POLICY: PG0142
ORIGINAL EFFECTIVE: 01/01/08
LAST REVIEW: 06/12/18

MEDICAL POLICY:
Telehealth Services

PARAMOUNT
Affiliate of ProMedica

GUIDELINES

This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder contract. Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards. This guideline is solely for explaining correct procedure reporting and does not imply coverage and reimbursement.

DESCRIPTION

Telemedicine and telehealth services are services where the physician or other healthcare professional and the patient are not at the same site. Examples of such services are those that are delivered over the phone, via the Internet or using other communication devices.

MEDICARE

According to Medicare, "Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment."

(When "you" is used in this policy, we are referring to physicians or practitioners at the distant site.)

ORIGINATING SITE

An originating site is the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:

- A rural Health Professional Shortage Area (HPSA) located in a rural census tract; or
- A county outside of a Metropolitan Statistical Area (MSA).

The originating sites authorized by law are:

- The offices of physicians or practitioners
- Hospitals
- Critical Access Hospitals (CAH)
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNFs)
- Community Mental Health Centers (CMHCs)

Note: Independent Renal Dialysis Facilities are not eligible originating sites.

DISTANT SITE

Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to State law) are:

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists (CRNAs)
- Clinical psychologists (CPs) and clinical social workers (CSWs). CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838
- Registered dietitians or nutrition professionals

The current list of telehealth services authorized by CMS includes:

Service	HCPCS/CPT Code
Telehealth consultations, emergency department or initial inpatient	HCPCS codes G0425–G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	HCPCS codes G0406–G0408
Office or other outpatient visits	CPT codes 99201–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	CPT codes 99231–99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	CPT codes 99307–99310
Individual and group kidney disease education services	HCPCS codes G0420 and G0421
Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training	HCPCS codes G0108 and G0109
Individual and group health and behavior assessment and intervention	CPT codes 96150–96154
Individual psychotherapy	CPT codes 90832–90834 and 90836–90838
Telehealth Pharmacologic Management	HCPCS code G0459
Psychiatric diagnostic interview examination	CPT codes 90791 and 90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961
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	CPT code 90963
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	CPT code 90964
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	CPT code 90965
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older	CPT code 90966
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 (effective for services furnished on and after January 1, 2017)	CPT code 90967
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 2-11 years of age (effective for services furnished on and after January 1, 2017)	CPT code 90968
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for	CPT code 90969

patients 12-19 years of age (effective for services furnished on and after January 1, 2017)	
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 (effective for services furnished on and after January 1, 2017)	CPT code 90970
Individual and group medical nutrition therapy	HCPCS code G0270 and CPT codes 97802–97804
Neurobehavioral status examination	CPT code 96116
Smoking cessation services	HCPCS codes G0436 and G0437 and CPT codes 99406 and 99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	HCPCS codes G0396 and G0397
Annual alcohol misuse screening, 15 minutes	HCPCS code G0442
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	HCPCS code G0443
Annual depression screening, 15 minutes	HCPCS code G0444
High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	HCPCS code G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	HCPCS code G0446
Face-to-face behavioral counseling for obesity, 15 minutes	HCPCS code G0447
Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	CPT code 99495
Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	CPT code 99496
Advance Care Planning, 30 minutes (effective for services furnished on and after January 1, 2017)	CPT code 99497
Advance Care Planning, additional 30 minutes (effective for services furnished on and after January 1, 2017)	CPT code 99498
Psychoanalysis	CPT codes 90845
Family psychotherapy (without the patient present)	CPT code 90846
Family psychotherapy (conjoint psychotherapy) (with patient present)	CPT code 90847
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	CPT code 99354
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	CPT code 99355
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)	CPT code 99356
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	CPT code 99357

for prolonged service)	
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit	HCPCS code G0438
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit	HCPCS code G0439
Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth (effective for services furnished on and after January 1, 2017)	HCPCS code G0508
Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth (effective for services furnished on and after January 1, 2017)	HCPCS code G0509
Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making (effective for services furnished on and after January 1, 2018)	HCPCS code G0296
Interactive Complexity Psychiatry Services and Procedures (effective for services furnished on and after January 1, 2018)	CPT Code 90785
Health risk assessment (effective for services furnished on and after January 1, 2018)	CPT Codes 96160 and 96161
Comprehensive assessment of and care planning for patients requiring chronic care management (effective for services furnished on and after January 1, 2018)	HCPCS Code G0506
Psychotherapy for crisis (effective for services furnished on and after January 1, 2018)	CPT Codes 90839 and 90840

For ESRD-related services, a physician, NP, PA, or CNS must furnish at least one “hands on” visit (not telehealth) each month to examine the vascular access site.

OHIO DEPARTMENT OF MEDICAID (ODM)

According to the Ohio Department of Medicaid (ODM), "Telemedicine" is the direct delivery of services to a patient via synchronous, interactive, real-time electronic communication that comprises both audio and video elements. The following activities are not telemedicine:

- The delivery of service by electronic mail, telephone, or facsimile transmission
- Conversations between practitioners regarding the patient without the patient present either physically or via synchronous, interactive, real-time electronic communication
- Audio-video communication related to the delivery of service in an intensive care unit

ORIGINATING SITE

"Originating site" is the physical location of the patient at the time a health care service is provided through the use of telemedicine. The originating site may be:

- The office of a medical doctor, doctor of osteopathic medicine, optometrist, or podiatrist
- A federally qualified health center, as defined in chapter 5160-28 of the Administrative Code, rural health center, or primary care clinic
- An outpatient hospital
- An inpatient hospital
- A nursing facility
- Approved outpatient clinical site

The originating site is responsible for documenting the medical necessity of the health care service provided through the use of telemedicine, for securing the informed consent of the patient, and for developing and maintaining progress notes.

When the originating site is located within a five mile radius from the distant site, providers at the distant or originating site are not eligible for payments related to telemedicine under this rule.

An originating site provider that is neither an inpatient hospital nor a nursing facility may submit a claim for a telemedicine originating fee. If such an originating site provider renders a separately identifiable evaluation and management service to the patient on the same date as the health care service delivered through the use of telemedicine, the provider may submit either a claim for the evaluation and management service or the telemedicine originating fee with the appropriate modifier. No originating site provider may receive both a telemedicine originating fee and payment for an evaluation and management service provided to a patient on the same day.

The payment amount for a health care service delivered through the use of telemedicine, a telemedicine originating fee, or an evaluation and management service is the lesser of the submitted charge or the maximum amount shown in Appendix DD to rule 5160-1-60 of the Administrative Code for the date of service.

DISTANT SITE

"Distant site" is the physical location of the treating practitioner at the time a health care service is provided through the use of telemedicine.

The rendering practitioner at the distant site must be a medical doctor, doctor of osteopathic medicine or licensed psychologist or a federally qualified health center, as defined in Chapter 5160-28 of the Administrative Code. When the rendering provider is a federally qualified health center the rendering practitioner must be a medical doctor, doctor of osteopathic medicine or licensed psychologist.

The distant site is responsible for maintaining documentation of the health care service delivered through the use of telemedicine and for sending progress notes to the originating site for incorporation into the patient's records.

Payment may be made for the following health care services delivered at the distant site:

- Evaluation and management services characterized as "office or other outpatient services"
- Evaluation and management services characterized as either "office or other outpatient consultations" or "inpatient consultations"
- Psychiatry services characterized as "psychiatric diagnostic procedures", "psychotherapy," "pharmacologic management," or "interactive complexity"

The distant site provider may submit a professional claim for the health care service delivered through the use of telemedicine. No institutional (facility) claim may be submitted by the distant site provider for the health care service delivered through the use of telemedicine. All appropriate codes and modifiers must be reported.

POLICY

Telehealth Services do not require prior authorization.

Online Medical Evaluation (98969, 99444) and Interprofessional telephone/Internet assessment and management services (99446-99449) are non-covered.

Telephone Calls

Paramount does not reimburse for telephone charges submitted with CPT codes 98966-98968, 99441-99443 or 99446-99449 with these exceptions:

1. In 2008, it was determined to cover the telephone services for HEDIS mental health initiative only, with co-pay, coinsurance, and deductibles waived.
   - Family Practice, Internal Medicine, Pediatrics and OB/GYN physicians may follow-up per phone call between two and four weeks following initiation of an antidepressant medication for a member 13 years of age or older.
   - This should be reported with procedure codes 99441-99443 and ICD-10-CM codes: F30.8, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.8, F34.9, F39, F43.21, F43.23
   - This reimbursement is limited to twice per calendar year per qualifying member.

2. In August 2012, it was determined to cover telephone services for follow-up care for children prescribed medication for attention deficit disorder with co-pay, coinsurance, and deductibles waived.

- Family Practice, Internal Medicine, Pediatrics, and Behavioral Health physicians may follow-up per phone call during days 31-300 following initiation of a medication for attention deficit disorder. If other office staff makes the follow-up telephone call, documentation must be reviewed and signed by the practitioner.
- This should be reported with procedure codes 99441-99443, 98966-98968 and ICD-10-CM codes: F90.0, F90.1, F90.2, F90.8, F90.9
- This reimbursement is limited to once per calendar year per qualifying member.

Internet Services
Paramount does not reimburse for CPT codes 98969, 99444 (Online Medical Evaluation) or 99446-99449, because these services do not involve direct, in-person patient contact.

HMO, PPO, Individual Marketplace, Advantage
These product lines will follow Ohio Department of Medicaid (ODM) guidelines.

Originating Site:
The following provider types will be eligible as an originating site, either using HCPCS code Q3014 or both GQ and 95 modifiers: Primary Care Clinic, Outpatient Hospital, Rural Health Clinic (Medical), Federally Qualified Health Clinic (Medical), Physician, Professional Medical Group, Podiatrist, and Optometrist.

When the following codes are billed in lieu of a Q3014, both a GQ and 95 modifier must be used to signify a telemedicine originating service was also present during the visit:
99201-99215
99241-99245
99251-99255
92002
92004
92012
92014
Providers will not be eligible for payment as an originating site for a Q3014 along with any of the CPT codes listed above for the same patient, same date of the service.

Providers are only eligible to bill the Q3014 on a professional claim.

Distant Site:
Distant site providers will be eligible for payment when the health care service is rendered by one of the following provider types: Physician, Psychologist, and Federally Qualified Health Center (Medical & Mental Health). Only resident modifiers will be accepted.

Providers billing for services rendered as a distant site will be eligible for payment when both the GT and 95 modifiers are used in conjunction with one of the following CPT codes:
99201-99215
99241-99245
99251-99255
90791-90792
90804-90858
90863

Providers are only eligible to bill as a distant site on a professional claim.

Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs):
When billing as an originating site, FQHCs/RHCs must use a T1015 HCPCS code with a UA modifier. The Q3014 must be included on the claim. FQHCs/RHCs will not be eligible for both services billed using a U1 and UA modifier.

Limitations:
Providers will not be eligible for payment when Q3014 and a CPT code with both GQ and 95 modifiers are submitted for the same patient, same date of service, and same provider.

Providers will not be eligible for payment when Q3014 or a CPT code with a GQ modifier and a CPT code with a GT modifier are submitted for the same patient, same date of service, and same provider.

Place of service ***home*** (POS 12) is not an acceptable place of service for either an originating or a distant site. Inpatient hospital, nursing facility, and inpatient psychiatric hospitals are additional place of service restrictions for an originating site payment. All current place of service restrictions for E&M and Psychiatric codes apply.

Elite
This product line will follow Centers for Medicare and Medicaid Services (CMS) guidelines.

As a condition of payment, you must use an interactive audio and video telecommunications system that permits real-time communication between you, at the distant site, and the beneficiary, at the originating site. Asynchronous "store and forward" technology, the transmission of medical information the physician or practitioner at the distant site reviews at a later time, is permitted only in Federal telemedicine demonstration programs in Alaska or Hawaii.

Medicare pays for a limited number of Part B services furnished by a physician or practitioner to an eligible beneficiary via a telecommunications system. For eligible telehealth services, the use of a telecommunications system substitutes for an in-person encounter.

Billing and Payment for Professional Services Furnished via Telehealth
For Federal telemedicine demonstration programs in Alaska or Hawaii, submit claims using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GQ if you performed telehealth services "via an asynchronous telecommunications system" (for example, 99201 GQ). By coding and billing the GQ modifier, you are certifying that the asynchronous medical file was collected and transmitted to you at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii.

For professional services furnished on or after January 1, 2017, to indicate that the billed service was furnished as a telehealth service from a distant site, submit claims for telehealth services using Place of Service (POS) 02: Telehealth: The location where health services and health related services are provided or received, through telehealth telecommunication technology. As of January 1, 2018, distant site practitioners billing telehealth services under the CAH Optional Payment Method submit institutional claims using the GT modifier.

You should bill the Medicare Administrative Contractor (MAC) for covered telehealth services. Medicare pays you the appropriate amount under the Medicare Physician Fee Schedule (PFS) for telehealth services. When you are located in a CAH and reassigned your billing rights to a CAH that elected the Optional Payment Method, the CAH bills the MAC for telehealth services, and the payment amount is 80 percent of the Medicare PFS for telehealth services.

Billing and Payment for the Originating Site Facility Fee
Originating sites are paid an originating site facility fee for telehealth services as described by HCPCS code Q3014. Bill the MAC for the originating site facility fee, which is a separately billable Part B payment.

Note: When a CMHC serves as an originating site, the originating site facility fee does not count toward the number of services used to determine payment for partial hospitalization services.

CODING/BILLING INFORMATION

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODES	
98966	Telephone E/M 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 seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment). This service involves 5-10 minutes of medical discussion.
98967	Telephone E/M 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 seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment). This service involves 11-20 minutes of medical discussion.
98968	Telephone E/M 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 seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment). This service involves 21-30 minutes of medical discussion.
98969	Online assessment and management service provided by a qualified non-physician health care professional to an established patient or guardian, using the Internet or similar electronic communications network
99441	Telephone E/M provided by a physician 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. This telephone service represents 5-10 minutes of medical discussion.

99442	Telephone E/M provided by a physician 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. This telephone service represents 11-20 minutes of medical discussion
99443	Telephone E/M provided by a physician 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. This telephone service represents 21-30 minutes of medical discussion.
99444	Online evaluation and management service provided by a physician to an established patient, guardian, or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network
99446	Interprofessional telephone/Internet 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 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 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 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
MODIFIERS	
GQ Modifier	Via asynchronous telecommunications systems
GT Modifier	Via interactive audio and video telecommunications systems
UA Modifier	Medicaid level of care 10, as defined by each state
95 Modifier	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system
HCPCS CODES	
Q3014	Telehealth originating site facility fee
T1015	Clinic visit/encounter, all-inclusive
ICD-10-CM CODES	
F30.8	Other manic episodes
F31.0	Bipolar disorder, current episode hypomanic
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features
F31.70	Bipolar disorder, currently in remission, most recent episode unspecified
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
F31.72	Bipolar disorder, in full remission, most recent episode hypomanic
F31.73	Bipolar disorder, in partial remission, most recent episode manic
F31.74	Bipolar disorder, in full remission, most recent episode manic
F31.75	Bipolar disorder, in partial remission, most recent episode depressed
F31.76	Bipolar disorder, in full remission, most recent episode depressed
F31.77	Bipolar disorder, in partial remission, most recent episode mixed
F31.78	Bipolar disorder, in full remission, most recent episode mixed
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission

F32.5	Major depressive disorder, single episode, in full remission
F32.8	Other depressive episodes
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.1	Dysthymic disorder
F34.8	Other persistent mood [affective] disorders
F34.9	Persistent mood [affective] disorder, unspecified
F39	Unspecified mood [affective] disorder
F43.21	Adjustment disorder with depressed mood
F43.23	Adjustment disorder with mixed anxiety and depressed mood
F90.0	Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.2	Attention-deficit hyperactivity disorder, combined type
F90.8	Attention-deficit hyperactivity disorder, other type
F90.9	Attention-deficit hyperactivity disorder, unspecified type

REVISION HISTORY EXPLANATION

11/01/08: No change
10/01/09: Updated per HEDIS
07/01/10: Updated
01/11/11: No change
08/17/12: Per Medical Policy Committee, it was determined to include coverage for diagnoses codes 314.00 and 314.01 to improve quality of care, and be in alignment with HEDIS initiatives.
08/22/12: Updated per HEDIS
02/04/13: Specialist 47 and 81 (neurologist) have been added to the benefit configuration to allow reimbursement coverage for telephone services for follow-up care for children prescribed medication for ADHD.
03/11/14: Changed title of policy from Telephone Evaluation and Management Services (Physician/Non-Physician) to Telehealth Services. Combined policies with PG-0143 Online Physician/Non-Physician Services and PG0197 TeleHealth Services. Added CPT codes 99446-99449, 0188T & 0189T. Changed policy to follow CMS guidelines for telehealth services with HEDIS exceptions for phone calls. ICD-10 Codes added from ICD-9 conversion. Policy reviewed and updated to reflect most current clinical evidence. Approved by Medical Policy Steering Committee as revised.
12/09/14: HMO, PPO, Individual Marketplace, & Advantage will now follow ODM's definition of an originating site per ODM 5160-1-18 Telemedicine dated 10/21/2014. Policy approved by Medical Policy Steering Committee as revised.
03/10/15: Reviewed ODM 5160-1-18 Telemedicine effective 1/2/15 and 2015 Medicare Telehealth Services. Added HCPCS codes Q3014, T1015 and Modifier UA. Removed CPT codes 0188T and 0189T. Added "Approved outpatient clinical site" to Originating Sites for ODM. Policy approved by Medical Policy Steering Committee as revised.
01/12/16: Added effective 01/01/16 codes 90963-90966, 99356, 99357 to the list of telehealth services authorized by CMS. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.
06/14/16: Determined codes G9481-G9490 do not need to be added to this policy per Medical Policy Steering Committee.
01/10/17: Added effective 01/01/17 codes 90967-90970, 99497-99498, G0508-G0509 to the list of telehealth services authorized by CMS. Added effective 01/01/17 telehealth modifier 95. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.
12/12/17: Added effective 01/01/18 codes 90785, 90839, 90840, 96160, 96161, G0296, & G0506 to the list of telehealth services authorized by CMS. Removed ICD-9 codes. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.
06/12/18: Per CMS as of January 1, 2018, the GT modifier is only allowed on institutional claims billed under CAH Method II. CMS eliminated the requirement to use the GT modifier (via interactive audio and video telecommunications systems) on professional claims for telehealth services. Use of the telehealth Place of Service (POS) Code 02 certifies that the service meets the telehealth requirements. Only the Elite product line will follow

these CMS guidelines. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Ohio Department of Medicaid http://jfs.ohio.gov/
American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
American Telemedicine Association, americantelemed.org
Industry Standard Review
Hayes, Inc.