University of Michigan Health Plan

BENEFIT COVERAGE POLICY

Title: BCP-50 Telemedicine Services

Payment Reimbursement Policy: PRP-15 Telemedicine Services

Effective Date: 07/01/2024

Important Information - Please Read Before Using This Policy

The following coverage policy applies to health benefit plans administered by UM Health Plan and may not be covered by all UM Health Plan plans. Please refer to the member's benefit document for specific coverage information. If there is a difference between this general information and the member's benefit document, the member's benefit document will be used to determine coverage. For example, a member's benefit document may contain a specific exclusion related to a topic addressed in a coverage policy.

Coverage determinations for individual requests require consideration of:

- The terms of the applicable benefit document in effect on the date of service.
- Any applicable laws and regulations.
- Any relevant collateral source materials including coverage policies.
- The specific facts of the particular situation.

Contact UM Health Plan Customer Service to discuss plan benefits more specifically.

1.0 Policy:

Health Plan covers telemedicine services, including services via a telemedicine vendor in accordance with state and federal laws and the member's contract.

For all non-network covered services to be paid at the network benefit level except for emergency/urgent services, prior approval is required.

Refer to member's benefit coverage document for specific benefit description, guidelines, coverage, and exclusions.

Effective January 1, 2022, coverage of Telemedicine services will be aligned with the CMS List of telehealth services. NOTE: The CMS list of telehealth services is reviewed in accordance with the regulatory review of this policy.

2.0 Background:

Telemedicine, as a subsection of Telehealth, is the use of telecommunication technology to connect a patient with a health care professional in a different location. Telehealth includes telemedicine, telemonitoring, and related administrative services.

Telemedicine was originally created as a way to treat patients who were located in remote places, far away from local health facilities or in areas with shortages of medical professionals. While telemedicine is still used today to address these problems, it's increasingly becoming a tool for improved access to medical care. Patients today want to spend less time in the provider's waiting room and to get immediate care for minor but urgent conditions when they need it.

Telemedicine parity provides for telemedicine visit coverage by health plans at similar costs as in-person visits with a health care provider. Not all states have laws to provide for telemedicine parity. Michigan Common Law-500-3476 - THE INSURANCE CODE OF 1956 states that "a health insurance policy shall not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the insurer" which includes live video.

3.0 Expectations for Telemedicine Services:

A. Professional services – evaluation, management and consultation services may be considered medically necessary when ALL the following conditions apply:

1. Standards of Care:

   a. The patient initiates the encounter and must be present for full duration of service at the time of the telemedicine visit allowing the provider to examine the patient in real time; AND

   b. The patient's clinical condition is considered to be of low complexity and while it may be an urgent encounter, it should not be an emergent clinical condition. The patient's clinical condition requires straight forward decision making and the need for a follow-up encounter is not anticipated; AND

   c. The extent of services provided via telemedicine includes at least a problem focused history and straight forward medical decision making as defined by the CPT manual; AND

   d. In general, an examination through telemedicine technology should provide the practitioner with information that is equivalent to a face-to-face examination and conforms to the standards of care expected of a face-to-face visit; AND

   e. The provider is expected to set appropriate expectations regarding the telemedicine visit, including prescribing policies, scope of practice, communication, emergency plans, and follow-up; AND

   f. Michigan requires a provider to obtain appropriate informed consent, which includes all the information that applies to routine office visits as well as a description of the potential risks, consequences, and benefits of telemedicine; AND

2. HIPAA - the telemedicine service must take place via a secure, HIPAA complaint interactive audio and/or video telecommunications system with provisions for the patient's privacy and security; AND

3. Communication – interactive telecommunications systems must be multi-media communication that, at a minimum, include audio equipment permitting real-time consultation between the patient and the consulting health care provider; AND

4. Documentation – a permanent record of telemedicine communications relevant to the medical care of the patient is maintained as part of the patient's medical record; AND

5. Legal issues – providers need to be aware of all relevant state and federal laws related to the use of telemedicine and include those that govern prescribing and the establishment of a doctor-patient relationship. In addition, providers need to be aware of relevant practice guidelines developed by the specialty societies as they relate to both in-person and telemedicine practices.

6. Services delivered via telemedicine should not be billed more than once within 7 days for the same episode of care or be related to an evaluation and management service performed within 7 days. E-visits billed within the post-operative period of a previously completed major or minor surgical procedure will be considered part of the global payment for the procedure and not paid separately.

7. Providers are expected to:

   a. Abide by state board and specialty training and supervision requirements; AND

   b. The services are provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located .

B. Eligible providers may include:

1. MD/DO.

2. Certified nurse midwife.
3. Clinical nurse practitioner.
4. Clinical psychologist.
5. Clinical social worker.
6. Physician assistant.

C. The following services are not covered as telemedicine services:
1. Crisis hotlines.
2. Routine preventive care.
3. Facsimile transmissions.
4. Installation or maintenance of any telecommunication devices or systems, software, applications for management of acute or chronic disease, or Store and Forward telecommunications.
5. Software or other applications for management of acute or chronic disease.
6. Store and Forward telecommunication (transferring data from one site to another using a camera or similar device that records [stores] an image that is sent via telecommunication to another site for consultation.
7. Provider-to-provider consultations when the member is not present.
8. Radiology interpretations.
9. Scheduling of appointments or diagnostic tests or reminders of scheduled appointments.
10. Requests for referrals.
11. Provider initiated e-mail.
12. Refilling or renewing existing prescriptions without substantial change in clinical situation.
13. Reporting normal test results.
14. Updating patient information.
15. Providing educational materials only or clarification of simple instructions.
16. Brief follow-up of a medical procedure to confirm stability of the patient's condition without indication of complication or new condition including, but not limited to routine global surgical follow-up.
17. Consultative message exchanges resulting in an office visit, urgent care or emergency care encounter on the within 24 hours for the same condition.
18. Brief discussion to confirm stability of the patient's chronic condition without change in current treatment.
19. A service that would not be charged for in a regular office visit.

D. Patients deemed not appropriate for telemonitoring include patients who:
1. Refuse or are unwilling to participate in telemonitoring.
2. Are unable to self-actuate or have no caregiver available to assist in use of telemonitoring equipment.
3. Are enrolled in hospice services.
4. Receive frequent clinical interventions (more than three times per week).

4.0 Coding:

Prior Approval Legend: Y = All lines of business; N = None required; 1 = HMO/POS; 2 = EPO/PPO; 3 = ASO Group L0000264; 4 = ASO Group L0001269 Non-Union & Union; 5 = ASO Group L0001631; 6 = ASO Group L0002011; 7 = ASO Group L000269 Union Only; 8 = ASO group L0002184; 9 = ASO group L0002237; 10 = ASO group L0002193.

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	N	Outpatient behavioral therapy visit
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	Y	Outpatient behavioral therapy visit
77427	Radiation treatment management, 5 treatments	N	Professional fees for surgical and medical services
90785	Interactive complexity (List separately in addition to the code for primary procedure)	N	Professional fees for medical and surgical services
90791	Psychiatric diagnostic evaluation	N	Outpatient behavioral health therapy visit
90792	Psychiatric diagnostic evaluation with medical services	N	Outpatient behavioral health therapy visit
90832	Psychotherapy, 30 minutes with patient	N	Outpatient behavioral health therapy visit
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	N	Outpatient behavioral health therapy visit
90834	Psychotherapy, 45 minutes with patient	N	Outpatient behavioral health therapy visit
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	N	Outpatient behavioral health therapy visit
90837	Psychotherapy, 60 minutes with patient	N	Outpatient behavioral health therapy visit

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	N	Outpatient behavioral health therapy visit
90839	Psychotherapy for crisis; first 60 minutes	N	Outpatient behavioral health therapy visit
90840	... each additional 30 minutes (List separately in addition to code for primary service)	N	Outpatient behavioral health therapy visit
90845	Psychoanalysis	Y	Outpatient behavioral health therapy visit
90846	Family psychotherapy (without patient present), 50 minutes	N	Outpatient behavioral health therapy visit
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	N	Outpatient behavioral health therapy visit
90853	Group psychotherapy (other than of a multiple-family group)	N	Outpatient behavioral health therapy visit
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 30 minutes	Y	Outpatient behavioral health therapy visit
90901	Biofeedback training by any modality	8, 9	Outpatient behavioral health therapy visit
90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	N	Physician office visit; OR Professional fees for medical and surgical services
90952	… with 2-3 face-to-face visits by a physician or other qualified health care professional per month	N	Physician office visit; OR Professional fees for medical and surgical services
90953	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month	N	Physician office visit; OR Professional fees for medical and surgical services
90954	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with	N	Physician office visit; OR Professional fees for medical and surgical services

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	4 or more face-to-face visits by a physician or other qualified health care professional per month		
90955	… with 2-3 face-to-face visits by a physician or other qualified health care professional per month	N	Physician office visit; OR Professional fees for medical and surgical services
90956	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month	N	Physician office visit; OR Professional fees for medical and surgical services
90957	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years if age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	N	Physician office visit; OR Professional fees for medical and surgical services
90958	… with 2-3 face-to-face visits by a physician or other qualified health care professional per month	N	Physician office visit; OR Professional fees for medical and surgical services
90959	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month	N	Physician office visit; OR Professional fees for medical and surgical services
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	N	Physician office visit; OR Professional fees for medical and surgical services
90961	… with 2-3 face-to-face visits by a physician or other qualified health care professional per month	N	Physician office visit; OR Professional fees for medical and surgical services
90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month	N	Physician office visit; OR Professional fees for medical and surgical services
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to	N	Physician office visit; OR Professional fees for medical and surgical

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents		services
90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	N	Physician office visit; OR Professional fees for medical and surgical services
90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, counseling of parents	N	Physician office visit; OR Professional fees for medical and surgical services
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older	N	Physician office visit; OR Professional fees for medical and surgical services
90967	End-stage renal disease (ESRD) related services related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age	N	Physician office visit; OR Professional fees for medical and surgical services
90968	… for patients 2-11 years of age	N	Physician office visit; OR Professional fees for medical and surgical services
90969	… for patients 12-19 years of age	N	Physician office visit; OR Professional fees for medical and surgical services
90970	… for patients 20 years of age and older	N	Physician office visit; OR Professional fees for medical and surgical services
92002	Ophthalmological services; medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	N	Professional fees for surgical and medical services
92004	Ophthalmological services; medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits	N	Professional fees for surgical and medical services
92012	Ophthalmological services; medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	N	Professional fees for surgical and medical services
92014	Ophthalmological services; medical examination and evaluation, with initiation or continuation of diagnostic and treatment	N	Professional fees for surgical and medical services

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	program; comprehensive, established patient, 1 or more visits		
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	Y	Professional fees for surgical and medical services
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	Y	Professional fees for surgical and medical services
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	Y	Professional fees for surgical and medical services
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	Y	Professional fees for surgical and medical services
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)	Y	Professional fees for surgical and medical services
92524	Behavioral and qualitative analysis of voice and resonance	Y	Professional fees for surgical and medical services
92526	Treatment of swallowing dysfunction and/or oral function for feeding	Y	Rehabilitation Therapy Services
92550	Tympanometry and reflex threshold measurements	N	Physician office visit; OR Professional fees for medical and surgical services
92552	Pure tone audiometry (threshold); air only	N	Physician office visit; OR Professional fees for medical and surgical services
92553	Pure tone audiometry (threshold); air and bone	N	Physician office visit; OR Professional fees for medical and surgical services
92555	Speech audiometry threshold	N	Physician office visit; OR Professional fees for medical and surgical services
92556	Speech audiometry threshold; with speech recognition	N	Physician office visit; OR Professional fees for medical and surgical services
92557	Comprehensive audiometry threshold evaluation and speech recognition	N	Physician office visit; OR Professional fees for medical and surgical services
92563	Tone decay test	N	Physician office visit; OR Professional fees for

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
			medical and surgical services
92565	Stenger test, pure tone	N	Physician office visit; OR Professional fees for medical and surgical services
92567	Tympanometry	N	Physician office visit; OR Professional fees for medical and surgical services
92568	Acoustic reflex testing, threshold	N	Physician office visit; OR Professional fees for medical and surgical services
92570	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing	N	Physician office visit; OR Professional fees for medical and surgical services
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	N	Physician office visit; OR Professional fees for medical and surgical services
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report	N	Physician office visit; OR Professional fees for medical and surgical services
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	N	Professional fees for surgical and medical services
92602	… subsequent reprogramming	N	Professional fees for surgical and medical services
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	N	Professional fees for surgical and medical services
92604	… subsequent reprogramming	N	Professional fees for surgical and medical services
92610	Evaluation of oral and pharyngeal swallowing function	N	Rehabilitation Therapy Services
92625	Assessment of tinnitus (includes pitch, loudness matching and masking)	N	Physician office visit; OR Professional fees for medical and surgical services
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or post-operative status of a surgically implanted	Y	Physician office visit; OR Professional fees for medical and surgical

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	device(s); first hour		services
92627	Evaluation of auditory function for surgically implanted device(s) candidacy or post-operative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)	Y	Rehabilitation Therapy Services
93750	Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report	N	Professional fees for surgical and medical services
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	N	Professional fees for surgical and medical services
93798	… with continuous ECG monitoring (per session)	N	Professional fees for surgical and medical services
94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day	N	Professional fees for surgical and medical services
94003	… hospital inpatient/observation, each subsequent day	N	Professional fees for surgical and medical services
94004	… nursing facility, per day	N	Professional fees for surgical and medical services
94005	Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more	N	Professional fees for surgical and medical services
94625	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)	N	Rehabilitation Therapy Services
94626	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)	N	Rehabilitation Therapy Services
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer,	N	Professional fees for surgical and medical

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Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	metered dose inhaler or IPPB device		services
95970	Electronic analysis of implanted neurostimulator pulse generator transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, or peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without reprogramming	N	Professional fees for surgical and medical services
95971	… with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	N	Professional fees for surgical and medical services
95972	… with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	N	Professional fees for surgical and medical services
95983	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional	N	Professional fees for surgical and medical services
95984	… with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)	N	Professional fees for surgical and medical services
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg,by Boston Diagnostic Aphasia Examination) with interpretation and report, per	N	Rehabilitation Therapy Services

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	hour		
96110	Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	N	Professional fees for surgical and medical services
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour	N	Professional fees for surgical and medical services
96113	… each additional 30 minutes (List separately in addition to code for primary procedure)	N	Professional fees for surgical and medical services
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	N	Professional fees for medical and surgical services
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)	N	Professional fees for medical and surgical services
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report.	Y	Rehabilitation Therapy Services
96127	Brief emotional/ behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation per standardized instrument	N	Outpatient behavioral therapy visit
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient	N	Outpatient behavioral therapy visit

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Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour		
96131	… each additional hour (list separately in addition to code for primary procedure)	N	Outpatient behavioral therapy visit
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	N	Outpatient behavioral therapy visit
96133	… each additional hour (list separately in addition to code for primary procedure)	N	Outpatient behavioral therapy visit
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes	N	Outpatient behavioral therapy visit
96137	… each additional 30 minutes (List separately in addition to code for primary procedure)	N	Outpatient behavioral therapy visit
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	N	Outpatient behavioral therapy visit
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)	N	Outpatient behavioral therapy visit
96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)	N	Outpatient behavioral health therapy visit and testing
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	N	Outpatient behavioral therapy visit
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	N	Outpatient behavioral health therapy visit and testing
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	N	Physician office visit; OR Professional fees for medical and surgical services
96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with	N	Physician office visit; OR Professional fees for medical and surgical

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Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	scoring and documentation, per standardized instrument		services
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	N	Physician office visit; OR Professional fees for medical and surgical services
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	N	Physician office visit; OR Professional fees for medical and surgical services
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	N	Physician office visit; OR Professional fees for medical and surgical services
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	N	Physician office visit; OR Professional fees for medical and surgical services
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	N	Outpatient behavioral therapy visit
96171	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	N	Outpatient behavioral therapy visit
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	8,9	Outpatient rehabilitation/habilitation therapy visit
97112	… neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	8,9	Outpatient rehabilitation/habilitation therapy visit
97116	… gait training (includes stair climbing)	8,9	Outpatient rehabilitation/habilitation therapy visit
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	8, 9	Rehabilitation Therapy Services
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem	8, 9	Rehabilitation Therapy Services

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)		
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan	N	Outpatient behavioral therapy visit
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes	N	Outpatient behavioral therapy visit
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes	Y	Outpatient behavioral therapy visit
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes	Y	Outpatient behavioral therapy visit
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	Y	Outpatient behavioral therapy visit
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	Y	Outpatient behavioral therapy visit
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present),	Y	Outpatient behavioral therapy visit

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	face-to-face with multiple sets of guardians/caregivers, each 15 minutes		
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes	Y	Outpatient behavioral therapy visit
97161	Physical therapy evaluation: low complexity, requiring these components…	8,9	Outpatient rehabilitation/habilitation therapy visit
97162	Physical therapy evaluation: moderate complexity, requiring these components…	8,9	Outpatient rehabilitation/habilitation therapy visit
97163	Physical therapy evaluation: high complexity, requiring these components…	8,9	Outpatient rehabilitation/habilitation therapy visit
97164	Re-evaluation of physical therapy established plan of care, requiring these components …	8,9	Outpatient rehabilitation/habilitation therapy visit
97165	Occupational therapy evaluation, low complexity, requiring these components …	8,9	Outpatient rehabilitation/habilitation therapy visit
97166	Occupational therapy evaluation, moderate complexity, requiring these components …	8,9	Outpatient rehabilitation/habilitation therapy visit
97167	Occupational therapy evaluation, high complexity, requiring these components …	8,9	Outpatient rehabilitation/habilitation therapy visit
97168	Re-evaluation of occupational therapy established plan of care, requiring these components …	8,9	Outpatient rehabilitation/habilitation therapy visit
97530	Therapeutic activities, direct patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	Y	Outpatient rehabilitation/habilitation therapy visit
97535	Self-care/home management training (e.g., 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	Y	Outpatient rehabilitation/habilitation therapy visit
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	Y	Outpatient rehabilitation/habilitation therapy visit
97750	Physical performance test or measurement and (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	Y	Outpatient rehabilitation/habilitation therapy visit
97755	Assistive technology assessment (eg, to	Y	Outpatient

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one on one contact by provider, with written report, each 15 minutes		rehabilitation/habilitation therapy visit
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise report), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	Y	Professional fees for medical and surgical services
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	Y	Professional fees for medical and surgical services
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	8, 9	Outpatient rehabilitation/habilitation therapy visit
97802	Medical nutrition therapy; initial assessment & intervention, individual, face to face with the patient, each 15 minutes	N	Outpatient therapeutic treatment services-nutritional counseling
97803	… re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	N	Outpatient therapeutic treatment services-nutritional counseling
97804	... group (2 or more individual[s]), each 30 minutes	N	Outpatient therapeutic treatment services-nutritional counseling
98960	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	N	Physician office visit; OR Professional fees for medical and surgical services
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	N	Physician office visit; OR Professional fees for medical and surgical services
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	N	Physician office visit; OR Professional fees for medical and surgical services
98966	Telephone assessment and management service provided by qualified non-physician health care professional to established patient, parent, or guardian and not originating from a related assessment and	N	Professional fees for medical and surgical services

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion		
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	N	Professional fees for medical and surgical services
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	N	Professional fees for medical and surgical services
99202 - 99205	Office or other outpatient visit for E&M of new patient …	N	Physician office visit; OR Professional fees for medical and surgical services
99211	Office or other outpatient visit for E&M of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	N	Physician office visit; OR Professional fees for medical and surgical services
99212 - 99215	Office or other outpatient visit for E&M of an established patient …	N	Physician office visit; OR Professional fees for medical and surgical services
99221-99223	Initial hospital care, per day, for E&M of a patient…	N	Professional fees for medical and surgical services
99231 - 99233	Subsequent hospital care, per day, for E&M of a patient …	N	Professional fees for medical and surgical services
99234-99236	Observation or inpatient hospital care, for E&M of a patient including admission and discharge on the same date…	N	Professional fees for medical and surgical services

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
99238-99239	Hospital discharge day management…	N	Professional fees for medical and surgical services
99281-99285	Emergency department visit for E&M of a patient…	N	Professional fees for medical and surgical services
99291	Critical care, E&M of critically ill or critically injured patient; first 30-74 min	N	Professional fees for medical and surgical services
99292	… each additional 30 minutes (List separately in addition to code for primary service)	N	Professional fees for medical and surgical services
99304-99306	Initial nursing facility care, per day, for E&M of a patient,…	N	Professional fees for medical and surgical services
99307 - 99310	Subsequent nursing facility care, per day, for E&M of a patient …	N	Professional fees for medical and surgical services
99315-99316	Nursing facility discharge day management…	N	Professional fees for medical and surgical services
99341	Home visit for the E&M of a new patient, which requires these 3 key components: A problem focused history; A problem focused exam; and Straightforward medical decision making	N	Professional fees for medical and surgical services
99342	Home visit for E&M of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused exam; and Medical decision making of low complexity	N	Professional fees for medical and surgical services
99344	Home visit for the E&M of an established patient, which requires these 3 key components: A comprehensive history; A comprehensive exam; Medical decision making of moderate to high complexity	N	Professional fees for medical and surgical services
99345	Home visit for the E&M of an established patient, which requires these 3 key components: A comprehensive interval history; A comprehensive exam; Medical decision making of moderate to high complexity	N	Professional fees for medical and surgical services
99347	Home visit for the E&M of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused exam; and Straightforward medical decision making	N	Professional fees for medical and surgical services
99348	Home visit for E&M of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused	N	Professional fees for medical and surgical services

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	interval history; An expanded problem focused exam; Medical decision making of low complexity		
99349	Home visit for E&M of a new patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed exam; and Medical decision making of moderate complexity	N	Professional fees for medical and surgical services
99350	Home visit for E&M of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive exam; Medical decision making of moderate to high complexity	N	Professional fees for medical and surgical services
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	N	Professional fees for surgical and medical services
99407	… intensive, greater than 10 minutes	N	Professional fees for surgical and medical services
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report E&M 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	N	Professional fees for medical and surgical services
99442	… 11 - 20 minutes of medical discussion	N	Professional fees for medical and surgical services
99443	... 21-30 minutes of medical discussion.	N	Professional fees for medical and surgical services
99468	Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less	N	Professional fees for medical and surgical services
99469	Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less	N	Professional fees for medical and surgical services
99471	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	N	Professional fees for medical and surgical services
99472	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days	N	Professional fees for medical and surgical services

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	through 24 months of age		
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration	N	Professional fees for medical and surgical services
99475	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	N	Professional fees for medical and surgical services
99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	N	Professional fees for medical and surgical services
99477	Initial hospital care, per day, for E&M of a neonate, 28 days of age or younger, who requires intensive observation, frequent interventions, and other intensive care services	N	Professional fees for medical and surgical services
99478	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)	N	Professional fees for medical and surgical services
99479	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight of 1500-2500 grams)	N	Professional fees for medical and surgical services
99480	Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 2501-5000 grams)	N	Professional fees for medical and surgical services
99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements	N	Professional fees for surgical and medical services
99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge. Medical decision making of at least moderate complexity during the service period. Face-to-face visit, within 14 calendar days of discharge	N	Professional fees for surgical and medical services
99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge. Medical decision making of high complexity during the	N	Professional fees for surgical and medical services

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	service period. Face-to-face visit, within 7 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	N	Professional fees for surgical and medical services
99498	… each additional 30 min (List separately in addition to code for primary procedure)	N	Professional fees for surgical and medical services
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	N	Nutritional counseling
G0109	Diabetes outpatient self-management training services, group session (2 or more) per 30 minutes	N	Nutritional counseling
G0136	Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5 to 15 minutes	N	Professional fees for surgical and medical services
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	N	Nutritional counseling
G0296	Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making)	N	Physician office visit; OR Professional fees for medical and surgical services
G0316	Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (Do not report G0316 on the same date of service as other prolonged services for evaluation and management codes 99358, 99359, 99418, 99415, 99416). (Do not report G0316 for any time unit less than 15 minutes)	N	Professional fees for surgical and medical services

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
G0317	Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99306, 99310 for nursing facility evaluation and management services). (Do not report G0317 on the same date of service as other prolonged services for evaluation and management codes 99358, 99359, 99418). (Do not report G0317 for any time unit less than 15 minutes)	N	Professional fees for surgical and medical services
G0318	Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99345, 99350 for home or residence evaluation and management services). (Do not report G0318 on the same date of service as other prolonged services for evaluation and management codes 99358, 99359, 99417). (Do not report G0318 for any time unit less than 15 minutes)	N	Professional fees for surgical and medical services
G0396	Alcohol and/or substance (other than tobacco) misuse structured assessment (eg, AUDIT, DAST), and brief intervention 15 to 30 minutes	N	Physician office visit; OR Professional fees for medical and surgical services
G0397	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes	N	Physician office visit; OR Professional fees for medical and surgical services
G0406	Follow up inpatient telehealth consultation, limited, physicians typically spend 15 minutes communicating with patient via telehealth	N	Professional fees for surgical and medical services
G0407	Follow up inpatient telehealth consultation, intermediate, physicians typically spend 25 minutes communicating with patient via telehealth	N	Professional fees for surgical and medical services
G0408	Follow up inpatient telehealth consultation, complex, physicians typically spend 35	N	Professional fees for surgical and medical

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	minutes communicating with patient via telehealth		services
G0410	Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes	N	Professional fees for surgical and medical services
G0420	Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour	N	Physician office visit; OR professional fees for medical and surgical services
G0421	Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour	N	Physician office visit; OR professional fees for medical and surgical services
G0422	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session	N	Outpatient rehabilitation/habilitation therapy visit
G0423	Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session	N	Outpatient rehabilitation/habilitation therapy visit
G0425	Initial inpatient telehealth consultation, typically 30 minutes communicating with the patient via telehealth	N	Professional fees for surgical and medical services
G0426	Initial inpatient telehealth consultation, typically 50 minutes communicating with the patient via telehealth	N	Professional fees for surgical and medical services
G0427	Initial inpatient telehealth consultation, typically 70 minutes or more communicating with the patient via telehealth	N	Professional fees for surgical and medical services
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit	N	Preventive Health Services
G0439	Annual wellness visit; includes a personalized prevention plan of service (PPS), subsequent visit	N	Preventive Health Services
G0442	Annual alcohol misuse screening, 15 minutes	N	Preventive Health Services
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	N	Physician office visit; OR professional fees for medical and surgical services
G0444	Annual depression screening, 15 min.	N	Physician office visit; OR professional fees for medical and surgical services
G0445	Semi-annual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior	N	Physician office visit; OR professional fees for medical and surgical services
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	N	Physician office visit; OR professional fees for medical and surgical services

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	N	Physician office visit; OR professional fees for medical and surgical services
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	N	Physician office visit; OR professional fees for medical and surgical services
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service	N	Professional fees for surgical and medical services
G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth	N	Professional fees for surgical and medical services
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	N	Professional fees for surgical and medical services
G0513	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (List separately in addition to code for preventive service)	N	Professional fees for surgical and medical services
G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code G0513 for additional 30 minutes of preventive service)	N	Professional fees for surgical and medical services
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	N	Professional fees for surgical and medical services
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	N	Professional fees for surgical and medical services
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)	N	Professional fees for surgical and medical services

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) (Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)	N	Physician office visit; OR professional fees for medical and surgical services
G3002	Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month	N	Physician office visit; OR professional fees for medical and surgical services
G3003	Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month (List separately in addition to code for G3002). (When using G3003, 15 minutes must be met or exceeded.)	N	Physician office visit; OR professional fees for medical and surgical services

NON-COVERED CODES		
Code	**Description**	**Benefit Plan Reference/ Reason**
0591T	Health and well-being coaching face-to-face; individual,	Specific exclusion - Personal

NON-COVERED CODES		
Code	**Description**	**Benefit Plan Reference/ Reason**
	initial assessment	trainer, exercise classes.
0592T	Health and well-being coaching face-to-face; individual, follow-up session, at least 30 minutes	Specific exclusion - Personal trainer, exercise classes.
0593T	Health and well-being coaching face-to-face; group (2 or more individuals), at least 30 minutes	Specific exclusion - Personal trainer, exercise classes.
92607	Evaluation for prescription for speech generating augmentive and alternative communication device, face to face with the patient; first hour	BCP-57 Outpatient Rehab/Hab Services: ST Specific Exclusion for "Speech Generating Devices"
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)	BCP-57 Outpatient Rehab/Hab Services: ST Specific Exclusion for "Speech Generating Devices"
92609	Therapeutic services for use of speech generating device, including programming and modification	BCP-57 Outpatient Rehab/Hab Services: ST Specific Exclusion for "Speech Generating Devices"
97150	Therapeutic procedure(s), group (2 or more individuals)	Not Medically Necessary
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes	Specific exclusion per benefit plans. BCP-06 Outpatient Rehab Services: PT/OT
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)	Non-covered service
G9685	Evaluation and management of a beneficiary's acute change in condition in a nursing facility	Not payable due to claims payment rule
Q3014	Telehealth originating site facility fee	Payment included in primary procedure.
T1014	Telehealth transmission, per minute, professional services bill separately.	Not an eligible charge

5.0 Unique Configuration/Prior Approval/Coverage Details:

None.

6.0 Terms & Definitions:

Distant site – is where the health care professional providing the professional service is located at the time the service is provided via a HIPAA complaint telecommunications system.

Face-to-face encounter – an encounter between a healthcare provider and a patient either in person or virtually through real-time audio with video technology.

Originating site **–** is where the patient is located at the time the service is being provided via a HIPAA compliant telecommunications system, such as, but not limited to a practitioner's office, hospital, health care clinic, skilled nursing facility, or the patient's home.

Store and Forward – the transfer of data from one site to another, using a camera or other similar device that records/stores an image and is forwarded via telecommunication to another site for consultation.

Telemonitoring – use of information technology to monitor patients at a distance, such as members who have a history of cardiac conditions including heart failure and hypertension, COPD, uncontrolled diabetes. Examples of telemonitoring information are blood pressure and pulse readings, pulse oximetry measurements, blood sugar readings, and/or weights to a provider's office at regular intervals.

Telemedicine – Virtual health visits to perform remote diagnosis and treatment of a patient by means of telecommunications technology.

Telehealth – Provision of healthcare services provided to a patient that is in a different physical location that the healthcare professional rendering services via telecommunication technology within state and federal law. Telemedicine services are inclusive of telehealth services.

7.0 References, Citations & Resources:

1. American Telehealth Association (ATA) Standards of Care, October 2014. Available at: https://www.healthit.gov/sites/default/files/telehealthguide_final_0.pdf.
2. Upper Midwest Telehealth Resource Centers, Frequently Asked Questions, 2019. Available at: https://www.umtrc.org/index.php?submenu=faqs&src=faq&category=Resources.
3. Michigan Legislature, The Insurance Code of 1956 (excerpt), Act 218 of 1956, Section 500.3476 Telemedicine services; provisions; definition. http://www.legislature.mi.gov/(S(gvdajtdvlvihrdgg32kq2ts0))/mileg.aspx?page=getObject&objectName=mcl-500-3476.
4. CMS 1135 waiver.
5. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.
6. https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes.

8.0 Appendices:

Appendix 1: page 21

9.0 Revision History

Original Effective Date: 01/01/2020

Next Review Date: 07/01/2025

Revision Date	Reason for Revision
2/18/20	1/1/20 code changes made.
3/20	COVID-19 codes added per CMS guidelines
5/20	Edited to change term date of temporary allowance of some services via telemedicine to be extended until 12/31/20.
12/20	Off cycle review; date extended for coverage of certain services via

	telemedicine
1/21	Annual review
3/21	Codes added to align with CMS Telehealth coverage; approved at BCC on 11-01-2021
11/22	Annual review; 48 codes added and 18 codes removed to align with CMS Telehealth coverage effective 11/2022. Added ASO groups: L0002237 and L0002193. Updated the description for code 97150 to match what is reflected in Auth Viewer, also moved code from covered code to non-covered code section, Updated Codes prior approval status for codes 90901, 97129, 97130 and 97763.
5/23	Added paragraph one in 2.0 background (aligned with PRP-15 Telemedicine Services language) Removed paragraph is section 2.0, "Telemedicine includes remote patient health monitoring, medical education, patient consultation via video conferencing, health wireless applications, and transmission of image medical reports" Removed "the patient initiates the medical or behavioral health encounter language from A. 1. a. Add language in section A. 1.a to include language from PRP-15 Revamped A. 7. provider language to mirror language in PRP-15 Telemedicine Services Removed C. 1 (services not covered) re: telephonic sessions. Removed 99201- from covered code list, code deleted 1/1/2021 (page 11) Moved codes 99441, 99442, and 99442 from the appendix 1 (which listed covered from 3/1/2020-12/31/2021) to the covered code section, these are covered by CMS with no end date. (page 13) Added new definitions to match PRP-15 Telemedicine Services (page 20) 9/23 EDITS per Gap Analysis: 90875 removed from Non-Covered section; 99334-99335 and 99354-99357 removed from policy due to being deleted codes as of 12/31/2022, updated PA requirements for 90901, 97129, 97130, and 97763 to alight with BCP-06.
7/2024	Removed language in “Background” regarding services allowed from 3/1/2020 to 123/31/2021 and removed Appendix 1. Added a note in section 1.0 Policy regarding alignment with CMS list to clarify that will be done in accordance with policy review. All codes from Appendix 1 that are still on CMS list moved to main code list. Added new codes to covered codes list from CMS list: 98966-98968, G0136. Added new codes to Non covered codes list from CMS list: 0591T-0593T. Removed codes from Covered list due to no longer on CMS list: S9152. 10/25/24 updates per Gap Analysis: updated 92626 to require PA to align with current code status, removed 99343 – this code terminated on 12/31/2022.