healthfirst
Health Insurance for New Yorkers

Telehealth Services

This document outlines the Healthfirst Telemedicine Reimbursement Policy. The lines of business impacted by this policy includes:

- Child Health Plus
- Commercial Plan
- Essential Plan
- Medicaid
- Medicaid-Health and Recovery Plan
- Medicare Advantage
- Medicaid Advantage Plus (CompleteCare)
- Qualified Health Plan

Please check back regularly for updates.

Telehealth is defined as the use of electronic information and communication technologies to deliver healthcare to patients remotely. Telehealth is designed to improve access to needed services and to improve the health of members. Telehealth is not available solely for the convenience of the practitioner when a face-to-face visit is more appropriate and/or preferred by the member. A list of telehealth codes appears at the end of the document.

The **originating site** is where the member is located at the time healthcare services are delivered to him/her by means of telehealth.

The **distant site** is any secure location within the fifty United States or United States territories where the telehealth provider is located while using telehealth to deliver healthcare services.

Telehealth Applications

Telemedicine uses two-way electronic audio-visual communications to deliver clinical healthcare services to a patient at an originating site by a telehealth provider located at a distant site. The totality of the communication of information exchanged between the physician or other qualified healthcare practitioner and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via face-to-face interaction.

Billing Guidelines for Telehealth Services

Private behavioral health practitioners should follow the general telehealth guidance within this document. OMH and OASAS behavioral health providers should refer to the separate OMH and OASAS specific guidance.

Healthfirst will consider reimbursement for services that can be provided via telehealth and there are no other telehealth codes used for that service. Use of approved codes should be aligned with the corresponding CMS rules/requirements associated with the codes listed in this guidance.

In addition, use of approved codes outlined in this guidance qualify for payment when appended with modifier 95 as well as service recognized by the AMA included with modifier 95:

- Modifier **95**: Synchronous telemedicine service through real-time interactive audio and video telecommunication system. Healthfirst requires modifier 95 for appropriate reimbursement.
- Modifier **25**: Significant, separately identifiable evaluation and management (E&M) service by the same physician or other qualified healthcare professional on the same day as a procedure or other service.
- If telehealth services are billed with POS 02 but without modifier 95, the claim will be denied.

Place of Service (POS) code to use when billing for telehealth:

- POS **02**: The location where health services and health-related services are provided or received through telehealth telecommunication technology.
- If telehealth services are billed with modifier 95 but without POS 02, the claim will be denied.

Telehealth Reimbursement Policy

Healthfirst will reimburse participating providers for covered telehealth services in accordance with the fee schedule applicable to the providers' contract. When billing telehealth services, providers must bill with POS code **02** and continue to bill modifier **95**.

Healthfirst recognizes the CMS-designated originating sites considered eligible for furnishing telehealth services to a patient in an originating site.

Examples of originating sites are:

- The office of a physician or practitioner;
- A hospital (inpatient or outpatient);
- A federally qualified health center (FQHC);
- A skilled nursing facility (SNF); and
- A community mental health center.

Healthfirst recognizes the CMS-designated practitioners eligible to be reimbursed for telehealth services.

Examples of practitioners are:

- Physician
- Nurse practitioner
- Clinical psychologist
- Clinical social worker

Application of Specific Telehealth Billing Rules

When both the originating site and the distant site are part of the same provider billing entity, there will only be one clinic payment. In these cases, only the originating site should bill for the telemedicine encounter.

Fee-for-Service Billing for Telemedicine by Site and Location

If services are provided through telemedicine to a member located in one of the following originating sites, the provider should bill for the telemedicine encounter as if the provider saw the member face to face in the office or Article 28 clinic setting using the appropriate billing rules.

Article 28 Clinic Originating Sites Billing Under Ambulatory Patient Groups (APG)

1. Institutional Component (Originating Site)

   a. When services are provided via telemedicine to a member located at an Article 28 originating site (outpatient department/clinic, emergency room), the originating site may bill only CPT code Q3014 (telehealth originating-site facility fee) through APGs to recoup administrative expenses associated with the telemedicine encounter.

   b. When a separate and distinct medical service, unrelated to the telemedicine encounter, is provided by a qualified practitioner at the originating site, the originating site may bill for the medical service provided in addition to Q3014. The CPT code billed for the separate and distinct service must be appended with modifier 25.

2. Practitioner (Professional) Component (Originating Site)

   a. When the originating site is an Article 28 hospital (outpatient department/clinic, emergency room) and a physician is onsite assisting or attending to the member during a telemedicine encounter, a physician claim cannot be billed. It is included in the facility reimbursement.

   b. When a separate and distinct medical service, unrelated to the reason for the telemedicine encounter, is provided by a physician at the originating site, the physician may bill for the medical service provided. The CPT code billed for the separate and distinct service must be appended with modifier 25. The professional component for all practitioner types, other than physicians, is included in the APG payment to the originating-site facility.

   c. When the originating site is an Article 28 free-standing diagnostic and treatment center (DTC), the professional component for all practitioners, including physicians, is included in the APG payment to the facility.

Article 28 Distant Sites Billing Under APGs

1. Institutional Component (Distant Site)

   a. When the distant-site practitioner is physically located at the Article 28 distant site, the distant site may bill Medicaid under APGs for the telemedicine encounter using the appropriate CPT code for the service provided. The CPT code must be appended with the applicable modifier (95).

   b. When the distant-site practitioner is not physically located onsite at the Article 28 facility, the distant site cannot submit an APG claim. It is included in the facility reimbursement.

2. Practitioner (Professional) Component (Distant Site)

   a. When the distant site is an Article 28 hospital outpatient department/clinic and telemedicine services are being provided by a physician, the professional component for all practitioner types is included in the APG payment to the distant-site facility.

   b. When the distant site is an Article 28 free-standing DTC, the professional component for all practitioners, including physicians, is included in the APG payment to the facility.

Office Setting or Other Secure Location – Billing by Originating and/or Distant-Site Practitioner

1. Practitioner (Professional) Component (Originating Site)

    a. When a telemedicine service is being provided by a distant-site practitioner to a member located in a private practitioner's office (originating site), the originating-site practitioner may bill CPT code Q3014 to recoup administrative expenses associated with the telemedicine encounter.

    b. When a telemedicine service is being provided by a distant-site practitioner to a member located in a private practitioner's office (originating site) and the originating-site practitioner provides a separate and distinct medical service unrelated to the telemedicine encounter, the originating-site practitioner may bill for the medical service provided in addition to Q3014. The CPT code billed for the separate and distinct medical service must be appended with modifier 25.

2. Practitioner (Professional) Component (Distant Site)

    a. If the distant-site practitioner is providing services via telemedicine from his/her private office or other secure location, the practitioner should bill the appropriate CPT code for the service provided. The CPT code should be appended with the applicable modifier (95).

Hospital Inpatient

When a telemedicine consultation is being provided by a distant-site physician to a member who is an inpatient in the hospital, payment for the telemedicine encounter may be billed by the distant-site physician. Other than physician services, all other practitioner services are included in the APR-DRG payment to the facility.

Skilled Nursing Facility

When the telehealth practitioner's services are included in the nursing home's rate, the telehealth practitioner must bill the nursing home. If the telehealth practitioner's services are not included in the nursing home's rate, the telehealth practitioner should bill Medicaid as if he/she saw the member face to face. The CPT code billed should be appended with the applicable modifier (95). Practitioners providing services via telehealth should confirm with the nursing facility whether their services are in the nursing home rate.

Federally Qualified Health Centers (FQHC)

1. FQHCs That Have "Opted Into" APGs: FQHCs that have "opted into" APGs should follow the billing guidance outlined above for sites billing under APGs.
2. FQHCs That Have Not "Opted Into" APGs - FQHC Originating Sites:

    a. When services are provided via telemedicine to a patient located at an FQHC originating site, the originating site may bill only the FQHC offsite services rate code (4012) to recoup administrative expenses associated with the telemedicine encounter.

    b. When a separate and distinct medical service, unrelated to the telemedicine encounter, is provided by a qualified practitioner at the FQHC originating site, the originating site may bill the Prospective Payment System (PPS) rate in addition to the FQHC offsite services rate code (4012).

    c. If a provider who is onsite at an FQHC is providing services via telemedicine to a member who is in their place of residence or other temporary location, the FQHC should bill the FQHC offsite services rate code (4012) and report the applicable modifier (95) on the procedure code line.

    d. If the FQHC is providing services as a distant-site provider, the FQHC may bill their PPS rate.

List of all Telehealth Codes

G Codes (G2010, G2012) are not Healthfirst-covered telehealth services. These codes will NOT be reimbursed. CPT Codes 99441, 99442, and 99443 should NOT be used in conjunction with modifier "95" or "GT".

SERVICE CODE	DESCRIPTION	RISK ADJUSTMENT ELIGIBLE
90785	Interactive complexity (List separately in addition to the code for primary procedure)	NO
90791	Psychiatric diagnostic evaluation	YES
90792	Psychiatric diagnostic evaluation with medical services	YES
90832	Psychotherapy, 30 minutes with patient	YES
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	YES
90834	Psychotherapy, 45 minutes with patient	YES
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	YES
90837	Psychotherapy, 60 minutes with patient	YES
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	YES
90839	Psychotherapy for crisis; first 60 minutes	YES
90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)	YES
90845	Psychoanalysis	YES
90846	Family psychotherapy (without the patient present), 50 minutes	YES
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	YES

SERVICE CODE	DESCRIPTION	RISK ADJUSTMENT ELIGIBLE
90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified healthcare professional per month	YES
90952	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2–3 face-to-face visits by a physician or other qualified healthcare professional per month	YES
90954	End-stage renal disease (ESRD) related services monthly, for patients 2–11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified healthcare professional per month	YES
90955	End-stage renal disease (ESRD) related services monthly, for patients 2–11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2–3 face-to-face visits by a physician or other qualified healthcare professional per month	YES
90957	End-stage renal disease (ESRD) related services monthly, for patients 12–19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified healthcare professional per month	YES
90958	End-stage renal disease (ESRD) related services monthly, for patients 12–19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2–3 face-to-face visits by a physician or other qualified healthcare professional per month	YES

SERVICE CODE	DESCRIPTION	RISK ADJUSTMENT ELIGIBLE
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 healthcare professional per month	YES
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 healthcare professional per month	YES
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	YES
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	YES
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	YES
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older	YES
90967	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age	YES
90968	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2–11 years of age	YES
90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12–19 years of age	YES
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	YES

SERVICE CODE	DESCRIPTION	RISK ADJUSTMENT ELIGIBLE
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified healthcare professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	YES
96150	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment	YES
96151	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment	YES
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual	YES
96153	Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)	YES
96154	Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)	YES
96160	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument	YES
96161	Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument	YES
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	YES
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	YES
97804	Medical nutrition therapy; group (2 or more individuals, each 30 minutes	YES

SERVICE CODE	DESCRIPTION	RISK ADJUSTMENT ELIGIBLE
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a problem-focused history; a problem-focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	YES
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	YES
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	YES
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	YES

SERVICE CODE	DESCRIPTION	RISK ADJUSTMENT ELIGIBLE
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	YES
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 healthcare professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	YES
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem-focused history; a problem-focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	YES
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	YES

SERVICE CODE	DESCRIPTION	RISK ADJUSTMENT ELIGIBLE
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	YES
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	YES
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem-focused interval history; a problem-focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	YES
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem-focused interval history; an expanded problem-focused examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.	YES

SERVICE CODE	DESCRIPTION	RISK ADJUSTMENT ELIGIBLE
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	YES
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem-focused interval history; a problem-focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.	YES
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem-focused interval history; an expanded problem-focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.	YES

SERVICE CODE	DESCRIPTION	RISK ADJUSTMENT ELIGIBLE
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.	YES
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.	YES
99354	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)	YES
99355	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)	YES
99356	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)	YES

SERVICE CODE	DESCRIPTION	RISK ADJUSTMENT ELIGIBLE
99357	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)	YES
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	YES
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	YES
99441	Telephone evaluation and management service by a physician or other qualified healthcare 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	NO
99442	Telephone evaluation and management service by a physician or other qualified healthcare 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	NO
99443	Telephone evaluation and management service by a physician or other qualified healthcare 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	NO
99495	Transitional Care Management Services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; medical decision making of at least moderate complexity during the service period; face-to-face visit within 14 calendar days of discharge	YES

SERVICE CODE	DESCRIPTION	RISK ADJUSTMENT ELIGIBLE
99496	Transitional Care Management Services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; medical decision making of high complexity during the service period; face-to-face visit within 7 calendar days of discharge	YES
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 healthcare professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	YES
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 healthcare professional; each additional 30 minutes (List separately in addition to code for primary procedure)	YES
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	YES
G0109	Diabetes outpatient self-management training services, group session (two or more), per 30 minutes	YES
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes	YES
G0296	Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making)	YES
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes	YES
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes	YES

SERVICE CODE	DESCRIPTION	RISK ADJUSTMENT ELIGIBLE
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth	YES
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth	YES
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth	YES
G0420	Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per 1 hour	YES
G0421	Face-to-face educational services related to the care of chronic kidney disease; group, per session, per 1 hour	YES
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth	YES
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth	YES
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth	YES
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit	YES
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit	YES
G0442	Annual alcohol misuse screening, 15 minutes	YES
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	YES
G0444	Annual depression screening, 15 minutes	YES
G0445	Semiannual high-intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training and guidance on how to change sexual behavior	YES

SERVICE CODE	DESCRIPTION	RISK ADJUSTMENT ELIGIBLE
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	YES
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	YES
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	YES
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)	YES
G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth	YES
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	YES
G0513	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)	YES
G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service)	YES
Q3014	Telehealth originating site facility fee (NOT SEPARATELY REIMBURSED BY HEALTHFIRST)	NO
T1014	Telehealth transmission, per minute, professional services bill separately. T1014 is included in other teleheatlh services and is considered a bundled service. Separate payment for this code will not be made. (NOT SEPARATELY REIMBURSED BY HEALTHFIRST)	NO