Clinical Practice Guideline: **Telehealth, Digital, and Phone-based Evaluation/Assessment and Management Services**

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Effective Date: **December 18, 2025**

Product: **Specialty**

Related Policies:
CPG 135: Physical Therapy Medical Policy/Guideline
CPG 155: Occupational Therapy Medical Policy/Guideline
CPG 166: Speech-Language Pathology/Speech Therapy Guideline
CPG 264: Acupuncture Services Medical Policy/Guideline
CPG 278: Chiropractic Services Medical Policy/Guideline

GUIDELINES

American Specialty Health – Specialty (ASH) considers telehealth services as medically necessary when medical necessity criteria are met per ASH clinical criteria for corresponding service(s) **and** when telehealth service(s) is/are carried out in compliance with state and federal regulatory requirements governing the operational and clinical scope of the service(s) **and** if the condition and members health status is appropriate for delivery of services in the telehealth environment.

Telehealth Services

Telehealth services (technologies between a practitioner in one location and a member in another location), may be reimbursed when **all of the following** conditions are met:

- Medical information is communicated in real-time with the use of HIPAA compliant synchronous audio-video communications equipment or other means approved by state and/or federal regulators. Synchronous audio-only services (i.e., telephone calls) are not considered telehealth services within the context of this policy, except as described in the *Telephone-based Evaluation and Management Services: Physician and Other Qualified Health Care Professionals* and *Telephone-based Assessment and Management Services: Qualified Nonphysician Health Care Professionals* sections below or as required by health plan clients.
- The real-time communication is between the member and the practitioner who is performing the service.
- The originating site (member location) and the distant site are reported in the medical record. The originating site is considered the place of service situs.
- All services provided are medically appropriate and necessary.

- The encounter satisfies the elements of the patient-practitioner relationship, as determined by the relevant healthcare regulatory board of the state where the member is physically located.
- The service is conducted in a manner that meets current state and federal privacy and security regulations and compliance expectations; and a permanent record of online communications relevant to the ongoing medical care and follow-up of the member is maintained as part of the member's medical record.

Covered Telehealth Services

Covered services (services that are eligible for reimbursement) may be limited by state and/or federal regulations and by health plan guidelines and benefit coverage policies. Refer to the applicable client summary for covered services, appropriate Current Procedural Terminology (CPT®) code usage, and the use of place-of-service codes and telehealth modifiers. The use of these place-of-service and telehealth modifier codes may vary by health plan due to health plan internal claims system configuration and/or health plan benefit design. Coding instructions may differ by health plan and may be altered during national or local disasters, during public health emergencies or during other identified events.

Incomplete healthcare services, such as when the service is not fully rendered due to technical interruptions or other service interruptions result in the partial delivery of care are not considered covered services.

Description/Background

The ASH management of telehealth services provided by ASH practitioners is designed to promote improved access to care by enabling flexible access to services for members and enable greater focus on self-directed care. Members will be able to receive telehealth services from an originating site – either their own home or other remote location - by connecting via an interactive telecommunications system with an ASH contracted/credentialed practitioner located at a distant site.

Licensure Guidelines for Appropriate Use of Telehealth Services

A healthcare practitioner must be licensed by, or otherwise under the jurisdiction of, the appropriate licensing board in the state where the telehealth session originates. The delivery of healthcare occurs where the member is located at the time telehealth services are accessed. Practitioners who treat using telehealth technologies are practicing healthcare and must possess appropriate licensure in the jurisdictions where a member is located and receives care unless compliance with licensure requirements has been explicitly waived for that jurisdiction, type of insurance coverage, and/or patient condition by federal or state regulators in response to national or local disasters, public health emergencies or other situations wherein the ability to access timely telehealth services needs to be enhanced or intensified.

Telehealth Services Delivery

Practitioners who participate in the delivery of telehealth services are expected to deliver services that meet the same quality and standards of practice as those who deliver face-to-face services. Practitioners are expected to be aware of and adhere to all relevant federal, state, and local regulations and guidelines and to provide only services within the accepted scope of practice.

Informed Consent

Prior to the delivery of telehealth services, the practitioner at the distant site, must verbally inform the member of the services that may be performed and obtain verbal consent from the member to receive those services. The verbal consent must be documented in the member's medical record and include the member's opportunity to ask questions about the visit/encounter. The consent obtained prior to treatment is consistent with the consent process for onsite care.

Consent must meet all federal and state laws and regulations and any applicable state board requirements in the state in which the member is physically located.

Practitioner-Patient Relationship

The practitioner-patient relationship is fundamental to the provision of acceptable health care. It is ASH's expectation that practitioners recognize the obligations, responsibilities, and member rights associated with establishing and maintaining a practitioner-patient relationship. The practitioner-patient relationship is typically considered to have been established when the practitioner identifies themselves as a licensed clinician, agrees to undertake diagnosis and/or treatment of the member, and the member agrees to be treated, whether or not there has been an encounter in person between the practitioner and member. However, the elements of establishing a patient-practitioner relationship are determined by the relevant healthcare regulatory board of the state where the member is physically located.

The practitioner should interact with the member in a culturally competent way and in the language familiar to that member. If the member cannot understand the practitioner because of a language barrier, ASH may provide language assistance, and if a language assistance line is not acceptable for the encounter(s), then telehealth services should not be rendered, and the patient should be referred to an in-clinic practitioner. It is up to the practitioner to use professional judgment to determine when the delivery of telehealth services is appropriate for the member case, and when it is not.

Evaluation and Treatment of the Member

A documented clinical evaluation (examination) and collection of relevant clinical history commensurate with the presentation of the member is required to establish a diagnosis(es) and identify underlying conditions and/or contra-indications to the treatment

recommended/provided. A relevant history and evaluation must be obtained prior to providing treatment. Treatment and consultation recommendations made in a telehealth setting will be held to the same standards of appropriate practice as those in traditional in-person settings. Following the initial telehealth visit the practitioner will determine whether ongoing telehealth services are warranted.

Telehealth Services Delivered Through a Synchronous Audio-Visual Platform

Delivering quality services through a synchronous audio-visual telehealth platform requires the development of additional skills and practices to provide an effective telehealth care experience. See the client summary for instructions on coding based on practitioner type utilizing this healthcare service platform. The following are the minimum expectations for the telehealth environment in which the practitioner is engaging the member via synchronous audio and visual technologies:

Device should be placed in a manner that allows both the practitioner and the patient the ability to communicate both verbally and visually. This includes:

- Being able to see the participant's face and facial expressions.
- Being able to observe body movements and functional activities for both evaluation and training purposes.
- The background behind the practitioner should be professional and not have distractions in the field of view, or background noise.

Additional tips and suggestions are provided in the ASH Provider Operations Manual.

Medicare Advantage Telehealth Services

Under the various Medicare Advantage (MA) plans (Part C Medicare) managed by ASH, health plans may elect to provide expanded coverage that includes selected telehealth services provided by ASH contracted practitioners. These services must be within the practitioner's state scope of practice, the services must be able to be performed via telehealth and must be based on the member's applicable Medicare Advantage benefit. When such coverage is available, ASH notifies practitioners through the applicable client summary. For example: when a chiropractic Medicare Advantage benefit is limited to only the core Medicare benefit (i.e., chiropractic spinal manipulation for spinal subluxations), telehealth services would not be available as spinal manipulation cannot be performed remotely. However, when a Medicare Advantage plan includes evaluation and management services or physical medicine and rehabilitation services within a benefit, chiropractors (or other healthcare provider types) may provide those services via telehealth (and only covered as explicitly defined by the Medicare Advantage benefit plan.) Some of the services that may be amenable to telehealth and covered under a Medicare Advantage benefit plan include but are not limited to:

- Evaluation and Management Services (99202-99205, 99211-99215)
- Physical and Occupational Therapy Evaluations (97161-97168)

- Speech Therapy Evaluations (92521-92524)
- Physical Medicine Therapeutic Procedures (97110, 97112, 97116, 97150, 97530, 97535, 97542)
- Speech Therapy (92507)
- Tests and Measurements (97750, 97755)
- Orthotic and Prosthetic Management/Training (97760, 97761)
- Developmental and Behavioral Screening/Testing (96110, 96112, 96113, 96127)
- Prolonged Services (99417)
- Brief Technology-Based Communication (e.g., Virtual Check-In) (98016)

Practitioners should verify through the member's specific client summary for any telehealth services available to the member and verify any guidance outlining the use of Place of Service codes and the health plan's required use of service modifiers (e.g., -GT, -GQ, -95).

Audio-only Evaluation and Management Services: Physician and Other Qualified Health Care Professionals

Synchronous audio-only Evaluation and Management (E/M) codes are used to report episodes of non-face-to-face services by a physician or other qualified health care professional when initiated by the patient or guardian. If the audio-only service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the pre-service work of the subsequent E/M service, procedure, and visit. If the synchronous audio-only refers to an E/M service performed and reported by the qualified health care professional within the previous 7 days (either physician/other qualified health care professional requested or unsolicited patient follow-up) or within the postoperative period of the procedure that was previously performed, then the services are considered part of the previous E/M service or procedure.

Synchronous audio-only E/M codes are time based, it is essential to document the date and length of the telephone call, in addition to other pertinent information, in the medical record.

Audio-Only – New Patient CPT® Code Description
Synchronous audio-only visit for the E/M of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion [codes 98008 – 98011] 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; by time

CPT® Code	Applicable time
98008	When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98009	When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98010	When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98011	When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. (For services 75 minutes or longer, use prolonged services code 99417)
Audio-Only – Established Patient CPT® Code Description	
Synchronous audio-only visit for the E/M of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion [codes 98012 – 98015] 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; by time	
CPT® Code	**Applicable time**
98012	When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.
98013	When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98014	When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98015	When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded. (For services 55 minutes or longer, use prolonged services code 99417)

Telephone-based Assessment and Management Services: Nonphysician Qualified Health Care Professionals

Telephone services are non-face-to-face assessment and management services provided by a nonphysician qualified health care professional to a patient using the telephone. These codes are used to report episodes of care by the qualified health care professional initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or the next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent assessment and management service, procedure, and visit. Likewise, if the telephone call refers to a service performed and reported by the

qualified health care professional within the previous seven days (either qualified health care professional requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of the previous service or procedure. (Do not report 98966-98968 if these codes have been reported and performed in the previous seven days.)

CPT® Code	CPT® Code Description
98966	Telephone assessment and management service provided by a nonphysician qualified 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 nonphysician qualified 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 nonphysician qualified 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 (E/M) Services

These are not considered telehealth services; do not use POS 02 and modifier 95. They are not on CMS's list of covered telehealth services, and do not use real-time, interactive audio-visual communication.

E-VISITS: In all types of locations including the patient's home, and in all areas (not just rural), established Medicare patients may have non-face-to-face patient-initiated communications with their doctors without going to the doctor's office by using online patient portals. These services can only be reported when the billing practice has an established relationship with the patient. For these E-Visits, the patient must generate the initial inquiry, and communications can occur over a 7-day period. The services may be

billed using CPT® codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. The patient must verbally consent to receive virtual check-in services. Medicare and deductible would apply to these services.

Medicare Part B also pays for E-visits or patient-initiated online evaluation and management conducted via a patient portal. Practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) can bill the following codes:

CPT® Code	CPT® 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

Clinicians who may not independently bill for evaluation and management visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these e-visits and bill the following codes:

CPT® Code	CPT® Code Description
98970	Nonphysician qualified 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. Replaced HCPCS code G2061.
98971	Nonphysician qualified 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. Replaced HCPCS code G2062.
98972	Nonphysician qualified 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. Replaced HCPCS code G2063.

The following are important points of consideration.

- These services can only be reported when the billing practice has an established relationship with the patient.
- This is not limited to only rural settings. There are no geographic or location restrictions for these visits.
- Patients communicate with their doctors without going to the doctor's office by using online patient portals.
- Individual services need to be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation.

The services may be billed using codes 99421-99423 and 98970-98973, as applicable. Medicare coinsurance and deductible would generally apply to these services.

Referrals for Emergency Services

An emergency plan is required and must be provided by the practitioner to the member when the care provided using telehealth technologies indicates that a referral to an acute care facility or emergency room for medical or mental health intervention is necessary for the safety of the member. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telehealth encounters.

Medical Records

The medical record established during the use of telehealth services must be accessible and documented for both the practitioner and the member, consistent with all established federal and state laws and regulations governing member medical records; as well as standards for medical documentation established by ASH.

Practitioners engaging in telehealth services must comply with all laws, rules and regulations governing the maintenance of member records, including member confidentiality requirements and duration of retention, regardless of the state where the records of any member within this state are maintained. Informed consents obtained in connection with an encounter involving telehealth services should also be filed in the medical record. Patients may request and practitioners must supply copies of medical records related to telehealth services according to state and federal medical documentation regulations.

Privacy and Security of Member Records and Exchange of Information

Practitioners should meet or exceed applicable federal and state legal requirements of health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and healthcare record retention rules. Sufficient privacy and security measures must be in place and documented to ensure confidentiality and integrity of member-identifiable information. Transmissions, including member e-mail, prescriptions, and laboratory results must be secure within existing technology (i.e., password protected, encrypted electronic

prescriptions, or other reliable authentication techniques) unless such compliance with such privacy and security measures has been waived by federal or state regulators in response to national or local disasters, public health emergencies or other situations wherein the ability to access timely telehealth services needs to be enhanced or intensified.

Telehealth Services Technology and Equipment

The synchronous audio-video systems used must, at a minimum, have the capability of meeting the procedural definition of the CPT® codes provided through the telehealth encounter. The communication equipment must be of a quality to adequately complete all necessary components to document the level of service for the code billed.

The technology and equipment utilized in the delivery of telehealth services must comply with all relevant safety laws, rules, regulations, and codes for technology and technical safety for devices that interact with members or are integral to diagnostic capabilities.

Healthcare Ethics and Integrity

The following basic principles make up the code of ethical conduct for the practice of telehealth services.

Practitioners will:

- Obtain informed consent from the member as required by law
- Protect the public and the profession by reporting any conduct that they consider unethical, illegal, or incompetent
- Respect the rights, responsibilities, welfare, and dignity of all members
- Provide care based on medical necessity of the member
- Be committed to providing competent care consistent with both the requirements and limitations of their profession.
- Refer patients to other facility locations or providers if telehealth services may not be appropriate or adequate for the patient's health care needs.
- Comply with the laws and regulations governing the practice of their healthcare profession and telehealth services

Practitioners will not:

- Engage in practices that may pose a conflict of interest
- Engage in conduct that constitutes harassment, verbal or physical abuse, or unlawful discrimination
- Practice while impaired such that the practitioner cannot practice with reasonable skill
- Misrepresent in any manner, either directly or indirectly, their skills, training, professional credentials, title, identity, or services

Confidentiality

All federal and state laws regarding the confidentiality of health care information and a member's rights to his or her medical information are applicable to telehealth services in the same manner as in-person services.

Non-Discrimination

ASH does not discriminate against a member, provider, or practitioner for any reason and does not support any discrimination against members for any reason, including but not limited to age, sex, gender identification, transgender person, marital status, religion, ethnic background, national origin, ancestry, race, color, sexual orientation, patient type (e.g., Medicaid), mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, source of payment, geographic location within the service area or based on political affiliation. ASH renders credentialing, clinical performance, and medical necessity decisions in the same manner, in accordance with the same standards, and within the same time availability to all members, providers, practitioners, and applicants.

Practitioner Scope and Training

Practitioners should practice only in the areas in which they are competent based on their education, training, and experience using telehealth services to deliver services within their scope of practice. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a member only if they are trained, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the member to the more expert practitioner.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a member's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is prudent for the practitioner to refer the member for appropriate co-management (e.g., to their

primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate.

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