



Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Application: Medicare Advantage, Commercial and Medicaid Products

Effective date: Commercial: 07/2008

Medicare Advantage: 02/2009

Policy number: CP2008102

Revision date: 04/2023

Related policies: [Telehealth and Other Virtual Services During the COVID-19 PHE](#)

Disclaimer: The intended audience of this medical claims payment policy is healthcare providers who treat Humana members. This policy is made available to provide information on certain Humana claims payment policies. This policy is a guideline only and does not constitute medical advice, guarantee of payment, plan pre-authorization, an explanation of benefits, or a contract. This policy does not govern whether a procedure is covered under a specific member plan or policy, nor is it intended to address every claim situation. Claims may be affected by other factors, such as: state and federal laws and regulations, provider contract terms, and our professional judgment. This policy is subject to change or termination by Humana. Humana has full and final discretionary authority for its interpretation and application. No part of this policy may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, electronic, mechanical, photocopying or otherwise without express written permission from Humana. When printed, this version becomes uncontrolled. For the most current information, always refer to the following website: [Humana.com/ClaimPaymentPolicies](https://www.humana.com/ClaimPaymentPolicies)

Overview

Telehealth is a method of delivering health care services via *electronic information and telecommunications technologies*. Not all health care services delivered via *electronic information and telecommunication technology* are considered *telehealth* services. Examples of other health care services delivered via *electronic information and telecommunications technologies* that are not *telehealth* services include interprofessional services and remote monitoring services.

The following policy outlines how Humana plans reimburse *telehealth* and other virtual services.

[Medicare Advantage Payment Policy](#)

[Commercial Payment Policy](#)

[Medicaid Payment Policy](#)

[Definitions of *Italicized* Terms](#)

[References](#)

[General Humana Resources](#)

[Medicare Advantage Additional Telehealth Benefit Code List](#)



Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Policy Number: CP2008102

Medicare Advantage Payment Policy

In addition to the policy, claims payments are subject to other plan requirements for the processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements.

The following policy applies to only professional services.

This policy does not apply for services rendered during the COVID-19 Public Health Emergency (PHE). For guidance applicable to dates of service during the COVID-19 PHE, refer to Humana's [Telehealth and Other Virtual Services During the COVID-19 PHE Claims Payment Policy](#).

Note: Humana allows an originating site fee, reported by *HCPCS code Q3014*, to facilities that provide administrative support for a professional's provision of a *telehealth* service if the patient is physically present at that facility. The originating site fee is not a *telehealth* service. The professional who provided the *telehealth* service is not eligible to receive reimbursement for the originating site fee in addition to the *telehealth* service provided.

Original Medicare Telehealth Services

Humana requires a provider to submit a charge for an *Original Medicare telehealth service* according to the applicable Centers for Medicare & Medicaid Services (CMS) guidance for the date of service. Humana Medicare Advantage (MA) plans allow *Original Medicare telehealth services* consistent with the applicable CMS guidance for the date of service. Humana MA plans deny charges for *Original Medicare telehealth services* that do not satisfy the applicable CMS guidance, including billing guidance regarding the appropriate place of service (POS) code or modifier, for the date of service.

For further information on the service codes that may be reported as an *Original Medicare telehealth service*, see CMS's [List of Telehealth Services](#).

Note: Humana MA plans are applying the same coverage-related waivers to *Original Medicare telehealth services*, as authorized by the Consolidated Appropriations Act, 2023.

Additional Telehealth Services

For dates of service beginning January 1, 2020, Humana MA plans also allow certain *additional telehealth services* that are not *Original Medicare telehealth services*. *Additional telehealth services* must meet the following criteria:

- The service must be one of those covered under the *additional telehealth service* benefit in the member's applicable Evidence of Coverage.
- The service must be provided by a physician or other qualified health care practitioner that has satisfied Humana's telehealth credentialing and recredentialing standards and has a valid and effective contract with Humana.
- The service must be provided by a physician or other qualified health care practitioner that satisfies the following requirements:
 - Meets all applicable licensure, certification and registration requirements, including Drug Enforcement Administration (DEA) registration, if applicable, in the state(s) in which they practice and the state in which the patient is located at the time of the encounter;
 - Is operating within the scope of their license; and
 - Meets professional practice standards in the state(s) in which they practice and the state in which the patient is located at the time of the encounter.
- The service must be provided using real-time interactive audio technology, and Humana encourages providers to simultaneously use real-time interactive video technology, when appropriate. For a charge for a particular service to be reimbursed, it must be possible to provide all the necessary components of the code with the real-time interactive technology used.
- The physician or other qualified health care practitioner must verify the member's identity before providing the service.
- The Humana member must provide verbal or written consent to receive the service, in accordance with state law.
- The Humana member must be present for the full duration of the service.



Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Policy Number: CP2008102

Services not meeting the criteria outlined above will not be allowed by Humana as *additional telehealth services*.

Unless prohibited by applicable federal statute or regulation, Humana plans allow *additional telehealth services* if it is medically appropriate to furnish the service via telecommunications-based technology, the service is coverable by the plan, and all applicable coding requirements are satisfied. For further information on the service codes that may be reported as *additional telehealth services*, see the [Medicare Advantage Additional Telehealth Services Benefit Code List](#) section of this policy.

Physicians are responsible for supervising any *additional telehealth services* provided to Humana MA members by nonphysician practitioners within their practices to ensure that such services conform in all respects to the requirements set forth herein.

Billing

Humana requires a provider report the POS code for an *additional telehealth service* with one of the following, as appropriate:

- POS code 02
- POS code 10
- The POS code that would have been reported had the service been furnished in person with *modifier 93*
- The POS code that would have been reported had the service been furnished in person with *modifier 95*

Humana requires providers to identify an audio-only service with *modifier 93*.

Note: The POS code billed for a service will determine whether that service is reimbursed with a *facility or nonfacility rate*.

Other Virtual Services

Humana MA plans also allow other virtual services that are covered by Original Medicare but are not *Original Medicare telehealth services*. These include, but are not limited to, e-visits, virtual check-ins and remote monitoring.

Humana requires a provider to submit a charge for a virtual service covered by Original Medicare according to the applicable CMS guidance. Humana MA plans allow such services consistent with the applicable CMS guidance. Humana MA plans deny charges for such services that do not satisfy the applicable CMS guidance.

Commercial Payment Policy

In addition to the policy, claims payments are subject to other plan requirements for the processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements.

The following policy applies to only professional services.

This policy does not apply for services rendered during the COVID-19 Public Health Emergency (PHE). For guidance applicable to dates of service during the COVID-19 PHE, refer to Humana's [Telehealth and Other Virtual Services During the COVID-19 PHE Claims Payment Policy](#).

Humana commercial plans allow *telehealth services* that meet the following criteria:

- The service must be provided by a physician or other qualified health care practitioner that satisfies the following requirements:
 - Meets all applicable licensure, certification and registration requirements, including DEA registration, if applicable, in the state(s) in which they practice and the state in which the patient is located at the time of the encounter;
 - Is operating within the scope of their license; and
 - Meets professional practice standards in the state(s) in which they practice and the state in which the patient is located at the time of the encounter.



Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Policy Number: CP2008102

- The service must be provided using real-time interactive audio technology, and Humana encourages providers to simultaneously use real-time interactive video technology, when appropriate. For a charge for a particular service to be reimbursed, it must be possible to provide all the necessary components of the code with the real-time interactive technology used.
- The physician or other qualified health care practitioner must verify the member's identity before providing the service.
- The Humana member must provide verbal or written consent to receive the service, in accordance with state law.
- The Humana member must be present for the full duration of the service.

A service not meeting the criteria outlined above will not be allowed by Humana as a *telehealth* service.

Unless prohibited by applicable federal or state statute or regulation, Humana plans allow *telehealth* and other services if it is medically appropriate to furnish the service via telecommunications-based technology, the service is coverable by the plan, and all applicable coding requirements are satisfied.

Billing

Humana requires a provider to submit a charge for a *telehealth* service with one of the following, as applicable: *modifier 93*, *modifier 95*, *modifier GT*, *POS code 02* or *POS code 10*.

Humana requires providers to identify an audio-only service with *modifier 93*.

Note: The POS code billed for a service will determine whether that service is reimbursed with a *facility or nonfacility rate*.

Medicaid Payment Policy

In addition to the policy, claims payments are subject to other plan requirements for the processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements.

Humana Medicaid plans allow *telehealth* services consistent with federal law and state Medicaid agency requirements.

Definitions of *Italicized Terms*

- ***Additional telehealth services:*** Telehealth services provided by an MA plan, beginning in plan year 2020, under Section 1852(m) of the Social Security Act and which are treated as a basic benefit rather than a supplemental benefit.
- ***Electronic information and telecommunication technology:*** Technologies and devices which enable secure electronic communications and information exchange and typically involve the application of secure real-time audio/video conferencing or similar services, remote monitoring, or store and forward medical data technology to provide or support health care services.
- ***Facility or nonfacility rate:*** A facility rate is the rate that would be applicable to services, under the Medicare Physician Fee Schedule (MPFS), when the patient received face-to-face services in a setting defined by the Centers for Medicare & Medicaid Services (CMS) as a facility setting. A nonfacility rate is the rate that would be applicable to services, under the MPFS, when the patient received face-to-face services in a setting defined by CMS as a nonfacility setting. A practitioner may have, for a particular procedure code, a nonfacility rate and a facility rate.
- ***HCPCS code Q3014:*** Telehealth originating site facility fee.
- ***Modifier 93:*** Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System.
- ***Modifier 95:*** Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System.
- ***Modifier GT:*** Via interactive video and video telecommunication systems. (For Medicare, effective January 1, 2018, modifier GT is only appropriate for use by critical access hospitals.)
- ***Original Medicare telehealth services:*** Telehealth services covered by Original Medicare under Section 1834(m) of the Social Security Act.
- ***Place of service code 02:*** Telehealth Provided Other than in Patient's Home.

- **Place of service code 10:** Telehealth Provided in Patient's Home.
- **Telehealth:** A means to deliver health care services to a patient at a different physical location than the health professional using electronic information or telecommunications technologies consistent with applicable state and federal law. Telehealth services include telemedicine services and are also known as virtual visits.

References

- Social Security Administration website. Social Security Act. Title 18. [Section 1834 – Special Payment Rules for Particular Items and Services](#). Paragraph (m) – Payment for Telehealth Services. [www.ssa.gov](#).
- Social Security Administration website. Social Security Act. Title 18. [Section 1852 – Benefits and Beneficiary Protections](#). Paragraph (m) – Provision of Additional Telehealth Benefits. [www.ssa.gov](#).
- U.S. Government Publishing Office website. Code of Federal Regulations. Title 42. [Section 410.78 – Telehealth Services](#). [www.ecfr.gov](#).
- U.S. Government Publishing Office website. Code of Federal Regulations. Title 42. [Section 414.65 – Payment for Telehealth Services](#). [www.ecfr.gov](#).
- U.S. Government Publishing Office website. Federal Register, Vol. 84, No. 73. Department of Health and Human Services. [Final Rule CMS-4185-F](#). [www.govinfo.gov](#).
- U.S. Department of Health and Human Services website. [Telehealth Policy Changes After the COVID-19 Public Health Emergency](#). [telehealth.hhs.gov](#).
- Centers for Medicare & Medicaid Services website. Medicare Claims Processing Manual. [Chapter 12 – Physicians/Nonphysicians Practitioners](#). Section 190 – Medicare Payment for Telehealth Services. [www.cms.gov](#).
- Centers for Medicare & Medicaid Services website. [List of Telehealth Services](#). [www.cms.gov](#).
- Centers for Medicare & Medicaid Services website. Medicare Learning Network. [MLN Fact Sheet: Telehealth Services](#). [www.cms.gov](#).
- Centers for Medicare & Medicaid Services website. [Place of Service Code Set: Place of Service Codes for Professional Claims](#). [www.cms.gov](#).
- Centers for Medicare & Medicaid Services HCPCS Level II and associated publications and services.
- American Medical Association's CPT and associated publications and services.

General Humana Resources

- [Availability](#) – Providers can register for access to information on a variety of topics such as eligibility, benefits, referrals, authorizations, claims and electronic remittances.
- [Claims processing edit notifications](#) – Alerts of upcoming claims payment changes are posted on the first Friday of each month.
- [Claims resources](#) – Providers can find information on referrals, authorizations, electronic claim submissions and more.
- [Education and news](#) – This page can help you find clinical guidelines, educational tools, Medicare and Medicaid resources, our provider magazine and other resources to help you do business with us.
- [Making it easier](#) – This page contains an educational series for providers and healthcare professionals.
- [Medical and pharmacy coverage policies](#) – Humana publishes determinations of coverage of medical procedures, devices and medications for the treatment of various conditions. There may be variances in coverage among plans.

Note: Links to sources outside of Humana's control are verified at the time of publication. Please report [broken links](#).

Medicare Advantage Additional Telehealth Services Benefit Code List

The following list of procedure codes serves as a guide to assist providers in determining which services may be reimbursable under Humana's Medicare Advantage *additional telehealth services* benefit. This list is subject to termination or modification by Humana at any time, without notice. Printed versions of this document may be out of date and do not control. For the most current and only controlling version of this guide, refer to the most current version of this policy published at the following website:

[Humana.com/ClaimPaymentPolicies](#).



Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Policy Number: CP2008102

This list does not constitute medical advice, guarantee of payment, plan pre-authorization, an explanation of benefits, or a contract. It does not govern whether a procedure is covered under a specific member plan or policy, nor is it intended to address every claim situation. Claims payment and coverage may be affected by other factors, including but not limited to federal laws and regulations, the member’s Evidence of Coverage, provider contract terms, coverage policies, medical necessity, and Humana’s professional judgment. Humana has full and final discretionary authority for its interpretation and application. No part of this may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, electronic, mechanical, photocopying or otherwise without express written permission from Humana.

A charge for any code in this list will not be reimbursed under Humana’s Medicare Advantage *additional telehealth services* benefit if any applicable *additional telehealth services* benefit criterion is not satisfied. Likewise, a charge for any code in this list will not be reimbursed under Humana’s Medicare Advantage *additional telehealth services* benefit if any applicable criterion of that code is not satisfied.

Code	Description
90785	Interactive complexity (List separately in addition to the code for primary procedure)
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient and/or family member
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient and/or family member
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 minutes with patient and/or family member
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)
90845	Psychoanalysis
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)
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
90952	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 2-3 face-to-face visits by a physician or other qualified health care professional per month
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
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 4 or more face-to-face visits by a physician or other qualified health care professional per month
90955	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 2-3 face-to-face visits by a physician or other qualified health care professional per month



Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Policy Number: CP2008102

Code	Description
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 or other qualified health care professional per month
90957	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 4 or more face-to-face visits by a physician or other qualified health care professional per month
90958	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 2-3 face-to-face visits by a physician or other qualified health care professional per month
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
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
90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
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
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, 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
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
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, and counseling of parents
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older
90967	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age
90968	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age
90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92521	Evaluation of speech fluency (eg, stuttering, cluttering)
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);
92524	Behavioral and qualitative analysis of voice and resonance
92556	Speech audiometry threshold; with speech recognition
92609	Therapeutic services for the use of speech-generating device, including programming and modification



Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Policy Number: CP2008102

Code	Description
92626	Evaluation of auditory rehabilitation status; first hour
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
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)
94625	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)
94626	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
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, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming
95971	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 simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
95972	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 complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
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
95984	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, 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)
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 hour
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
96113	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; each additional 30 minutes (List separately in addition to code for primary procedure)

Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Policy Number: CP2008102

Code	Description
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
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)
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
96127	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument
96130	Psychological 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
96131	Psychological 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; each additional hour (List separately in addition to code for primary procedure)
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
96133	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; each additional hour (List separately in addition to code for primary procedure)
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
96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
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)
96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in



Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Policy Number: CP2008102

Code	Description
	addition to code for primary service)
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
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)
96202	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes
96203	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes (List separately in addition to code for primary service)
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
97130	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; 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
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
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
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
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
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
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), 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
97537	Community/work reintegration training (eg, 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
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
98960	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; individual patient
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



Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Policy Number: CP2008102

Code	Description
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
98970	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
98971	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
98972	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
99221	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99222	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
99223	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
99231	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
99232	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.



Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Policy Number: CP2008102

Code	Description
99233	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
99234	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99235	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.
99236	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.
99238	Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter
99239	Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter
99281	Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional
99282	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making
99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically



Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Policy Number: CP2008102

Code	Description
	appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99315	Nursing facility discharge management; 30 minutes or less total time on the date of the encounter
99316	Nursing facility discharge management; more than 30 minutes total time on the date of the encounter
99341	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99342	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99344	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99345	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
99347	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99348	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99349	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99350	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
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; 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
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



Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Policy Number: CP2008102

Code	Description
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 (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
99415	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)
99416	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service)
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99469	Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger
99472	Subsequent 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
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
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
99477	Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or younger, who requires intensive observation, frequent interventions, and other intensive care 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)
99479	Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)
99480	Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)
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: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (eg, home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks,

Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Policy Number: CP2008102

Code	Description
	Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 60 minutes of total time is spent on the date of the encounter.
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.
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, At least moderate level of medical decision making during the service period, Face-to-face visit, within 14 calendar days of discharge
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, High level of medical decision making during the 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
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)
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.
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.
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) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes
G0296	Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making)
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)
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



Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Policy Number: CP2008102

Code	Description
	report G0317 for any time unit less than 15 minutes)
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)
G0323	Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month. (These services include the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners who are authorized by Medicare to prescribe medications and furnish E/M services, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team)
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth
G0420	Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour
G0421	Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour
G0422	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session
G0423	Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit
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
G0445	Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes
G0447	Face-to-face behavioral counseling for obesity, 15 minutes
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)
G0508	Telehealth consultation, critical care, initial , physicians typically spend 60 minutes communicating with the patient and providers via telehealth



Claims Payment Policy

Subject: Telehealth and Other Virtual Services

Policy Number: CP2008102

Code	Description
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth
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)
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)
G2011	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes
G2077	Periodic assessment; assessing periodically by qualified personnel to determine the most appropriate combination of services and treatment (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure
G2080	Each additional 30 minutes of counseling in a week of medication assisted treatment, (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure
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)
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, 99483 for office or other outpatient evaluation and management services.) (Do not report G2212 on the same date of service as codes 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)
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 care e.g., physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. Requires 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. (When using G3002, 30 minutes must be met or exceeded)
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)
H0031	Mental health assessment, by nonphysician
H0032	Mental health service plan development by nonphysician