JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Reimbursement Policies** **Reimbursement Policies**	*Policy Number*	RPC.042
		Effective Date	01/01/2025
		Approval Date	02/18/2025
	Subject **Priority Partners (PPMCO) Telemedicine and Telehealth Services**	*Supersedes Date*	12/27/2024
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This document applies to the following Participating Organizations:

Priority Partners

Keywords: Remote Patient Monitoring, Telehealth, Telemedicine

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I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and

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Medicare rules. JHHC reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows CMS guidelines and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHC may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHC strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

This policy provides basic reimbursement guidance on the appropriate reporting of telehealth/telemedicine (telehealth) services, when rendered to a JHHP Priority Partner member, within the provider's scope of practice, under state and federal law. JHHP will reimburse Telehealth/Telemedicine and virtual health services reported on a CMS-1500 or CMS-1450 (UB-04) or their electronic equivalents, when billed in accordance with the members covered plan benefits, and when all technical requirements and billing guidelines are met.

III. POLICY STATEMENT

JHHP will reimburse for covered telehealth services that a physician or practitioner provides via 2-way, interactive technology (or telehealth), for a Priority Partners member. For the purpose of this policy, the terms Telehealth and Telemedicine are used interchangeably and encompass virtual healthcare services. JHHP will align with regulatory, state and federal guidance to identify physician and non-physician services that are eligible as reimbursable or non-reimbursable, as applicable to the member's plan. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including, but not limited to, legislative mandates, provider contracts, and/or the member's benefit coverage, prior authorization, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. BILLING GUIDELINES AND PAYMENT METHODOLOGY

1. Telehealth/Telemedicine services are reimbursed in accordance to the Code of Maryland Regulations (COMAR) and Maryland Medicaid.
2. In alignment with CMS and MDH guidance, JHHP does **NOT** allow for the reimbursement of Telemedicine/Telehealth services, CPT 98000-98015.
3. Providers delivering services via telehealth submit claims in the same manner the provider uses for in-person services. Providers should use the place of service code that would be appropriate as if it were a non-telehealth claim.
   - *Example: If a distant site provider is rendering services at an off-site office, use the place of service office (11).*
4. Providers must include the "GT" modifier with the billed procedure code to identify services rendered via audio-video telehealth.
5. Claims submitted for telehealth services rendered via audio-only must include the "UB" modifier.
6. Consistent with MDH guidance, Store and Forward technology is only covered for dermatology, ophthalmology, or radiology services under the Physician Services at COMAR 10.09.02.07.

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7. Covered services rendered as a telehealth service follow the same preauthorization requirements as if the service was rendered face-to-face.
8. When submitting claims for telehealth services, the appropriate CPT/HCPCS code, Revenue code, modifier, Place of Service (POS), and/or Type of Bill (TOB) must be reported correctly or the claim may be denied.
9. CPT code 99600 with modifier GT is only payable in POS 12.
10. Appropriate documentation, in the patient's record, must support all codes billed. JHHP may conduct medical record documentation reviews on a randomly selected sample of practitioners or on providers who render services outside their regular scope of practice or assigned specialty.
    - Refer to the JHHP resources and guidelines for all of our health plans for additional information for Medical Record Standards Documentation.
11. JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
    - Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.
12. Providers must document, in the participant's medical record, the participant's signed consent or the emergency situation that prevented obtaining consent.

V. TELEHEALTH REPLACEMENT CODES

In alignment with the Federal Register CY 2025 Payment Policies Under the Physician Fee Schedule recommendation, we are providing the following telehealth coding crosswalk as courtesy to our providers (this list is not all-inclusive):

CMS Unrecognized Codes	Suggested Replacement Codes
98000	99202
98001	99203
98002	99204
98003	99205
98004	99212
98005	99213
98006	99214
98007	99215
98008	99202
98009	99203
98010	99204
98011	99205
98012	99212
98013	99213
98014	99214
98015	99215

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VI. REMOTE PATIENT MONITORING (RPM)

1. In alignment with MDH guidance, JHHP will reimburse providers for Remote Patient Monitoring (RPM), when billed with HCPCS code S9110.
2. Referrals for RPM may cover an episode of up to 60 days of monitoring.
3. Eligible Priority Partner members may only receive one (1) unit of RPM per 30-day period, and four (4) units within a 365-day period, regardless of who is rendering the service.
4. Reimbursement for RPM is per 30 days of monitoring, which covers:
   - Equipment installation;
   - Participant education for using the equipment; and
   - Daily monitoring of the information transmitted for abnormal data measurements.
5. RPM services do not include and JHHP will not pay for:
   - RPM equipment;
   - Upgrades to RPM equipment; or
   - Internet services for participants

VII. INAPPROPRIATE BILLING of TELEHEALTH/TELEMEDICINE SERVICES

1. Do not report telehealth services with POS codes 02 (Telehealth-Other than home) and 10 (Telehealth-Home). The billing provider should use the location of the rendering practitioner.
2. In alignment with MDH, JHHP does not reimburse for Telephone E/M services (98966-98968), but does allow for Audio-only E/M visits, levels 99211-99213.
3. Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.
4. Unless specific benefits are provided under the member's contract, JHHP considers services for the following indications ineligible/not meeting requirements as a telehealth service:
   - When technical difficulties prevent the delivery of all or part of the telehealth session;
   - Request for medical refills or referrals;
   - Reporting of test results;
   - Provision of education materials;
   - Scheduling;
   - Registration or updating billing information;
   - Appointment reminders;
   - Interpretation of lab or radiology services by providers who are non-licensed (for telemedicine services);
   - Telecommunication between providers without the participant present;
   - An electronic mail message between a provider and participant; or
   - A facsimile transmission between a provider and participant;

VIII. EXCEPTIONS and EXCLUSIONS

JHHP will process and reimburse claims in accordance with Code of Maryland Regulations (COMAR) and the Maryland Department of Health (MDH) guidance. Please consult the authoritative guidance found on these entities' websites, to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.

IX. CODES, TERMS and DEFINITIONS

Definition of Terms

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Term	Definition
Asynchronous Telehealth	Asynchronous telehealth is also called “store and forward”, is communication or information shared between providers, patients, and caregivers that occur at different points in time. Examples include: • Messaging with follow-up instructions or confirmations • Images sent for evaluation • Lab results or vital statistics
Audio-only	Telephone calls, which are considered audio transmissions, per the CPT definition, are non-face-to-face E/M services provided to a patient using the telephone by a Physician or Other Qualified Health Care Professional, who may report E/Mt services.
Distance Site	In alignment with MDH guidance, a distant site is the location where a physician or practitioner provides telehealth. All distant site providers enrolled in Maryland Medicaid may provide services via telehealth if telehealth is a permitted delivery model within the rendering provider’s scope of practice.
Evaluation and Management (E/M) Services	Per the CPT manual, E/M services (CPT 99202-99499) guidelines have sections that are common to all E/M categories and sections that are category specific. These guidelines are to be used by the reporting physician or other qualified healthcare professional to select the appropriate level of service. The E/M section of the CPT® manual is divided into broad categories and further divided into sub-categories of E/M services.
Originating Site	In accordance MDH guidance, the originating site may be any secure location, approved by the participant and the provider, for the delivery of services.
Place of Service (POS)	The POS code set provides setting information necessary to appropriately pay claims correctly and is generally used to reflect the actual setting where the member receives the face-to-face service.

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Remote Patient Monitoring (RPM)	For the purpose of this policy, RPM is a service that uses digital technologies to collect medical and other forms of health data from individuals and electronically transmits that information securely to health care providers for assessment, recommendations, and interventions. Providers should order RPM when it is medically necessary to improve chronic disease control and it is expected to reduce potentially preventable hospital utilization. Devices used for RPM must be FDA-approved and they must be able to automatically transmit data and information to the provider without patient interference.
Remote Therapeutic Monitoring (RTM)	Services may be performed by physician, qualified health care practitioner, or staff under the supervision of the physician; must monitor an acute care or chronic condition, where data is used to develop and manage a treatment plan; may include initial set-up and education on use of equipment, daily recordings or alerts, and 20 or more minutes a month of interactive treatment management between the patient and provider.
Physician or Other Qualified Health Care Professional	A Physician or Other Qualified Health Care Professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group who report with the same Federal Tax Identification Number (TIN). Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.
Synchronous Telemedicine	Involve interactive, electronic information exchange in at least two directions in the same time period. Allows the delivery of health care at a distance via real-time, two-way transmission of digitized video images between two or more locations. Providers and/or providers and patients can exchange medical information for the purpose of obtaining an expert opinion, diagnostic support regarding the care of a patient, and/or direct patient care.

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Technology-Assisted Communication	Multimedia communication equipment permitting two-way real-time interactive communication between a patient at an originating site and a distant site provider at a distant site.
Telehealth/Telemedicine	The use of electronic information and telecommunications technologies to support long distance clinical health care, patient and professional health-related education, public health, and health administration. Telehealth/Telemedicine includes such technologies as telephones, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. The use of a telecommunication system to provide services for the purpose of evaluation and treatment when the patient is at one location and the rendering provider is at another location.
Virtual Check-in	Brief patient initiated virtual technology-based communication service with physicians or certain other practitioners where the communication is not related to a medical visit within the previous 7 days and doesn't lead to a medical visit within the next 24 hours (or soonest appointment available).

CPT Codes

CPT Codes	Definition
S9110	Remote Patient Monitoring (RPM) or telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month.
99202-99499	Please refer to the AMA CPT book for all E/M CPT descriptors located in the Evaluation and Management section (99202-99499). There are many code categories. Each category may have specific guidelines, or the codes may include specific details.

Place of Service (POS) Codes

POS Code	Definition
02	Telehealth Provided Other than in Patient's Home. The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.

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10	Telehealth Provided in Patient's Home. The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.

Modifiers

Modifier	Definition
GT	Services delivered via telehealth using two-way audio-visual technology assisted communication.
UB	Identifies the claim as a telephonically delivered service.

X. REFERENCES

This policy has been developed through consideration of the following:

- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- Billing for telehealth | Telehealth.HHS.gov
- COMAR 10.09.49 Telehealth Services
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Federal Register CY 2025 Payment Policies Under the Physician Fee Schedule
- Maryland Medicaid Professional Services Provider Manual
- Maryland Medicaid PT 37-23 Reimbursement for Remote Patient Monitoring
- MDH Transmittals
- NCCI for Medicaid | CMS

XI. REVISION HISTORY

Date	Review or Revision	Reason for Modification	Approved By
2/18/2025	Revision	Align with CPT and CMS updates	Reimbursement Policy Committee (RPC)
10/09/2024	New Policy	N/A	Reimbursement Authorizations and Coding Committee (RAC)

XII. POLICY NOTIFICATION CHART

	Yes/No	If yes in 2nd column, notify the following department of policy revisions:
Does this policy relate to NCQA?	No	Quality Improvement

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Does this policy relate to Qlarant/MDH requirements?	No	Quality Improvement
Does this policy relate to DHA contractual requirements?	No	USFHP Administration

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