Telehealth Services

Policy Number:	M20160729060
Effective Date:	10/1/2016
Sponsoring Department:	NCM – Network Reimbursement
Impacted Department(s):	

Type of Policy: ☒ Internal ☒ External

Data Classification: ☐Confidential ☐Restricted ☒Public

Applies to (Line of Business):

☐ Corporate (All)
☒ State Products, if yes which plan(s): ☒MediSource; ☒MediSource Connect; ☒Child Health Plus; ☒Essential Plan
☒Medicare, if yes, which plan(s): ☒MAPD; ☐PDP; ☒ISNP; ☒CSNP
☒ Commercial, if yes, which type: ☒Large Group; ☒Small Group; ☒Individual
☒ Self-Funded Services *(Refer to specific Summary Plan Descriptions (SPDs) to determine any pre-authorization or pre-certification requirements and coverage limitations. In the event of any conflict between this policy and the SPD of a Self-Funded Plan, the SPD shall supersede the policy.)*

Excluded Products within the Selected Lines of Business (LOB)

N/A

Applicable to Vendors? Yes ☐ No☒

Purpose and Applicability:

To provide coverage and reimbursement guidelines for services furnished via telehealth.

Policy:

This policy describes coverage and reimbursement for telehealth services provided by Independent Health network providers and does not apply to Independent Health telemedicine vendors.

Note that for the purposes of this policy, ***telehealth*** is defined as the delivery of any healthcare service via electronic means. ***Telemedicine*** is defined specifically as synchronous audiovisual visits.

A summary of ***telehealth*** coverage follows on the table on the next page. The table includes a flag indicating if the service code is included in the Primary Value Global Patient Management Payment (GPMP) code set for eligible primary care providers.

Details on ***telemedicine*** coverage follow the **telehealth** summary table. Here is an example of telemedicine that is currently covered fee-for-service for ***all*** **lines of business:**

> **A specialist (MD, DO, NP or PA) uses telemedicine to evaluate and manage a patient who is on vacation in Manhattan. Billing is E&M code with -GT modifier and place of service -02.**

Independent Health

Types of Telehealth Services

	Service	Codes	Brief Description (1)	Commercial	Medicare	State	Self-funded	Included in GPMP for primaries (2)
1	**Telemedicine**	Any code that can be performed via telemedicine	Synchronous audiovisual encounter	Covered	Covered	Covered	See Summary Plan Description (SPD) for individual plan	X
2	**Phone calls**	**See rows 8 and 9 below for options.** Codes 99441-3 and 98966-8, "Telephone evaluation/assessment & management" are not covered.						X
3	**E-visits for physicians and APPs**	99421-3	Digital evaluation by online, email, or other HIPAA-compliant medium	Covered	Covered	Not Covered		
4	**E-visits other than by physicians and APPs**	98970-2, G2061-3	Digital care by online, email, or other HIPAA-compliant medium	Covered	Covered	Not Covered		
5	**Remote monitoring**	99453-4, 99091, 99457-8, 99473-4	Remote patient monitoring by device	Covered	Covered	Only 99091 covered		
6	**Interprofessional consultation**	99446-9, 99451-2	Interprofessional consultation via phone/ internet/ EHR	Covered	Covered	Not Covered		99452 only included
7	**Store and forward**	G2010	Stand-alone evaluation of forwarded data or image (asynchronous)	Covered	Covered	Not Covered *Bill as telemedicine with GQ modifier*		X
8	**Virtual check-in**	G2012	5-10 minute discussion; includes phone, patient-initiated.	Covered	Covered	Not Covered		X
9	**Virtual check-in**	G0071	**For FQHCs and RHCs only.** Patient-initiated.	Not Covered	Covered	Not covered		X

(1) For detailed descriptions, see the CPT or HCPCS manual.

(2) The "Global Per Member Payment" is the monthly global payment to primaries through the Primary Value program.

Telemedicine Services

A ***telemedicine service*** must be provided by an ***eligible provider*** and billed using an ***eligible code*** with an ***appropriate modifier*** and ***appropriate place of service code*** (see definitions below table). The member and provider can be anywhere in the United States or its territories. Other conditions and limitations are below under "Notes".

Eligible providers for *telemedicine*
(synchronous audiovisual visits)

	Commercial	Medicare	Self-Funded	State
Physician	X	X	See Summary Plan Description (SPD) for individual plan	X
Dentist	X	X		X
PA	X	X		X
NP	X	X		X
RN (1)	X	X		X (2)
Clinical Nurse Specialist (1)		X		
Podiatrist	X	X		X
Optometrist	X	X		X
Psychologist	X	X		X
Licensed Clinical Social Worker	X	X		X
Speech Language Pathologist	X	X		X
Physical Therapist	X	X		X
Occupational Therapist	X	X		X
Diabetes Educator	X	X		X
Asthma Educator	X	X		X
Genetic Counselor	X	X		X
Hospitals	X	X		X
Other Article 28 facilities		X		X
Home Care Agency	X			X
Hospice	X	X		X
CASAC (1)	X	X		X
Mental health clinic	X	X		X
OPWDD day and residential progs.	X			
Midwives	X	X		X
CRNA		X		
Dietician/ nutrition professional		X		
Audiologists	X	X		X

(1) Independent Health does not credential these providers.
(2) RNs only allowed to receive data via remote patient monitoring for State.

Eligible codes for telemedicine

Any code inherently specified as telemedicine in the descriptor or a code otherwise billable as a face-to-face visit, provided that the quality of care of the telemedicine visit is not meaningfully different from a face-to-face visit, or that a face-to-face visit is not practically possible.

Appropriate modifiers for telemedicine

Commercial/Self-Funded: *no modifier required*; modifiers "95" or "GT" may be submitted for informational purposes.

Medicare: *no modifier required*; modifiers "95" or "GT" may be submitted for informational purposes.

State: Use the "95" modifier when appropriate in accordance with Appendix P in the CPT manual, otherwise the "GT" modifier for those services for which modifier "95" cannot be used. When billing for store and forward technology, general telemedicine billing rules apply however a "GQ" modifier should be used rather than "95" or "GT"

Appropriate place of service code for telemedicine

Use place of service code "02".

Notes:

- This policy addresses Independent Health's position on coverage and payment for telehealth services. In performing and billing for telehealth services, there are multiple other regulatory issues for a provider to consider that are beyond the scope of this policy.
- While this policy allows for payment if the patient and provider are out-of-state, there may be regulations in other states that prohibit such visits.
- The NYS Telehealth Parity law requires commercial insurers and Medicaid to provide reimbursement for services delivered via telehealth if those services would have been covered if delivered in person.
- Operational requirements: Providers must obtain consent from members to deliver telehealth services. Member liabilities apply. All technology must be HIPAA-compliant. For telemedicine, the provider must verify the patient's identity, and for HIPAA purposes, both provider and patient must be in a confined space with the door closed.
- For Medicare, out-of-network providers may only bill for codes on the CMS telehealth services list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- For all lines of business, if the provider is out-of-network, prior authorization may be required.

- When the originating site for a telemedicine visit is a healthcare facility or provider office, and when the originating site and distant site are not part of the same provider network/group/tax id, then both the originating site and the distant site can bill for their services. The originating site may bill for their administrative time and technology cost under HCPCS Code Q3014.
- If all or part of the telehealth service is undelivered or terminated due to technological errors, no payment will be provided to either site.
- OMH and OASAS require agency approval of telepsychiatry and telepractice, respectively. OMH requires approval by the field office through submission of a written plan and attestation. OASAS requires approval for a certified program to become designated to provide telepractice services. Designation requires submission of a written plan and attestation.
- If the originating site and/or the distant site is an article 28 facility, the provider must be credentialed at that site/those sites.
- Certain providers may require a face-to-face visit prior to telemedicine visits, based on federal regulations (e.g. DEA) and licensure requirements. In general, a provider prescribing a controlled substance must conduct a face-to-face visit.
- State behavioral health telemedicine visits should be billed to Beacon.

The code(s) listed in this Independent Health policy may not be all-inclusive. Independent Health reserves the right to review and update the coding in this policy when necessary to meet coding changes. Inclusion of a code within this policy does not guarantee reimbursement for that service. All codes may not be eligible for coverage to all providers due to individual procedure privileging requirements, medical management policy, or as determined by the member's individual contract benefit language.

Definitions

Telehealth is the use of electronic information and communication technologies in order to provide a health care service. Telehealth includes health care services furnished via telemedicine, store and forward technologies and remote patient monitoring. Telehealth must meet the minimum federal and state requirements for privacy and security, including but not limited to HIPAA Security Rules and New York Public Health Law §2805-u.

Telemedicine is the use of synchronous, real-time electronic audio-visual communications.

Originating Site is the location of the member at the time of the health care service via telehealth.

Distant Site is the location of the practitioner at the time of the health care service via telehealth.

Store-and-Forward involves the asynchronous, electronic transmission of a member's health information in the form of patient-specific pre-recorded videos and/or digital images from a provider at an originating site to a telehealth provider at a distant site.

References

Related Policies, Processes and Other Documents

Non-Regulatory references

https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/ryan-haight-act

Regulatory References

CMS-4185-F (Final Rule for Telehealth for Medicare Advantage)
(§§ 422.100, 422.135, 422.252, 422.254, and 422.264)
New York Public Health Law §2805-u
New York Public Health Law Article 29-G, Social Services Law § 367-u, and Insurance Law § 3217-h
Chapter 15 of the "Medicare Benefit Policy Manual" (Publication 100-02)
Chapter 12 of the "Medicare Claims Processing Manual" (Publication 100-04)
NYS Medicaid update February 2019:
https://www.health.ny.gov/health_care/medicaid/program/update/2019/feb19_mu_speced.pdf

Version Control

Sponsored By:
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