Updated! Expanded Coverage and Reimbursement for Virtual Visits and Telehealth

April 13, 2020

We've updated our Telemedicine, Telehealth, & Virtual Care Services medical policy. A copy is attached.

Please be sure to refer to the section Telehealth coverage during Public Health Emergency (PHE) and note:

HAP has aligned its telehealth billing requirements with the Centers for Medicare and Medicaid Services.

- Non-traditional telehealth services: When billing professional claims for non-traditional telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with the Place of Service (POS) equal to what it would have been in the absence of a PHE, along with a modifier 95, indicating that the service rendered was actually performed via telehealth.
- Traditional telehealth services: Traditional telehealth services professional claims should reflect the designated POS code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site. There is no change to the facility/non-facility payment differential applied based on POS. Claims submitted with POS code 02 will continue to pay at the facility rate.
- Institutional claims: There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

Reminder!
Only one POS may be submitted on the same claim. Please be sure to submit appropriate COVID-19 treatment and testing codes.

Remember, you can find the most up-to-date policy when you log in at **hap.org** and select *Benefit Admin Manual* under *More*.

Telemedicine, Telehealth & Virtual Care Services

DESCRIPTION

Telehealth, telemedicine, virtual care services and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a Member's health. The method of health care delivery is rapidly expanding utilizing computers, cell phones, tables or other mobile devices to add access and remove barriers to care. Telemedicine technology falls into two general categories: synchronous care and asynchronous care. Telemedicine typically involves the application of secure audio/video conferencing for real-time interactive communication. To be considered telemedicine under Michigan State law [Section 500.3476 of the Insurance Code of 1956 (excerpt), Act 218 of 1956][1] the health care professional must be able to examine the patient via a real-time, interactive audio or video, or both, telecommunication system and the patient must be able to interact with the off-site health care professional at the time the services are provided.

COVID-19 RESPONSE:

- During the Medicare-defined covid-19 pandemic time frame, coverage for Medicare Advantage Plan Members will follow Medicare guidelines for broadened access to telemedicine services.
  - MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET: Medicare coverage and payment of virtual services **https://www.samhsa.gov/sites/default/files/medicare-telemedicine-health-care-fact-sheet.pdf**
- HAP Empowered/Medicaid Members will follow the State of Michigan MDHHS guidelines for COVID-19 Response.
  - Michigan Medicaid policy bulletins: **https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42553-87513--,00.html**
- HAP/AHL Commercial and Individual product Members are covered following the Medicare telehealth guidelines in effect for the Covid-19 pandemic time frame.

EXPANDED TELEMEDICINE SERVICES:

- To support social distancing recommendations during this time, the telemedicine adjustments apply to all diagnosis and conditions, not just COVID-19 related concerns.
  - Applies to all Medicare Advantage, HAP/AHL Commercial & Individual product Members.
  - HAP Empowered/Medicaid Members continue to follow MDHHS directives.
- All Members may make the call for telehealth services from their home.
- All Members may utilize audio-only interactive technology if audio/video technology is not available or inaccessible.
- It is expected that codes selected for claims will accurately reflect the services rendered.
- Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services are covered as telehealth services.
  - Applies to all Medicare Advantage, HAP/AHL Commercial & Individual product Members.
  - HAP Empowered/Medicaid Members continue to follow MDHHS directives.
- Autism Spectrum Evaluation & Treatment: Covered via audio and/or audio-video telemedicine access for HAP/AHL Commercial & Individual product Members during this time frame. Please refer to the Benefit Administration Manual policy: Autism Spectrum Disorders, Evaluation and Treatment for coverage criteria.

COVERED CODES - resources

Medicare resource	**Medicare Telehealth Services List @ https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes** (includes covid-19 updates and the 85 added Telehealth codes)
Medicaid resource	**HAP Empowered/Medicaid Members follow the Medicaid fee schedule https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-159815--,00.html**
Medicaid Covid-19 fee schedule	**Michigan Medicaid Covid-19 fee schedule @ https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-523789--,00.html**

COVERED CODES [NOTE: HAP Empowered/Medicaid Members follow the Medicaid fee schedule]

96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
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

	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)
99224	Subsequent Observation Care, Per Day, For The Evaluation And Management Of A Patient, Problem Focused
99225	Subsequent Observation Care, Per Day, For The Evaluation And Management Of A Patient, Expanded
99226	Subsequent Observation Care, Per Day, For The Evaluation And Management Of A Patient, Detailed
99407	Smoking and Tobacco Use Cessation Counseling Visit; Intensive, Greater than 10 Minutes
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
99447	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review
99448	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review
99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes
G0071	Payment for communication technology-based services for 5 minutes or more of a virtual (nonface-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
G0508	Telehealth consultation, critical care, initial , physicians typically spend 60 minutes communicating with the patient and providers via telehealth
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not

	originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
G2061	Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes
G2062	Qualified nonphysician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes
G2063	Qualified nonphysician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes
G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month
G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)

ADDITIONAL COVERED CODES for Commercial Plan Members [per State of Michigan telehealth regulations, NOTE: HAP Empowered/Medicaid Members follow the Medicaid fee schedule]

98966	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; 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
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
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
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

SERVICES THAT MAY BE COVERED when identified as Telehealth and included on the Medicare Telehealth Services List

..	**Please note: List is not all inclusive. CMS Temporary Additions for the PHE for the COVID-19 Pandemic are covered but not listed.** Standard billing guidelines apply to these services. Service components for each code must be met or exceeded for the level of service selected.
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

90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient 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
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
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
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
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
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 younger than 2 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
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
96150	Health & Behavior Assessment, Ea 15 Minutes; Initial Assessment [code termed 1/1/2020]
96151	Health & Behavior Assessment, Ea 15 Minutes; Re-Assessment [code termed 1/1/2020]

96152	Health & Behavior Intervention, Ea 15 Minutes; Individual [code termed 1/1/2020]
96153	Health & Behavior Intervention, Ea 15 Minutes; Group (2+ Patients) [code termed 1/1/2020]
96154	Health & Behavior Intervention, Ea 15 Minutes; Family (W/Patient Present) [code termed 1/1/2020]
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
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
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least

	2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
99354	Prolonged evaluation and management or psychotherapy 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 hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)
99355	Prolonged evaluation and management or psychotherapy 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 for prolonged service)
99356	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)
99357	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)
99406	Smoking and Tobacco Use Cessation Counseling Visit; Intermediate, Greater than 3 Minutes up to 10 Minutes
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
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 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)
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes outpatient self-management training services, group session (two 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 (ldct) using low dose ct scan (service is for eligibility determination and shared decision making)
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
G0420	Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per 1 hour
G0421	Face-to-face educational services related to the care of chronic kidney disease; group, per session, per 1 hour
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
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)
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)

NON-COVERED HCPCS CODES

S9110	Telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month
T1014	Telehealth transmission, per minute, professional services bill separately

Telehealth Modifiers [inclusion on this list does not imply coverage]

95	Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System
G0	Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (informational modifier)
GQ	Via Asynchronous Telecommunications systems
GT	Service via interactive audio and video telecommunication systems [critical access hospitals]

Place of Service

02	Telehealth: The location where health services and health related services are provided or received, through a telecommunication system.

COVERAGE CRITERIA

Telehealth coverage during Public Health Emergency (PHE):

- Health Alliance Plan (HAP) continues to cover telehealth (telemedicine) and, like Medicare, has expanded its telehealth coverage during the COVID-19 pandemic.
- Medicare telehealth guidelines apply to all HAP/AHL Commercial and individual product members and Medicare Advantage members.
- HAP Empowered/Medicaid Members will follow the State of Michigan MDHHS guidelines for COVID-19 Response.

Billing:

- HAP reimburses all providers for telemedicine
- Office/outpatient E/M level selection for services when furnished via telehealth can be based on MDM or time.
- HAP expects that codes selected for claims accurately reflect the services rendered.
- Documentation requirements follow CMS policy and provide additional flexibility during this PHE.
- HAP has aligned its telehealth billing requirements with the Centers for Medicare and Medicaid Services.
    - Non-traditional telehealth services: When billing professional claims for non-traditional telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with the Place of Service (POS) equal to what it would have been in the absence of a PHE, along with a modifier 95, indicating that the service rendered was actually performed via telehealth.
    - Traditional telehealth services: Traditional telehealth services professional claims should reflect the designated POS code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site. There is no change to the facility/non-facility payment differential applied based on POS. Claims submitted with POS code 02 will continue to pay at the facility rate.
    - Institutional claims: There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

Audio only/audio and visual:

- Audio-only interactive technology may be used if audio/video technology is not available or inaccessible. For audio-only access, HAP is in agreement with the following CMS decision.
    - In the context of the PHE for the COVID-19 pandemic, especially in the case that two-way, audio/video technology might not be available, CMS concedes that there are many circumstances where prolonged, audio-only communication between the practitioner and the patient could be clinically appropriate. CMS notes that existing telephone E/M codes, in both description and valuation, are the best way to recognize the relative resource costs of these kinds of services. Therefore, CMS is finalizing on an interim basis for the COVID-19 public health emergency, separate payment for CPT codes 98966-98968 and CPT codes 99441-99443.
- It remains our expectation that practitioners will document E/M visits as necessary to ensure quality and continuity of care.

Providers:

- Telehealth services are covered for providers including physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, nutritionists, licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology.

Autism Spectrum Evaluation & Treatment:

- Autism Spectrum evaluation and treatment is covered. Please refer to the Benefit Administrative Manual policy: Autism Spectrum Disorders, Evaluation & Treatment for coverage criteria.

Medicare temporary additions for PHE telemedicine services are covered for HAP commercial, individual and Medicare Members (list may not be all-inclusive):

Code	Description	Code	Description	Code	Description	Code	Description
77427	Radiation tx management X5	90853	Group psychotherapy	90953	Esrd serv 1 visit p mo <2yr	90959	Esrd serv 1 vst p mo 12-19
90962	Esrd serv 1 visit p mo 20+	92507	Speech/hearing therapy	92521	Evaluation of speech fluenc	92522	Evaluation of speech fluenc
92523	Speech sound lang comprehen	92524	Behavral qualit analys voic	96130	Psycl tst eval phys/qhp 1st	96131	Psycl tst eval phys/qhp ea
96132	Nrpsyc tst eval phys/qhp 1st	96133	Nrpsyc tst eval phys/qhp ea	96133	Nrpsyc tst eval phys/qhp ea	96136	Psycl/nrpsyc tst phy/qhp 1s
96137	Psycl/nrpsyc tst phy/qhp ea	96138	Psycl/nrpsyc tech 1st	96139	Psycl/nrpsyc tst tech ea	97110	Therapeutic exercises

97112	Neuromusulcar reeducation	97116	Gait training therapy	97161	PT Eval low complex 20 min	97162	PT Eval mod complex 30 min
97163	PT Eval high complex 45 min	97164	PT re-eval est plan care	97165	OT eval low complex 30 min	97166	OT eval mod complen 45 min
97167	OT eval high complex 60 min	97168	OT re-eval est plan care	97535	Self care mngment training	97750	Physical Performance Test
97755	Assistive Technology Assess	97760	Orthotic mgmt&traing 1st en	97761	Prosthetic traing 1st enc	99218	Initial observation care
99219	Initial observation care	99220	Initial observation care	99221	Initial hospital care	99222	Initial hospital care
99223	Initial hospital care	99234	Obser/hosp same date	99235	Obser/hosp same date	99236	Obser/hosp same date
99238	Hospital discharge day	99239	Hospital discharge day	99281	Emergency dept visit	99282	Emergency dept visit
99283	Emergency dept visit	99284	Emergency dept visit	99285	Emergency dept visit	99291	Critical care first hour
99292	Critical care addl 30 min	99304	Nursing facility care init	99305	Nursing facility care init	99306	Nursing facility care init
99315	Nursing fac discharge day	99316	Nursing fac discharge day	99327	Domicil/r-home visit new pa	99328	Domicil/r-home visit new pa
99334	Domicil/r-home visit est pa	99335	Domicil/r-home visit est pa	99336	Domicil/r-home visit est pa	99337	Domicil/r-home visit est pa
99341	Home visit new patient	99342	Home visit new patient	99343	Home visit new patient	99344	Home visit new patient
99345	Home visit new patient	99347	Home visit est patient	99348	Home visit est patient	99349	Home visit est patient
99350	Home visit est patient	99468	Neonate crit care initail	99469	Neonate crit care subsq	99471	Ped critical care initial
99472	Ped critical care subsq	99473	Self-meas bp pt educaj/trai	99475	Ped crit care age 2-5 init	99476	Ped crit care age 2-5 subsq
99477	Init day hosp neonate care	99478	Ic lbw inf < 1500 gm subsq	99479	Ic lbw inf 1500-2500 g subs	99480	Ic inf pbw 2501-5000 g subs
99483	Assmt & care pln cog imp						

Telemedicine Services

- **Telehealth visits** use interactive real-time telecommunication technology for office, hospital visits and other services that generally occur in-person. These communications are initiated by the Member.
- **E-visits** are nonface-to-face patient-initiated online evaluation and management services provided via an online patient portal. These services can only be reported when the billing practice has an established relationship with the Member. For E-Visits, the Member must generate the initial inquiry and communications can occur over a 7-day period.
- **Virtual check-in visits** are short patient-initiated communications with a healthcare practitioner via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image. These virtual check-ins are for Members with an established (or existing) relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available). The practitioner may respond to the Member's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

Telemedicine Technology

- **Synchronous telehealth care** consists of live interaction (audio/video conference) between Member and Provider permitting two-way, real-time communications between the Member at the originating site and the healthcare professional at the distant site. These visits typically are used for office, hospital visits and other services that generally occur in-person. May be used by Members in either an established patient-provider relationship or as a new patient. Examples include:
    - Audio-Video visit:
        - AmWell visit
        - MyChart Mobile Video Visits
            - MyCare On Demand video visit: Member initiates contact and waits for next available provider (not pre-scheduled)
            - Scheduled Video visits: the video visit is pre-scheduled similar to an office visit
    - Clinic-to-clinic or consultative telehealth visit (visit is between two health professionals with the Member present at the hosting or requesting end)
- **Asynchronous telehealth care** are those communications with a delayed response from the recipient. There is no real-time interaction. Asynchronous telehealth care, also known as store and forward messaging, involves messaging (including condition-driven questionnaires) or data submission (monitoring) that the provider will respond to within a specified time frame. These communications are used by Members in an established patient-provider relationship.
    - Messaging
    - E-consult
    - Remote monitoring
        - E-home care

- Tele-radiology readings)

COVERAGE CRITERIA:

1. **Telehealth visit**: Evaluation, management and consultation services using synchronous (real-time, interactive) telehealth technologies are covered for HAP/AHL Members when ALL of the following are met:
    a. The Member and provider must be present at the time of the consultation.
    b. The provider must be HAP contracted.
    c. The consultation must take place via an interactive audio and/or video HIPAA compliant telecommunication system (provider equipment). Medicare Members must follow Medicare guidelines.
        i. **Acceptable Equipment**: Common Skype is not acceptable for telehealth purposes; however, professional Skype-like products are available with technology that meets compliance. Health Insurance Portability and Accountability Act (HIPAA) guidelines require that any software transmitting protected personal health information meet a 128-bit level of encryption, at a minimum, need auditing, archival and backup capabilities. State laws must also be followed.
2. **E-visits or Online digital evaluation and management service**: Members may have non-face-to-face patient-initiated communications with their doctors without going to the doctor's office by using online patient portals. These services can only be reported when the billing practice has an established relationship with the Member. The Member must verbally consent to receive virtual check-in services.
    a. For these E-Visits, the Member must generate the initial inquiry and communications can occur over a 7-day period.
    b. Medicare Advantage plan Members: The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable.
    c. Commercial plan Members: The services may be billed using CPT codes 99421-99423 and CPT codes 98970 - 98972, as applicable.
3. **Virtual check-ins**: Virtual check-ins are for Members with an established (or existing) relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available). The Member must verbally consent to receive virtual check-in services.
    a. Virtual check in services may be furnished through several communication technology modalities, such as telephone (G2012). The practitioner may respond to the Member's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.
    b. In addition, separate from these virtual check-in services, captured video or images can be sent to a physician (G2010).

For ANY form of telemedicine service:

1. A permanent record of the telemedicine communications must be maintained as part of the Member's medical record.
2. The provider must be a health care professional who is licensed, registered or otherwise authorized to provide health care in the state where the Member is located at the time the telemedicine service is rendered.
    a. Provider specialties eligible to provide telemedicine services include:
        i. Physicians
        ii. Nurse Practitioners (NPs)
        iii. Physician Assistants (PAs)
        iv. Certified Nurse-Midwives (CNMs)
        v. Clinical Nurse Specialists (CNSs)
        vi. Certified Registered Nurse Anesthetists (CRNAs)
        vii. Clinical Psychologists (CPs)
        viii. Clinical Social Workers (CSWs)
        ix. Registered Dietitians (RDs) or Medical Nutritional Professionals (MNTs)
    b. Appropriate informed consent which includes a description of potential risks, consequences, and benefits of telemedicine is obtained.
    c. All services provided are medically necessary and appropriate for the Member.
3. Coverage of services is based on the Member's subscriber documents. Please refer to those resources for information regarding eligibility for coverage, network or provider requirements. If the Member has coverage for the services discussed in this policy, then the medical criteria applies.
    a. HAP has contracted with AmWell to provide telemedicine services for urgent care services. AmWell does not provide urgent care services for Behavioral Health indications for HAP/AHL Members.
4. Medicaid Providers should refer to:
    a. The Michigan Medicaid Provider Manual for coverage criteria, located at: **http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf**
    b. The Michigan Medicaid Fee Schedule located at: **http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html**

LIMITATIONS

1. Telemedicine services are subject to all terms and conditions of the Member's HAP/AHL subscriber contract, including, but not limited to, required copayments, coinsurances, deductibles, and approved amounts.

2. Any claims for Member reimbursement for telemedicine services must include standard claim data including provider NPI, billing address and procedure/service codes.
3. Provider Type and Telemedicine services: 99441-99443; 98970 - 98972
    a. The communication should be performed through HIPAA-compliant platforms, like an electronic health record portal or secure email.
        i. Nonevaluative electronic communication of test results does not qualify for this type of code.
    b. Qualified health care professional [physician]:
        i. New AMA CPT® guidelines indicate certain codes are appropriate when a patient initiates a service performed by a physician or other qualified healthcare professional (QHP).
        ii. The codes all begin with the same phrasing, which sets out the basic requirements: “Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days.” They are time-based:
            A. 99421: 5-10 minutes
            B. 99422: 11-20 minutes
            C. 99423: 21 or more minutes
    c. Non-qualified health care professional [non-physician]:
        i. There are alternative codes (98970-98972) that are almost identical to 99421-99423. The difference is that the descriptors for 98970-98972 state that a “Qualified nonphysician health care professional” performs the service.
        ii. This provider type would include speech-language pathologists, physical therapists, occupational therapists, social workers, and dietitians.
        iii. The codes all begin with the same phrasing, which sets out the basic requirements: "online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days". They are time-based:
            A. 98970: 5-10 minutes
            B. 98971: 11-20 minutes
            C. 98972: 21 or more minutes

EXCLUSIONS

Telehealth coverage exclusions during Public Health Emergency (PHE):

- Some concessions have been made to address the current PHE when billed with CMS telehealth CPT/HCPCS codes.
    - MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET: Medicare coverage and payment of virtual services **https://www.samhsa.gov/sites/default/files/medicare-telemedicine-health-care-fact-sheet.pdf**
- Please refer to the CMS guidelines for a current list of the added Teleheath PHE codes.
    - Medicare Telehealth Services List @ **https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes** (includes covid-19 updates and the added Telehealth codes)
- HAP/AHL Medicare, Commercial and Individual product Members are covered following the Medicare telehealth guidelines in effect for the Covid-19 pandemic time frame. These guidelines have expanded the services available by telemedicine and now include options for E&M and office evaluation services. The preventive medicine service codes [99381-99387; 99391-99397] are not included in those guidelines, therefore preventive services described by codes: 99381-99387; 99391-99397 are not covered for HAP/AHL Members as a telemedicine service.

1. The following services are not covered as telehealth services:
    a. E-mail or text only communication
    b. Installation or maintenance of any telecommunication devices or systems.
    c. Facsimile transmissions.
    d. Software or other applications for management of acute or chronic disease.
    e. Appointment scheduling.
    f. Request for medication refill.
    g. Scheduling diagnostic tests.
    h. Reporting normal test results.
    i. Updating patient demographic information.
    j. Providing educational materials.
    k. Services that would not typically be charged during a regular office visit.
    l. Requests for referrals.
    m. Provider initiated e-mail.
    n. Clarification of simple instructions.
    o. Formal imaging interpretation by a radiologist.
    p. Provider-to-provider consultations when the Member is not present.
    q. Reminders for healthcare related issues.

r. Brief follow-up after a medical procedure to confirm stability of the Member's condition without indication of complication or new condition including, but not limited to, routine global surgical follow-up because the service is included in the global reimbursement.
s. Telehealth services where information is exchanged and further evaluation is required such that the Member is subsequently advised to seek face to face care by the same provider within 48 hours.
t. Online medical evaluations that occur within 7 days after a face to face evaluation and management service performed by the same provider for the same condition, whether provider requested or unsolicited patient follow-up.

2. Telehealth services are not covered for HAP/AHL Members who:
   a. Are unwilling or refuse the service.
   b. Are unable to self-actuate or have no caregiver available who is able to assist.
   c. Are enrolled in hospice care.
   d. Receive clinical interventions at a high frequency (greater than three times per week).
3. Telehealth services are not covered when billed by a non-HAP/AHL contracted or affiliated provider and/or company.

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4. Michigan Medicaid Provider Manual. **http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf**
    a. Billing & Reimbursement for Institutional Providers
        i. SECTION 6 – HOSPITAL CLAIM COMPLETION – INPATIENT
            A. 6.5 TELEMEDICINE
        ii. SECTION 7 – HOSPITAL CLAIM COMPLETION – OUTPATIENT
            A. 7.27 TELEMEDICINE
        iii. SECTION 8 - REMITTANCE ADVICE
            A. 8.14 OTHER SERVICE REVENUE CODES
    b. Behavioral Health and Intellectual and Developmental Disability Supports and Services
        i. SECTION 3 – COVERED SERVICES
            A. 3.26 TELEMEDICINE
        ii. SECTION 4 – TELEMEDICINE
        iii. SECTION 18 – BEHAVIORAL HEALTH TREATMENT SERVICES/APPLIED BEHAVIOR ANALYSIS
            A. 18.9.D. TELEPRACTICE FOR BHT SERVICES
    c. Children's Special Health Care Services
        i. SECTION 9 – BENEFITS
            A. 2.3 TELEMEDICINE
    d. Federally Qualified Health Centers and Tribal Health Centers
        i. 7.4 COVERED SERVICES
    e. Home and Community Based Services
    f. Home Health
        i. SECTION 1 – GENERAL INFORMATION
            A. 1.1 FACE-TO-FACE ENCOUNTER
    g. Hospital
        i. SECTION 3 – COVERED SERVICES
            A. 3.33 TELEMEDICINE
    h. Nursing Facility Coverages
        i. 10.35 TELEMEDICINE
    i. Practitioner
        i. SECTION 17 – TELEMEDICINE

j. RURAL HEALTH CLINICS
    i. SECTION 3 – BENEFITS
        A. 3.3 TELEMEDICINE
k. School Based Services
    i. 2.4.C. TELEPRACTICE FOR SPEECH, LANGUAGE AND HEARING SERVICES
l. Tribal Health Centers
    i. SECTION 3 – BENEFITS

This Benefit policy discusses the medical criteria for covered services. Coverage of services for Members is based on the Member's subscriber documents and are subject to all terms and conditions including specific exclusions and limitations. This type of document includes the following: Subscriber contract and associated riders; Member Benefit Guide; or an Evidence of Coverage document (for Medicare Advantage Members).
HAP HMO/POS and AHL EPO/PPO Members:
If there is a discrepancy between this policy and coverage described in the subscriber documents, the Member's subscriber documents will apply.
ASO Members:
Coverage as discussed in this policy may not apply to employer groups that are self-funded (referred to as an ASO group [Administrative Services Only]). Each ASO group determines the coverage available to their members which is found in the ASO Benefit Guide and associated riders. If a member has coverage for the type of service covered by this policy, then the medical criteria as discussed in this policy applies to those services.
Medicare Advantage Plan Members:
Coverage is based on Medicare (CMS) regulations and guidelines which include the NCDs (National Coverage Decision) and LCDs (Local Coverage Decision) for our area. When no coverage determination has been made by CMS, then this policy will apply.
Medicaid Plan Members:
For Medicaid/Healthy Michigan Plan members coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: **http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html**. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: **http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html**, the Michigan Medicaid Provider Manual will apply.

EFFECTIVE DATE

01/01/2015

REVISED DATE

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REVIEWED DATE

03/18/2020