

**Applies to:****Commercial Products**

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Plan Commercial products

**Public Plans Products**

- Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
- Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
- Tufts Health RITogether – A Rhode Island Medicaid Plan
- Tufts Health One Care – A dual-eligible product

**Senior Products**

- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
- Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

The following payment policy applies to Tufts Health Plan contracting providers who render telehealth services.

**Note:** Audit and disclaimer information is located at the end of this document.

---

**Policy**

Tufts Health Plan covers medically necessary telehealth and/or telemedicine services consistent with applicable state mandates and in accordance with the member's benefit plan document. Services covered under telehealth should be clinically appropriate and not require in-person assessment and/or treatment. Tufts Health Plan defers to the provider to make this determination.

All Tufts Health Plan contracting providers, including specialists and urgent care facilities, may provide telehealth/telemedicine services to members for medical, behavioral health, ancillary health, and home health care visits (i.e., skilled nursing, PT, OT, and ST) for new and existing patients. For more information on provider telehealth responsibilities, refer to the *Telehealth Responsibilities* section of the Providers chapter in the Provider Manuals for [Commercial](#) and [Tufts Health Public Plans](#).

**Documentation Requirements**

Documentation requirements for telehealth/telemedicine services are the same as those required for any face-to-face encounter, with the addition of the following:

- A statement that the service was provided using telehealth/telemedicine consult;
- The location of the patient;
- The location of the provider; and
- The names of all persons participating in the telehealth/telemedicine service or telephone consultation service and their role in the encounter.

**Note:** Providers do not need to use the Teladoc platform to provide services to members. Teladoc is an additional benefit available to some Commercial members that is outside the scope of this payment policy.

---

**General Benefit Information**

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics, including cost share, should be verified prior to initiating services by logging on to the secure Provider [portal](#) or by contacting [Provider Services](#).

---

**Referral/Prior Authorization/Notification Requirements**

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider

responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the [Referral, Prior Authorization, and Notification Policy](#).

The same referral requirements apply for telehealth/telemedicine services for Commercial and Tufts Health Direct products as for in-person visits. Referral requirements continue to be waived for Senior Products, Tufts Health Together, and Tufts Health One Care.

All plans requiring a referral or prior authorization to receive OON services should refer to the [Referring to Out-of-Network Providers Policy](#).

## Billing Instructions

Unless otherwise stated, Tufts Health Plan follows industry-standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

### POS Codes

- **02:** Patient is not located in their home
- **10:** Patient is in their home (a location other than a hospital or other facility where the patient receives care in a private residence)

### Modifiers

- **93:** Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system; may only be appended to services listed in Appendix T of the AMA CPT Manual
- **95:** Synchronous telemedicine service rendered via a real-time interactive audio/video telecommunications system
  - Append to services listed in Appendix P of the AMA CPT Manual
  - May be appended to MassHealth-covered BH alcohol and drug treatment HCPCS codes (Tufts Health Plan SCO, Tufts Health Together, and Tufts Health One Care only)
- **FQ:** Audio-only communication technology (to be used with BH services)
- **FR:** Supervising practitioner was present through two-way, audio/video communication technology
- **GT** Interactive audio/video telecommunication systems
  - Required on the institutional claim for the distant-site provider when there is an accompanying professional claim containing POS 02 or 10
- **GQ:** Asynchronous telecommunications system
- **G0:** Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke
- **V3:** services rendered via audio-only telehealth; may only be billed for DOS through March 31, 2023
- Providers should bill with the appropriate license-level modifier and all other billing guidelines, as specified in the applicable [payment policies](#)
- Do not append modifiers to procedure codes that are inherently telehealth services (e.g., Q3014, 98966, or 99441) as this is indicated by the appropriate POS code. Claims incorrectly billed with these modifiers may result in a denial.

### Professional Claims

- Telehealth/telemedicine claims must be reported with the appropriate Place of Service (POS) code, CPT/HCPCS code(s), and applicable modifier(s)

### Facility Claims

- Claims must be reported with the appropriate CPT/HCPCS code(s), modifier(s), and the appropriate revenue code(s)
- Modifier GT is required on the institutional claim for the distant-site provider when there is an accompanying professional claim containing POS 02 or 10 (effective for DOS on or after April 1, 2023 for Tufts Health Plan SCO, Tufts Health Together, and Tufts Health One Care claims)
  - **Note:** Modifier GT may only be appended to institutional claims for Tufts Health Plan SCO, Tufts Health Together, or Tufts Health One Care members

Providers must bill the following code combination(s) for telehealth services:

Product(s)	POS	Modifier(s)
Commercial	02 or 10	93
Tufts Health Direct		95
Tufts Health RITogether		GT
Tufts Medicare Preferred HMO/PPO	02 or 10	95 GQ

		FQ FR	GT G0
Tufts Health Plan SCO Tufts Health Together Tufts Health One Care	02 or 10	93 95 FQ FR <i>Effective for DOS on or after April 1, 2023, claims billed without a required modifier will deny</i>	GQ GT (institutional claims only) V3 (only for DOS through 3/31/23)

---

## Compensation/Reimbursement Information

Providers are compensated according to the applicable network contracted rates and applicable fee schedules.

Effective for DOS on or after March 1, 2023, telehealth/telemedicine services rendered to Commercial members are subject to a 20% reduction, unless otherwise specified in the provider's health services agreement and/or applicable state regulations. Behavioral health providers in M.A. and R.I. as well as PCPs and registered dietitians/nutritionists in R.I. will continue to be compensated at the applicable in-person fee schedule/allowable amount.

Effective for DOS on or after August 1, 2023, telehealth/telemedicine services rendered to Tufts Health Direct members will also be subject to a 20% reduction of the in-person rate (**Note:** this does not apply to BH providers).

**Note:** For Medicare products, under CMS rules, special codes already exist for certain telephonic services and those codes will be paid at the CMS fee schedule.

Services provided outside usual office hours through interactive mechanisms are not eligible for the addition of a 99050, 99051, 99053, 99056, 99058, or 99060 code, since interactive services are not limited to standard office hour time frames.

Communication with the member's PCP and other treating providers is expected as part of the service and is not compensated separately. Provider-to-provider discussions without the member being present are not separately compensated.

---

## Related Policies and Resources

- [Evaluation and Management Professional Payment Policy](#)
- [Provider Resource Center](#)

---

## Publication History

- October 2023: Clarified modifier GT institutional claims billing instructions for Tufts Health Together, Tufts Health Unify, and Tufts Health Plan SCO claims
- June 2023: Updated compensation amount for services rendered to Tufts Health Direct members, effective for DOS on or after August 1, 2023
- March 2023: Updated modifier information for Tufts Health Together, Tufts Health Unify, and Tufts Health Plan SCO, effective for DOS on or after April 1, 2023
- February 2023: Clarified provider exceptions for 20% fee schedule decrement, effective for DOS on or after March 1, 2023
- December 2022: Updated compensation amount for services rendered to Commercial members, effective for DOS on or after March 1, 2023; added billing instructions for modifier 93
- September 2022: Policy created to reflect non-COVID-state billing and coverage guidelines effective for dates of service on or after September 1, 2022

---

## Background and disclaimer information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable),

adherence to Plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.