interim basis to relax enforcement of this aspect of the descriptors and is extending virtual check-ins and remote evaluations to both new and established patients.
- Documentation in the medical record must demonstrate medical necessity. Cannot be billed for scheduling appointments or conveying test results.

Virtual Check-ins	
Code	**Descriptor**
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
G2012	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not 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.

E-visits (CPT codes 99421-99423 and G2061-G2063):

Fallon Health is covering medically necessary e-visits (CPT codes 99421-99423 and HCPCS codes G2061-G2063) for all plan members during the COVID-19 State of Emergency. E-visits are patient-initiated communications via an online patient portal. Communications can occur over a 7-day period.

- An online patient portal is a secure online website that gives patients 24-hour access to their personal health information from anywhere with an Internet connection by using a secure username and password.
- Physicians and other qualified healthcare professionals who may independently bill for evaluation and management (E/M) services can provide and bill for medically necessary e-visits using CPT codes 99421, 99422 and 99423.
- Clinicians who may not independently bill for E/M services (for example, clinical psychologists, clinical social workers, registered dietitians or nutrition professionals, physical therapists, occupational therapists and speech language pathologists) can provide and bill for medically necessary e-visits using HCPCS codes G2061, G2062, and G2063.
- Consent is required for non-face-to-face services and must be documented in the medical record. Consent must be obtained at least annually. During the COVID-19 Emergency, consent may be obtained at the time a service is furnished.
- E-visits are not telehealth services. Please do not submit claims for e-visits with Place of Service Code 02.
- While the code descriptors refer to “an established patient,” for the duration of the COVID-19 public health emergency, Medicare is exercising discretion on an interim basis to relax enforcement of this aspect of the descriptors and is extending e-visits (CPT 99421-99423 and HCPCS G2061-G2063) to both new and established patients, accordingly, Fallon Health will allow e-visits for new and established Medicare Advantage, NaviCare, Summit ElderCare and Fallon Health Weinberg PACE plan members.
- E-visits are time-based codes. The length of the encounter must be documented in the medical record, in addition to the nature of the encounter and other pertinent information

documenting medical necessity. Because these codes are for a 7-day period of time, they cannot be billed more than once every 7 days.

E-visits	
Code	**Descriptor**
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes.
99422	Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes.
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.
G2061	Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes.
G2062	Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes.
G2063	Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes

COVID-19 Remote Patient Monitoring for MassHealth ACO, NaviCare and Summit ElderCare Members – Effective for dates of service on or after March 12, 2020, Fallon Health will cover COVID-19 Remote Patient Monitoring (RPM) for MassHealth ACO and NaviCare plan members, in accordance with MassHealth Managed Care Entity Bulletin 29. COVID-19 RPM is a bundle of services designed by MassHealth to facilitate in-home monitoring of plan members with confirmed or suspected COVID-19. Physicians, Community Health Centers, Acute Outpatient Hospitals, Hospital Licensed Health Centers and Group Practices may render COVID-19 RPM bundled services to plan members who meet criteria specified in MassHealth All Provider Bulletin 294.

Providers rendering COVID-19 RPM bundled services to plan members must at a minimum:

1. Ensure that a physician, physician assistant, nurse practitioner, or paraprofessional, such as a licensed practical nurse or medical assistant, checks in with the plan member at least daily to assess symptoms and record home monitoring data (e.g., oxygen saturation and temperature) for seven (7) consecutive days.
    a. Daily check-ins can be conducted in-person or by telehealth.
    b. Providers must make their best effort to contact members and must document outreach attempts throughout the seven-day period.
    c. Providers who determine that a member receiving COVID-19 RPM bundled services no longer requires those services must document this in the member's medical record, including the reason for that determination (i.e., improvement in condition, transition to inpatient care, etc.).
    d. One subsequent 7-day COVID-19 RPM bundle is covered if medically necessary.
2. Convene, on a daily basis, a multidisciplinary team to review the status of members receiving COVID-19 RPM bundled services and coordinate care needs identified through

monitoring. At a minimum, the multidisciplinary team must include a physician, staff involved in the care of the member, and staff conducting outreach to the member.
3. Perform at least one in-person or telehealth E/M service over the course of the seven-day period, consistent with patient need and medical necessity. This is not billable.
4. Ensure that the member has access to a pulse oximeter and thermometer at the start of COVID-19 RPM. If the member does not have access to a pulse oximeter and thermometer, the provider must provide this equipment and may not bill the member, Fallon Health or MassHealth for this equipment. Upon completion of COVID-19 RPM, the provider may let the member keep any equipment furnished to the member for use during monitoring or the provider may collect it.

Providers rendering COVID-19 RPM bundled services to plan members must bill CPT code 99423 with modifier U9 and Place of Service 02 or 12 on the first day of the COVID-19 RPM bundle. The RPM bundle is intended to cover all COVID-19-related E/M services for the seven-day period. No other E/M service (in-person or telehealth visit), telephone service or home visit is payable during the seven-day period. Payment will not be prorated if the member ultimately requires fewer than seven days of COVID-19-RPM services. Additional services, such as pharmacy, behavioral health or substance use disorder services may be billed. Providers may bill a facility fee for the COVID-19 RPM bundle if such a fee is permitted under the provider's contract. The facility fee may be billed only once during the seven-day period. The facility fee must be billed with:

- Revenue code 0762 (observation)
- CPT code 99423 with modifier U9
- U07.01 as the primary diagnosis code

Place of service

This policy applies to telehealth services.

Policy history

Origination date:	03/01/2015
Previous revision date(s):	07/01/2015 – Introduced policy. 01/01/2017 - Updated policy section.
Connection date & details:	March 2017 – Added new codes.
	April 2018 – Removed GT modifier requirement for Medicare Plans.
	January 2019 – Added outpatient reimbursement of Telemedicine.
	January 2020 – Annual review, no updates.
	March 16, 2020 – Notification of changes to coverage and reimbursement of telehealth services provided during the State of Emergency in Massachusetts.
	April 30, 2020 – Removed modifier 95 requirement; added telephone services, virtual check-ins and e-visits.
	June 1, 2020 – Added Preventive visits and COVID-19 Remote Patient Monitoring.
	June 26, 2020 – Added Summit ElderCare and Fallon Health Weinberg PACE to coverage and reimbursement sections as applicable; clarified UB-04 billing for services delivered via telehealth; added initial and subsequent hospital care and hospital discharge day management to list of Telehealth Services for commercial and MassHealth ACO.

The criteria listed above apply to Fallon Health Plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.