Telemedicine and telehealth services are covered when Medicare coverage criteria are met.

COVID-19 Public Health Emergency Waivers and Flexibilities: In response to the COVID-19 Public Health Emergency, CMS has updated some guidance for certain telehealth/telemedicine services. The Secretary of Health and Human Services declared on January 31, 2020 to allow beneficiaries in all areas of the country to receive telehealth services, including at their home. Under the waiver, limitations on where Medicare patients are eligible for telehealth will be removed during the emergency. In particular, patients outside of rural areas, and patients in their homes will be eligible for telehealth services, effective for services starting March 6, 2020. This waiver will end 151 days after the conclusion of the PHE.

For details, refer to the following Coronavirus Waivers/Flexibilities:
- [COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers](https://www.chsaonline.org) (Updated 10/13/2022)
- [Medicare Telehealth Frequently Asked Questions (PDF)](https://www.cms.gov) (now included in all-inclusive FAQs) (Updated 01/07/2021)
- [Long-Term Care Nursing Homes Telehealth and Telemedicine Toolkit (PDF)](https://www.cms.gov) (Dated 03/27/2020)
- [End-Stage Renal Disease (ESRD) Provider Telehealth and Telemedicine Toolkit (PDF)](https://www.cms.gov) (Dated 03/20/2020)
- [HHS Telehealth Guidance and Information](https://www.cdc.gov)

Note: When deciding coverage for this service, the member specific document must be referenced. Coverage must comply with all applicable network and benefit limitations.

Telemedicine/telehealth services including consultation, office visits, individual psychotherapy and pharmacologic management delivered via a telecommunications system are covered when the following criteria are met:

- Member requires services that telecommunication system can be substituted for a face to face “hands on” encounter for services within the Medicare scope of coverage
  - The use of a telecommunications system may substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other physician fee schedule (PFS) services. The various services and corresponding current procedure terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes are listed on the CMS website at [List of Telehealth Services for Calendar Year 2023 (ZIP)](https://www.cms.gov) - Updated 11/01/2022. (Accessed January 17, 2023)

Note: Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer recognizes office/outpatient or inpatient consultation CPT codes for payment of office/outpatient or inpatient visits. Instead, physicians and practitioners are instructed to bill a new or established patient office/outpatient visit CPT code or appropriate hospital or nursing facility care code, as appropriate to the...
Members are eligible for telehealth services only if they are presented from an originating site located in either a rural health professional shortage area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA) set by the Health Resources and Services Administration (HRSA).

Notes:

- For telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke (acute stroke telehealth services), as determined by the secretary. Specifically, section 1834(m)(6)(A) of the Act removes the restrictions on the geographic locations and the types of originating sites where acute stroke telehealth services can be furnished. Section 1834(m)(6)(B) of the Act specifies that acute stroke telehealth services can be furnished in any hospital, critical access hospital, mobile stroke units or any other site determined appropriate by the Secretary, in addition to the current eligible telehealth originating sites. For additional information refer to the Medicare Claims Processing Manual, Chapter 12, § 190.3.7 – Payment for Telehealth for Individuals with Acute Stroke.

- Effective January 1, 2014, rural HPSAs include HPSAs located outside of a county outside of an MSA as well as those located in rural census tracts as determined by the Office of Rural Health Policy. Also, effective January 1, 2014, geographic eligibility for an originating site is established for each calendar year based upon the status of the area as of December 31st of the prior calendar year. For specific requirements, refer to the Medicare Claims Processing Manual, Chapter 12, § 190.2.

- For HPSA shortage statistics as of December 31, 2019, refer to the HRSA website at: https://data.hrsa.gov/data/download?data=SHORT#SHORT. (Accessed January 17, 2023)

Telemedicine/telehealth services using non-interactive telecommunications systems that do not permit real-time communication between the member and distant site provider are not covered.

Medicare practitioners who may bill for a covered telehealth service are listed below (subject to state law):

- Physician
- Nurse practitioner
- Physician assistant
- Nurse midwife
- Clinical nurse specialist
- Clinical psychologist*
- Clinical social worker*
- Registered dietitian or nutrition professional
- Certified registered nurse anesthetist

*Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare.

Refer to the Medicare Claims Processing Manual, Chapter 12, § 190-190.7. (Accessed January 17, 2023)

Policy History/Revision Information

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<th>Summary of Changes</th>
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<tr>
<td>02/01/2023</td>
<td><strong>Coverage Guidelines</strong></td>
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<tr>
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<td>- Revised language pertaining to COVID-19 Public Health Emergency (PHE) Waivers and</td>
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Summary of Changes

- In particular, patients outside of rural areas, and patients in their homes will be eligible for telehealth services, effective for services starting Mar. 6, 2020
- This waiver will end 151 days after the conclusion of the PHE
- Updated list of applicable Coronavirus Waivers/Flexibilities:
  - Added reference link to:
    - COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers
    - Medicare Telehealth Frequently Asked Questions
    - Long-Term Care Nursing Homes Telehealth and Telemedicine Toolkit
    - End-Stage Renal Disease (ESRD) Provider Telehealth and Telemedicine Toolkit
    - HHS Telehealth Guidance & Information
  - Removed reference link to:
    - Medicare Telemedicine Healthcare Provider Fact Sheet
    - Centers for Medicare & Medicaid Services (CMS) Comprehensive List of Coronavirus Waivers & Flexibilities

Supporting Information
- Archived previous policy version MCS092.02

Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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