Telehealth Services – Community Care Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

☐ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☐ MassHealth ACO
☐ NaviCare HMO SNP
☐ NaviCare SCO (Medicaid-only)
☐ Summit Eldercare PACE
☐ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

Policy

This policy applies to coverage and reimbursement for health care services delivered via telehealth. This policy does not apply to telehealth services rendered by the Plan's telehealth vendor (Teladoc). The policy does apply to behavioral health services. Carelon Behavioral Health is the Plan's behavioral health vendor. Carelon manages coverage and reimbursement of care and services for the evaluation, diagnosis, treatment or management of members with mental health, developmental or substance use disorders. Providers may contact Carelon Behavioral Health directly at https://www.carelonbehavioralhealth.com/providers/.

The Plan covers health care services delivered via telehealth by plan providers when:

(a) the health care services are covered by way of in-person consultation or delivery; and
(b) the health care services may be appropriately provided through the use of telehealth.

References

1. Code of Massachusetts Regulations, Title 211, Part 52. Managed Care Consumer Protections and Accreditation of Carriers, Section 52.16 – Access to Covered Services through Telehealth.
2. Massachusetts General Laws, Chapter 176G, Section 33: Coverage for Health Care Services Delivered via Telehealth by a Contracted Health Care Provider.

Terminology

The following terms, as used in this policy, have the following meanings:

Telehealth is defined as the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including, but not limited to:

(i) interactive audio-video technology;
(ii) remote patient monitoring devices;
(iii) audio-only telephone; and
(iv) online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring of a patient's physical health, oral health, mental health or substance use disorder condition.

Health care cervices or health services are services for the evaluation, consultation, prescribing, diagnosis, prevention, treatment, management, cure or relief of a physical, behavioral, substance use disorder or mental health condition, illness, injury or disease.

- Health care services provided via telehealth shall conform to the standards of care applicable to the telehealth provider's profession and specialty. Such services shall also conform to applicable federal and state health information privacy and security standards as well as standards for informed consent.

- As long as the technology meets these standards, the Plan will not limit the method or form by which telehealth is delivered to members. The appropriate use of telehealth may depend on the patient and/or situation, and is ultimately decided by the provider. Telehealth is more appropriate for some services than others. Physicians have a responsibility to ensure that the member receives appropriate care which may be in-person care. Members have the right to decline to receive services via telehealth and instead opt for in-person care.

Evidence of Coverage is any certificate, contract or agreement of health insurance including riders, amendments, endorsements and any other supplementary inserts or a summary plan description pursuant to § 104(b)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1024(b), issued to an Insured specifying the Benefits to which the insured is entitled.

All covered health care services to which the member is entitled are described in the Evidence of Coverage.

Behavioral health services are care and services for the evaluation, diagnosis, treatment or management of patients with mental health, developmental or substance use disorders.

Primary care services are services delivered by a primary care provider.

Asynchronous or asynchronous telehealth is an exchange of information regarding a patient that does not occur in real time, including but not limited to the secure collection and transmission of a patient's medical information, clinical data clinical images, laboratory results, or a self-reported medical history.

Chronic disease management means care and services for the management of chronic conditions, including

(a) conditions, defined by the federal Centers for Medicare and Medicaid Services that include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, cancer, and coronary artery disease;
(b) congenital anomalies and hereditary conditions; and
(c) other chronic conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both.

Distant site means the site at which the physician or practitioner is located at the time the service is provided via health.

Originating site means where the member is located at the time the health care service is furnished via telehealth. The scope of telehealth originating sites for services provided via telehealth includes any site in the U.S. where the member is at the time of the telehealth service, including the member’s home.

Eligible Providers

Consistent with Centers for Medicare & Medicaid Services (CMS) 42 CFR § 410.78 (b)(2) and subject to State law, providers eligible to furnish health care services via telehealth are:

- physicians
- nurse practitioners
- physician assistants
- certified nurse-midwifes
- clinical nurse specialists
- clinical psychologists
- clinical social workers
- registered dieticians or nutrition professionals

Beginning with dates of service on or after January 1, 2024:

- Marriage and family therapists
- Mental health counselors

Additionally, telehealth services can be provided by a physical therapist, occupational therapist, speech language pathologist, or audiologist through December 31, 2024. During the COVID-19 Public Health Emergency (PHE), Fallon Health aligned with Medicare to allow physical therapists, occupational therapists, speech-language pathologists, and audiologists to furnish telehealth services for Community Care members. Many of the Medicare telehealth flexibilities that were in place during the PHE have been extended temporarily including the flexibility that telehealth services can be provided by physical therapists, occupational therapists, speech-language pathologists and audiologists. Fallon Health will continue to align with Medicare regarding this flexibility, which is currently set to expire on September 30, 2025 without Congressional action.

Interstate Telehealth Services

Regarding practicing telehealth across state lines, the prevailing state regulatory approach maintains that the location of the patient dictates the state laws that govern the practice of medicine. In other words, a physician must be compliant with all laws, including physician licensure laws, of the state in which the patient is located when they receive care (Massachusetts Medical Society, Telehealth and Virtual Care, available at: https://www.massmed.org/Practice-Support/Telehealth-and-Virtual-Care/Telehealth-and-Virtual-Care/).

The Massachusetts Board of Registration in Medicine deems a physician to be practicing medicine in Massachusetts when the patient is physically located in Massachusetts. A physician licensed by the Board whose license does not restrict practice to a particular location may engage in the practice of medicine with respect to patients in Massachusetts irrespective of whether the physician is physically located in Massachusetts. A physician licensed by the board whose license does restrict practice to a particular location may engage in the practice of medicine with respect to patients in Massachusetts only from the location identified on his or her license. (Board of Registration in Medicine, Policy 2020-01, Amended October 6, 2022).

Categories of Services Ineligible for Delivery Via Telehealth

Health care services that are inappropriate for delivery via any telehealth modality include:

- Acute Inpatient Hospital Services
- Ambulance Services
- Ambulatory Surgery Services
- Anesthesia Services
- Chiropractic Services
- Durable Medical Equipment
- Laboratory Services
- Prosthetics and Orthotics
- Skilled Nursing Facility Services
- Renal Dialysis Services
- Surgery Services
- Transportation Services
- X-Ray/Radiology Services

Health care services that are currently eligible for delivery via telehealth includes consultations, office visits and psychotherapy. For the health care services that are not similar to consultations, office visits, psychotherapy, such as the services listed above, the use of telehealth to furnish these service has not been shown to provide clinical benefit to the member.

Privacy and Security Standards

Providers delivering services via telehealth must meet all laws and regulations regarding the protection of patient data, including, but not limited to, compliance with HIPAA, 42 CFR Part 2, and 201 CMR 17. This includes storage, access, and disposal of written and electronic medical records.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security, and Breach Notification Rules (HIPAA Rules) establish standards to protect patients' protected health information. All telehealth services provided by covered health care providers and health plans must comply with the HIPAA Rules. Covered health care providers and health plans must use technology vendors that comply with the HIPAA Rules and will enter into HIPAA business associate agreements in connection with the provision of their video communication products or other remote communication technologies for telehealth.

The HIPAA Privacy Rule requires that covered entities apply reasonable safeguards to protect the privacy of protected health information (PHI) from impermissible uses or disclosures, including when providing telehealth services.

The HIPAA Security Rule applies to electronic protected health information, which is PHI transmitted by, or maintained in, electronic media. The HIPAA Security Rule does not apply to audio-only telehealth services provided by a covered entity that is using a standard telephone line, often described as a traditional landline, because the information transmitted is not electronic. Covered entities using telephone or other systems that transmit ePHI need to apply the HIPAA Security Rule safeguards to those technologies. Note that an individual receiving telehealth services may use any telephone system they choose and is not bound by the HIPAA Rules when doing so. In addition, a covered entity is not responsible for the privacy or security of individuals' health information once it has been received by the individual's phone or other device (Office for Civil Rights. Guidance on HIPAA and Audio-Only Telehealth. June 13, 2022).

Documentation for Services Delivered via Telehealth

Providers delivering services via telehealth must meet all standards required by the HIPAA Rules governing patient healthcare records. This includes storage, access, and disposal of written and electronic medical records.

Documentation requirements for any form of telehealth are the same as those for documenting in-person care, in addition:

Provider and patient location: The physical location of the provider and member during the service must be documented in the medical record. If the patient's home is the location of service, and the address is already in the medical record, then you just need to include in your note that the visit took place at the patient's home.

Type of telehealth technology used: Documentaton in the medical record indicating that the service was provided via telehealth and the type of telehealth technology used, i.e., two-way interactive audio-video, two-way interactive audio-only, etc.

Consent: Appropriate patient informed consent, whether verbal or written, for the use of telehealth must be obtained and documented in the member's permanent medical record. Consent may be obtained at the time the service is delivered. In general, auxiliary personnel under general supervision of the billing practitioner can get patient consent for these services.

Eighteen (18) is the age of majority in Massachusetts for all purposes, including consent to medical treatment. Children under 18 are minors and the permission of their parents or guardians is required before they receive many kinds of medical treatment (M.G.L. Chapter 231, Section 85P).

Time: Physicians have the choice to bill office/outpatient evaluation and management (E/M) encounters (99202-99205, 99211-99215) solely based on medical decision making (MDM) or the total time spent on the date of that encounter. If time is to be used to calculate the E/M code rather than MDM, physicians should include the total amount of time they spent associated with that visit on the date of service in determining which code to use. Besides face-to-face time in the exam room or in a telehealth encounter, this also includes prep time and follow-up work on that same date. Important notes:

- There is no requirement to document the total time spent if the physician is not using time to calculate the level of service.
- If using time to determine the level of service, there is no requirement to spend the correlating amount of time on the encounter.

The Plan will use the medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time spent (whether documented via a start/stop time or documentation of total time) if time is relied upon to support the service delivered via telehealth.

As with all professional services, proper coding and timely reimbursement are dependent upon complete and accurate documentation. Medical record documentation must support the claims and must be retained in the member's permanent medical record. The CPT code(s) chosen must best represent the service provided. A a condition of payment the member must be present and participating in the service.

Reimbursement

Rates of payment for health care services delivered via telehealth are the same as rates of payment for services delivered via traditional (e.g., in-person) methods.

Member cost-sharing (copayment, coinsurance, deductible) for health care services delivered via telehealth are the same as cost-sharing for services delivered via traditional (e.g., in-person) methods.

Referral/notification/prior authorization requirements

Telehealth is the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology to deliver health care services.

Referral, notification and prior authorization requirements for health care services delivered via telehealth are the same as referral, notification and prior authorization requirements for services delivered via traditional (e.g., in-person) methods.

Billing/coding guidelines

Providers must use place of service (POS) 02 or 10 when submitting professional claims (CMS 1500/837P) for a health care services delivered via telehealth.

- **POS 02: Telehealth Provided Other than in Patient's Home**
  Descriptor: The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
- **POS 10: Telehealth Provided in Patient's Home**
  Descriptor: The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.

Modifier 93 (synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system) may be used for reporting audio-only services for codes listed in Appendix T of the AMA CPT Manual.

Modifier 95 (synchronous telemedicine service rendered via real-time Interactive audio and video telecommunications system) may be used for reporting audio-video telehealth services on professional claims for codes listed in Appendix P of the AMA CPT Manual.

Modifier 95 is required on claims for services delivered via telehealth on institutional claims (CMS-1450/837I).

The Plan does not reimburse Q3014 (Telehealth originating site facility fee).

COVID-19 Related Services

In accordance with Section 70 of Chapter 260 of the Acts of 2020, member cost-sharing is waived for professional services related to COVID-19 when claims are submitted with ICD-10 diagnosis code U07.1, Z11.52, Z20.822, J12.82 or U09.9, except as noted below.

Note: An HDHP may continue to provide benefits related to the treatment of COVID-19 before satisfaction of the applicable minimum deductible for plan years ending on or before December 31, 2024, pursuant to IRS Notice 2023-37. For subsequent plan years, an HDHP is not permitted to provide health benefits associated with treatment of COVID-19 without a deductible, or with a

deductible below the minimum deductible (for self-only or family coverage) for an HDHP, except as otherwise provided in this notice.

Preventive Medicine Services

Preventive visits are critical to ensuring the health and well-being of our members. Fallon Health will reimburse plan providers for preventive medicine services (CPT codes 99381-99387 and 99391-99397) delivered via telehealth when such services are clinically appropriate for the member (i.e., the physical examination can be deferred) and the plan member has given their informed consent. Documentation must include a plan for follow-up for any components of the preventive medicine service deferred due to telehealth. Fallon Health will not reimburse an additional preventive medicine service or E/M service to complete the components of the preventive medicine service that were not performed during the visit that took place via telehealth and the member cannot be charged.

Code	Descriptor
90785	Interactive complexity (list separately in addition to the code for primary procedure)
90791	Psychiatric diagnostic examination
90792	Psychiatric diagnostic examination 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 procedure)
90845	Psychoanalysis
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
90853	Group psychotherapy (other than of a multiple-family group)
90863	Pharmacologic management, including prescription and review of medications, when performed with psychotherapy services (List separately in addition to the code for the 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 patents; 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 patents; 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 patents; 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 patents; 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 patents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
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 patents; with 1 face-to-face visit 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 patents; 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 patents; 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 patents; 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 home 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 home dialysis less than a full month of service, per day, for patients younger than 2-11 years of age
90969	End-stage renal disease (ESRD) related services for home dialysis less than a full month of service, per day, for patients younger than 12-19 years of age
90970	End-stage renal disease (ESRD) related services for home dialysis less than a full month of service, per day, for patients younger 20 years of age and older

96110	Developmental screening, per instrument, scoring and documentation
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgement, e.g., 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 judgement, e.g., 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 the code for primary procedure)
96127	Brief emotional/behavioral assessment (eg, depression inventory) with scoring and documentation, per standardized instrument
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 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
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
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 total time on the date of the encounter for code selection, 15 must be met or exceeded
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 total time on the date of the encounter for code selection, 30 minutes must be spent ofr exceeded.
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 total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
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 total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

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 total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
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 total time on the date of the encounter for code selection, 20 minutes must be meet or exceeded
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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
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 total time for on the date of the encounter for code selection, 40 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.
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.
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, 20 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 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.
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 a low level medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination,

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

G0136	Administration of a standardized, evidence-based SDOH assessment, 5–15 minutes, not more often than every 6 months
G0270	Medical Nutrition therapy; reassessment and subsequent intervention(s) for change in diagnosis, individual, each 15 minutes
G0444	Annual depression screening, 15 minutes
G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month
G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (List separately in addition to code for primary procedure).

Telemedicine Codes (CPT 98000–98015)
The CPT Editorial Panel that issues and maintains the CPT code set created new telehealth codes effective January 1, 2025. These CPT codes describe specific services that previously required code/modifier combinations to adequately describe the type of telehealth service provided. These new (non-reimbursed) codes include: 98000-98007 (synchronous audio-video) and 98008-98015 (synchronous audio-only).

Consistent with CMS, Fallon Health will not reimburse for these new telehealth CPT codes. Fallon Health will continue to require our providers to submit telehealth services using an existing CPT code (e.g., 99202-99205, 99211-99215) with Place of Service 02 or 10 and modifier 93 and 95 as appropriate, as described above.

Services that are "inherently non face-to-face"
Services that are inherently non face-to-face and thus, do not have an in-person counterpart, are not considered telehealth services. Inherently non-face-to-face services should not be reported with Place of Service 02 or 10 or any telehealth modifiers. Inherently non-face-to-face services should be reported with the POS code that the provider would typically use to report services, for example, a physician's office (POS 11) or hospital outpatient department (POS 19 or 22). Examples of services that are inherently non face-to-face services include remote imaging of the retina for the detection or monitoring of disease (CPT 92227, 92228), external mobile cardiovascular telemetry (CPT 93228, 93229), external patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days (CPT 93268, 93270, 93271, 93272).

Brief Communication Technology-Based Service (CPT 98016)
Brief Communication Technology-Based Service (CPT 98016) is a non face-to-face patient-initiated services with physicians or other qualified health care professionals (physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives) who can report an evaluation and management (E/M) service.

Consent is required for non-face-to-face services and must be documented in the medical record. This helps ensure patients are engaged and aware of their cost sharing responsibilities.

CPT code 98016 does not require the use of audio or video technology. Furnishing the complete service described by CPT code 98016 must involve 5-10 minutes of medical discussion (and the code descriptor does not include MDM as means of code selection). CPT code 98016 should not be reported if it originates from a related E/M service furnished within the previous 7 days, or, if the clinical interaction leads to another E/M or procedure within the next 24 hours or the soonest available appointment. If the virtual check-in described by CPT 98016 leads to an E/M visit in the next 24 hours, and if that E/M is reported based on time, then the time from the virtual check-in

may be added to the time of the resulting E/M visit to determine the total time on the date of encounter for the resulting E/M.

CPT	Description
98016	Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion

Telephone Services (CPT 98966, 98967, 98968)
Telephone services (CPT 98966-98968) are non-face-to-face assessment and management services provided to a patient using the telephone by a qualified health care professional. Services provided by qualified nonphysician practitioners must be within the legal scope of practice of the nonphysician practitioner and rendered under the required supervision, if applicable.

The following providers may report telephone services using CPT codes 98966-98968:
- clinical psychologists
- clinical social workers
- registered dieticians or nutrition professionals

Beginning with dates of service on or after January 1, 2024:
- Marriage and family therapists
- Mental health counselors

Additionally, telephone services (CPT 98966-98968) can be provided by a physical therapist, occupational therapist, speech language pathologist, or audiologist through September 30, 2025.

Consent is required for non-face-to-face services and must be documented in the medical record. This helps ensure patients are engaged and aware of their cost sharing responsibilities.

Per CPT, telephone services (CPT 98966-98968) are used to report episodes of care provided by the qualified health care professional initiated by an established patient or the parent or guardian of an established patient.

- If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the telephone service is not reported; rather the encounter is considered part of the presevice work of the subsequent assessment and management service, procedure or visit.
- Likewise, if the telephone service refers to an assessment and management service performed and reported by that individual provider within the previous seven days or within the postoperative period of the previously completed procedure, then the service is considered part of that previous service or procedure.

Do not report CPT 98966, 98967, or 98968, if 98966, 98967, or 98968 have been reported by the same provider in the previous seven days for the same problem.

Telephone services (CPT 98966-98968) are time-based codes. The length of the telephone encounter must be documented, in addition to the nature of the service and other pertinent information, in the medical record.

Telephone services (CPT 98966-98968) may not be reported for new patients.

Reminder: Inherently non-face-to-face services, including telephone services (CPT 98966-98968) should not be reported with Place of Service 02 or 10 or any telehealth modifiers. Inherently non-face-to-face services should be reported with the POS code that the provider would typically use

to report health care services, for example, a physician's office (POS 11) or hospital outpatient department (POS 19 or 22).

Code	Description
98966	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
98967	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
98968	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

Online Digital Evaluation and Management Services (CPT 99421, 99422, 99423)
Online digital evaluation and management (E/M) services (99421, 99422, 99423) are non face-to-face patient-initiated services with physicians or other qualified health care professionals (physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives). Online digital E/M services require physician or other qualified health care professional's evaluation, assessment, and management of the patient. These services are not for nonevaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M. While the patient's problem may be new to the physician or other qualified health care professional, the patient is an established patient. Patients initiate these services through HIPAA-compliant platforms, such as electronic health record portals, secure email or other digital applications, which allow digital communication with the physician or other qualified health care professional.

Consent is required for non-face-to-face services and must be documented in the medical record. This helps ensure patients are engaged and aware of their cost sharing responsibilities.

For online digital E/M services provided by a qualified nonphysician health care professional who may not report E/M services, such as, licensed clinical social workers, clinical psychologists, registered dieticians or nutritional professionals see

Online digital E/Ms are reported once per seven-day period. The seven-day period begins with the physician's or other qualified health care professional's initial, personal review of the patient-generated inquiry. Online digital E/Ms are time based codes. Physician's or other qualified health care professional's cumulative time service includes review of the initial inquiry, review of patient records or data pertinent to the assessment of the patient's problem, personal physician or other qualified health care professional interaction with clinical staff focused on the patient's problem, development of management plans, including physician or other qualified health care professional generation of prescriptions or ordering of tests, and subsequent communication with the patient through online, telephone, email, or other digitally supported communication, which does not otherwise represent a separately reported E/M Service. All professional decision making, assessment, and subsequent management by phsyicians or other qualified health care professionals in the same group practice contribute to the cumulative service time of the patient's online digital E/M service. Online digital E/M services require permanent documentation storage of the encounter.

- If within seven days of the initiation of an online digital E/M service, a separately reported E/M service occurs, then the work devoted to the online digital E.M servie is incorporated into the separately reported E/M visit. This includes E/M visits that are provided through telehealth.
- If the patient initiates an online digital E/M service for the same or a related problem within seven days of a previous E/M service, then the online digital E/M service is not reported. If the online digital E/M service is related to a surgical procedure and occurs during the postoperative period of a previously completed procedure, then the online digital E/M service is not reported separately.
- If the patient generates an initial online digital E/M service for a new problem within seven days of a previous E/M service that addressed a different problem, then the online digital E/M service may be reported separately.
- If the patient presents with a new, unrelated problem during the seven-day perior of an online digital E/M service, then the physician's or other qualified health care professional's time spent on evaluation, assessment and management of the additional problem is added to the cumulative service time of the online digital E/M service for that seven-day period.

Reminder: Inherently non-face-to-face services, including online digital E/M services (CPT 99421, 99422, 99423) should not be reported with Place of Service 02 or 10 or any telehealth modifiers. Inherently non-face-to-face services should be reported with the POS code that the provider would typically use to report health care services, for example, a physician's office (POS 11) or hospital outpatient department (POS 19 or 22).

Code	Description
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.

Online Digital Assessment and Management Service (CPT 98970, 98971, 98972)
Online digital assessment and management services (98970, 98971, 98972) are non-face-to-face patient-initiated digital services with qualified nonphysician health care professionals that require qualified nonphysician health care professional patient evaluation and decision making to generate an assessment and subsequent management of the patient. These services are not for the nonevaluative electronic communication of test results, scheduling of appointments, or other communication that does not include assessment and management.

While the patient's problem may be new to qualified nonphysician health care professional, the patient is an established patient. Patients initiate these services through HIPAA-compliant platforms, such as electronic health record portals, secure email or other digital applications, which allow digital communication with the qualified nonphysician health care professional.

The following providers may report online digital assessment and management services using CPT codes 98970, 98971, 98972:
- clinical psychologists
- clinical social workers
- registered dieticians or nutrition professionals

Beginning with dates of service on or after January 1, 2024:
- Marriage and family therapists
- Mental health counselors

Consent is required for non-face-to-face services and must be documented in the medical record. This helps ensure patients are engaged and aware of their cost sharing responsibilities.

Additionally, online digital assessment and management servicesmay be provided by a physical therapist, occupational therapist, speech language pathologist, or audiologist through September 30, 2025.

Online digital assessment and management services (98970, 98971, 98972) are reported once per seven-day period. The seven-day period begins with the qualified nonphysician health care professional's initial, personal review of the patient-generated inquiry. Online digital E/Ms are time based codes. Qualified nonphysician health care professional's cumulative time service includes review of the initial inquiry, review of patient records or data pertinent to the assessment of the patient's problem, personal qualified nonphysician health care professional interaction with clinical staff focused on the patient's problem, development of management plans, including qualified nonphysician health care professional generation of prescriptions or ordering of tests, and subsequent communication with the patient through online, telephone, email, or other digitally supported communication. All qualified nonphysician health care professionals in the same group practice who are involved in an online digital assessment contribute to the cumulative service time devoted to the patient's online digital assessment. Online digital assessments require permanent documentation storage of the encounter.

- If the patient generates the initial online digital inquiry within sseven days of a previous treatment or E/M service and both services relate to the same problem, or the online digital inquiry occurs within the postoperative period of a previously completed procedure, then the qualified nonphysician health care professional's online digital assessment may not be separately reported.
- If the patient generates an initial online digital inquiry for a new problem within seven days of a previous service that addressed a different problem, then the qualified nonphysician health care professional online digital assessment is reported separately
- If a separately reported evaluation service occurs within seven days of the qualified nonphysician health care professional's initial review of the online digital assessment, codes 98970, 98971 98972 may not be reported.
- If the patient presents with a new, unrelated problem during the seven-day perior of an online digital assessment, then the qualifiedvnonphysician health care professional's time spent assessing the additional problem is added to the cumulative service time of the online digital assessment for that seven-day period.

Reminder: Inherently non-face-to-face services, including online digital E/M services (CPT 99421, 99422, 99423) should not be reported with Place of Service 02 or 10 or any telehealth modifiers. Inherently non-face-to-face services should be reported with the POS code that the provider would typically use to report health care services, for example, a physician's office (POS 11) or hospital outpatient department (POS 19 or 22).

Code	Description
98970	Qualified nonphysician health care professional online digital assessment and management service, for an established patient, 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 assessment and management service, for an established patient, 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 assessment and management service, for an established patient, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

Place of service

This policy applies to services delivered via telehealth in all settings.

Policy history

Origination date:	September 1, 2024
Connection date & details:	July 2024 – Introduced as new policy. April 2025 – Under Billing/coding guidelines, deleted Telephone Services section (CPT odes 99441, 99442, 99443 have been deleted), added a new section for Telemedicine Codes, added new section for Brief Communication Technology-Based Service; under Policy, Eligible Providers, updated to indicate that physical therapists, occupational therapists, speech-language pathologists, and audiologists may furnish telehealth services through September 30, 2025.

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