Interim Telemedicine Payment Policy (COVID-19 Pandemic) – RETIRED (05/11/2023, to Coincide with the End of the Public Health Emergency)

Related Payment Policy Guidelines

- Up-to-date **telemedicine** guidance can be found at: Telemedicine
- Up-to-date **specimen collection** guidance can be found at: Laboratory and Pathology Services
- Up-to-date **vaccine** information can be found at: Preventive Services and Vaccines and Immunizations

Policy

To meet the needs of our network providers and members during the COVID-19 pandemic, this Telemedicine Payment Policy temporarily replaces our existing policy until further notice. This policy outlines how Mass General Brigham Health Plan will reimburse Telemedicine/Telehealth services rendered during the COVID-19 pandemic.

Telemedicine is defined as the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including, but not limited to interactive audio-video technology; remote patient monitoring devices; audio-only telephone; and, 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.

Mass General Brigham Health Plan Reimburses

Mass General Brigham Health Plan complies with MA Chapter 260 of the Acts of 2020. Due to the COVID-19 pandemic Mass General Brigham Health Plan will not impose specific requirements on the type of technology that is used to deliver services (including any limitations on audio-only or live video technologies). This will support the diagnosis and treatment of COVID-19, as well as minimize exposure to members that require clinically appropriate, medically necessary covered services for other conditions during this pandemic. These changes will be in place until further notice. It would not be appropriate to report a telephone only (telehealth) service that requires face-to-face interaction. Services may be reimbursed when all the following conditions are met:

- Services rendered are clinically appropriate, medically necessary covered services.
- The components of any evaluation and management services (E&M) provided via the telemedicine technologies includes at least a problem focused history and straight forward medical decision making, as defined by the current version of the Current Procedural Terminology (CPT) manual.
- Providers performing and billing telemedicine/telehealth services are eligible to independently perform and bill the equivalent face-to-face service.
- The service is conducted and a permanent record of online communications relevant to the ongoing medical care and follow-up of the patient is maintained as part of the patient's medical record.
- Services are filed with the appropriate modifiers and place of service codes.

Mass General Brigham Health Plan Does Not Reimburse:

- Services incidental to an E&M service, counseling, or medical services covered by this policy. Examples include, but are not limited to: Reporting of test results, Provision of educational materials, administrative matters, including but not limited to, scheduling, registration, updates to billing information, reminders, and requests for medication refills or referrals or ordering of diagnostic studies
- A Telemedicine/Telehealth service that occurs the same day as a face-to-face visit when performed by the same provider for the same condition.
- Telemedicine/Telehealth E&M services that are performed on the same day as a surgical procedure, unless it is a significant and separately identifiable service, or it is above and beyond the usual preoperative and postoperative care associated with the procedure.
- Telehealth transmission, per minute.
- A follow-up preventive visit when initial preventive visit has been rendered via telehealth

Member Cost-Sharing

The provider is responsible for verifying the member's coverage, out of pocket expenses (including but, not limited to; copayments, coinsurance and deductible where applicable) and benefit limitations.

COVID-19 Specimen Collection and Labs during the Public Emergency

In an effort to help prevent the spread of the COVID-19, Mass General Brigham Health Plan, in alignment with the DOI and other regulatory guidance, is expanding the scope of allowed specimen

collection and lab services, when clinically appropriate and medically necessary, as ordered by provider.

Note: Pass-through billing is not permitted except during the MA State of Emergency, under the following conditions:

A participating non-lab provider may bill on behalf of a non-participating lab for COVID-19 PCR and antigen testing only. The non-lab provider must append modifier 90 to the line containing the COVID-19 lab test and include the non-participating lab NPI in the referring provider field on the claim.

In alignment with CMS which serves as a basis for Mass General Brigham Health Plan's rate development, beginning January 1, 2021, we will lower the base payment amount for COVID-19 diagnostic tests run on high-throughput technology. Also beginning January 1, 2021, we will make an additional payment to laboratories for a COVID-19 diagnostic test run on high throughput technology if the laboratory:

- Completes the test in two calendar days or less AND
- Completes the majority of their COVID-19 diagnostic tests that use high throughput technology in two calendar days or less for all their patients (not just their Medicare patients) in the previous month

Note: Providers contracted with Mass General Brigham Health Plan to provide care to MGB ACO members, must refer to MassHealth bulletins and transmittals, for guidance and details on billing and reimbursement of specimen collection and COVID-19 lab tests:

State or Federally Supplied COVID-19 Vaccines

Mass General Brigham Health Plan has ensured timely access to critical health care services for our members. As part of that commitment, Mass General Brigham Health Plan will cover the administration of all COVID-19 vaccines that receive emergency use authorization (EUA) or full approval from the Food and Drug Administration (FDA), at no cost to our members.

The vaccine products will be distributed by the Massachusetts Department of Public Health (MDPH) to providers at no cost. The vaccine manufacturers will ship the vaccine products to long-term care facilities also at no cost. Please visit the MDPH vaccine website at www.mass.gov/covidvaccine for more information and the distribution timeline. Vaccine administration is separately reimbursable.

Vaccine Billing Instructions:

- Submit a CPT vaccine/toxoid product code for each administered vaccine/toxoid product on a single claim line, with a count of one.
- Append Modifier SL to each CPT vaccine/toxoid product code in the first modifier field when the vaccine is state or federally supplied. (Mass General Brigham Health Plan uses post payment audit data to confirm compliance with the billing guidelines for state or federally vaccines.)
- Bill the vaccine administration code separately

Provider Billing Guidelines and Documentation

Telemedicine visits must be billed on a CMS 1500 Form, unless UB04 billing for professional services is supported within the provider contract. If the provider contract supports UB04 billing for professional services, the provider must bill the appropriate revenue codes, CPT codes, and applicable modifier(s).

Code Reference Grid

Codes listed below are for reference purposes only. The listing of a service or device code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the Member's Plan of Benefits.

Code	Telephonic & Digital E&M Code Descriptions
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
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

Code	Telephonic & Digital E&M Code Descriptions
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
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
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

Code	Non-Reimbursable Code Description
99072	Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease

Code	Specimen Collection Code Descriptions

G2023	Specimen collection for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source; Code deleted 05/12/2023
G2024	Specimen collection for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) from an individual in a SNF or by a laboratory on behalf of an HHA, any specimen source; Code deleted 05/12/2023
C9803	Hospital outpatient clinic visit specimen collection for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source; Not separately reimbursable beginning 05/12/2023, to coincide with the end of the public health emergency

Modifiers

Modifier	Description
90	Reference (outside laboratory) Laboratory procedures are performed by a party other than the treating or reporting physician
93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system (Effective January 1, 2022)
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunication system
FQ	The service was rendered using audio-only communication technology
FR	The supervising practitioner was present through two-way, audio/video communication technology (Effective January 1, 2022)
G0	Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke
GQ	Via asynchronous telecommunications system
GT	Via interactive audio and video telecommunications system
CR	Catastrophe or disaster related

Diagnoses

Code	Description
U07.1	COVID-19
U09.9	Post COVID-19 condition, unspecified
M35.81	Multisystem inflammatory syndrome
Z01.81	Encounter for preprocedural examinations (*please include 6th character for exam description*)

Code	Description
Z11.52	Encounter for screening for COVID-19
Z20.822	Contact with and (suspected) exposure to COVID-19

Covered diagnosis codes for COVID-19 evaluation and treatment:

- Evaluation for suspected Covid-19:
  - Asymptomatic individuals with actual or suspected exposure to COVID-19 or for symptomatic individuals with actual or suspected exposure to COVID-19 and the infection has been ruled out, or test results are inconclusive or unknown:
    - Facility claims use Z20.822 as the primary diagnosis
    - Professional claims use Z20.822 pointed to the line for the related service

- Confirmed diagnosis for Covid-19:
  - Facility claims use U07.1 as the primary diagnosis
  - Professional claims use U07.1 pointed to the line for the related service

- Multisystem Inflammatory Syndrome for individuals with multisystem inflammatory syndrome (MIS) and COVID-19:
  - Facility claims use U07.1 as the primary diagnosis
  - Professional claims U07.1 and M35.81 pointed to the claim line for the related service

- Multisystem Inflammatory Syndrome due to post Covid-19 condition
  - For facility claims use U09.9 and M35.81 billed together
  - For professional claims use U09.9 and M35.81 pointed to the line claim for the related service

- Patients receiving preoperative evaluations only:
  - ICD-10-CM Coding Guidelines instruct to sequence first a code from subcategory Z01.81 (Encounter for preprocedural examinations)

Updates to Telemedicine Place of Service Codes: Effective 1/1/2022:

POS 02: Telehealth Provided Other than in Patient's Home:
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:

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.

Providers must use Place of Service (POS) 02 or POS 10 when submitting a professional claim for services provided via telehealth and must append the appropriate modifier below to indicate the type of modality. Professional telehealth claims are required to have one of the following modifiers:

- Modifier 95 to indicate services rendered via audio-video telehealth
- Modifier GQ to indicate services rendered via asynchronous telehealth

Providers must include modifier GT when submitting a facility claim for services provided via telehealth.

Related Coding

Vaccine Codes
Monoclonal Antibody Codes
Covid-19 Lab Grid

Related Mass General Brigham Health Plan Payment Guidelines

Laboratory and Pathology
General Coding and Billing
Vaccines and Immunizations Payment Policy
Evaluation and Management Services
Modifiers

Publication History

Topic: COVID-19	Owner: Network Management
March 31, 2020	*Original documentation of policy*
April 27, 2020	*Added preventive E/M codes; clarified in-person reimbursement for MassHealth members*
June 10, 2020	*Added Telemedicine codes; added COVID-19 specimen collection codes; added COVID-19 lab & antibody codes; added UB04 telemedicine billing language*
August 24,2020	*Update for modifier 90 for PCR & Antigen lab test effective July 29th, Added modifier CR and CS*
September 25,2020	*Update with new code 99072*

November 30, 2020	*Update for Cost sharing waiver clarification and remove modifier CR*
January 14, 2021	*Update for COVID-19 vaccine administration and CMS Changes, Medicare Payment to Support Faster COVID-19 Diagnostic Testing*
February 28, 2021	*Added codes Q0245 and M0245*
March 08, 2021	*Added codes 91303 and 0031A*
April 09, 2021	*Added SL modifier*
September 24, 2021	*Added new codes, administrative edits, update to MassHealth Bulletin link. Updated COVID-19 Testing, Treatment, and Vaccine Coding Grid to include the latest antibody treatment codes and administrative codes for the third doses of the Moderna (0013A) and Pfizer (0003A) vaccines.*
March 2, 2022	*Updates to coding grid, modifiers, place of service codes, and administrative edits.*
June 15, 2022	*Updates to COVID-19 coding grid*
July 29, 2022	*Updates to COVID-19 coding grid*
September 20, 2022	*Updates to COVID-19 coding grid*
October 25, 2022	*Updates to COVID-19 coding grid*
December 20, 2022	*Updates to COVID-19 coding grid*
January 1, 2023	*Document rebrand*
May 11, 2023	*Policy retired*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

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