

Highmark Reimbursement Policy Bulletin



Bulletin Number: RP-046
Subject: Telemedicine and Telehealth Services
Effective Date: July 15, 2019 **End Date:**
Issue Date: March 30, 2020 **Revised Date:** March 6, 2020
Date Reviewed: March 2019
Source: Reimbursement Policy

Applicable Commercial Market	PA	<input checked="" type="checkbox"/>	WV	<input checked="" type="checkbox"/>	DE	<input checked="" type="checkbox"/>
Applicable Medicare Advantage Market	PA	<input checked="" type="checkbox"/>	WV	<input checked="" type="checkbox"/>		
Applicable Claim Type	UB	<input checked="" type="checkbox"/>	1500	<input checked="" type="checkbox"/>		

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy outlines the Plan's reimbursement for telemedicine, telehealth, virtual-care, or eVisit services. The term "telehealth" is often used in conjunction with telemedicine and is intended to include a broader range of services using telecommunication technologies, including videoconferencing. Unless otherwise provided herein and unless as specifically set forth in the Delaware Telemedicine Mandate – House Bill 69 Section of this Policy, "telehealth" shall include telemedicine, telehealth, virtual care, and eVisit services deemed covered services by the Plan or its affiliates.

Definitions

Distant Site: The location of an appropriately licensed health care provider while furnishing health care services by means of telecommunication.

Originating Site: The location of the patient at the time a telecommunication service is furnished.

Place of Service "02": The location where health services and health related services are provided or received, through a telecommunication system.

Modifier GQ: Via asynchronous telecommunications system.

Modifier GT: Via Interactive Audio and Video Telecommunications systems.

Modifier 95: Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System.

Note: In accordance with the telehealth waiver issued by The Centers for Medicaid and Medicare Services (CMS) related to the 2019 novel coronavirus, some of the requirements for reporting the telehealth modifiers above, for example GQ, may also be waived or altered during the PHE period. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Reimbursement for telehealth services is determined according to individual, group, or customer benefits. Coverage for telehealth is limited to the types of services already considered a covered benefit under the member's specific plan. Coverages and reimbursements for telehealth services are limited to those services performed between a licensed clinician and a member/patient.

When a covered benefit, evaluation and management and consultation services delivered through telehealth for *new and established patients may be reimbursed under the following conditions:

***Note:** In accordance with the telehealth waiver issued by The Centers for Medicaid and Medicare Services (CMS) related to the 2019 novel coronavirus, new patients will be permitted to receive telehealth services beginning March 6, 2020, until the Public Health Emergency (PHE) declared by the Department of Health and Human Services (HHS) expires. Also, some of the requirements below and throughout this policy may also be waived or altered during the PHE period. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

1. Professional services rendered via an interactive telecommunication system are only eligible for reimbursement to the provider rendering the telehealth services. A provider rendering face-to-face care should report the appropriate codes for the in-person services.
2. The patient must be present at the time of all billed services unless the billed code is for exclusive use with *asynchronous* services or as specifically allowed under state law. If state law requires a face-to-face examination PRIOR to the delivery of telehealth services, the face-to-face services must be concluded and documented in the medical record prior to the initiation of any related telehealth visits.
3. All services provided must be medically appropriate and necessary.
4. The consultation/evaluation and management service must take place via an interactive audio AND video telecommunications system (unless exceptions are allowed by applicable laws). Interactive telecommunications systems must be multi-media communication which, at minimum, includes audio and video equipment permitting real-time (synchronous) consultation among the patient and practitioner at the Originating Site and the practitioner at the Distant Site.
5. The technology platform used by the provider must meet technology security requirements, including being both HIPAA and HITECH compliant.

6. Thorough, appropriate documentation of telehealth services and other communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

Note: Provider should consult published guidance from the Office of Civil Rights (OCR) of HHS related to HIPAA and HITECH compliance during the PHE.

The following codes are not eligible for reimbursement under the telehealth policy as they do not include both audio and video communication:

98966 98967 98968 99441 99442 99443 99446 99447 99448 99449

Note: These codes are eligible for reimbursement during the PHE period.

Eligible Providers

Providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face to face service.

Note: The requirement above may be waived or altered during the PHE declared by HHS pursuant to state requirements.

Virtual PCP and Retail Clinic Visits

When billing professional services (1500/837P), Virtual PCP Visits and Virtual Retail Clinic Visits should be billed with Evaluation & Management (E&M) CPT codes (99201-99205; 99211-99215) applicable to the services provided and with the GT or 95 modifier indicating the use of interactive audio and video telecommunications technology.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code (99201-99205; 99211-99215 or G0463) with the GT or 95 modifiers and the revenue code 780.

Note: Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP Facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Virtual visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits) or treatment.
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

***Note:** Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Virtual Behavioral Health Visits

When billing professional services (1500/837P), virtual behavioral health services should be billed with existing mental health CPT codes applicable to the services provided with a GT or 95 modifiers indicating the use of an interactive (synchronous) audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code with the GT or 95 modifiers and the appropriate behavioral health revenue code (900-919).

Note: Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP Facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Virtual behavioral health visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

Note: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Specialist Virtual Visit

The Originating Site can be either a medical site or an approved non-medical site. Only a medical Originating Site (i.e. PCP's office, outpatient facility, etc.) is eligible for reimbursement of an access fee. The Plan will accept HCPCS code Q3014 ("telehealth Originating Site facility fee") for the service. Claims for the medical Originating Site's access fee will be accepted as either professional (1500/837P) or outpatient facility (UB-04/837I using revenue code 780).

Note: No other service reported on the medical Originating Site claim will be eligible for payment by the Plan or the member.

Providers/facility at the Originating Site should bill procedure code Q3014.

Note: Code Q3014 is not covered if billed with a non-covered professional service.

The access fee is an all-inclusive fee that includes all medical Originating Site fees including, without limitation, providing a physical location for the virtual visit as well as providing all equipment to be utilized

for the secure connection. No other fees may be billed to either the Plan or to the member by the medical Originating Site and all contractual member hold harmless requirements shall apply.

Note: The Plan will reimburse only one claim per encounter for the medical Originating Site access fee.

The Plan will accept only a professional claim (1500/837P) for the provider's evaluation/assessment services provided at the Distant Site.

Evaluation and management (E&M) visits (99201-99205; 99211-99215) and consultation services (99241-99245) are eligible codes for the specialist's services rendered at the Distant Site. The procedure code(s) representing the specialist's services must be billed with GT or 95 modifiers. The service appended with one of these modifiers is only billed by the specialty practitioner.

Note: Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP Facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Specialist Virtual Visit services that the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

***Note:** Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Teledermatology

The Plan will accept claims for teledermatology services from dermatologists billing on a 1500 claim form or 837P electronic format. Services should be billed using procedure code 99421, 99422 or 99423.

Outpatient facility claims (UB-04/837I) should be billed using procedure code 99421, 99422 or 99423 and revenue code 780.

Note: A telehealth modifier is not needed with the 99421, 99422 or 99423 code as the description of the code already indicates the service is "online".

Encounter Documentation Requirements

All telehealth encounter documentation in the medical record is expected to meet the same minimum standards as required by face-to-face visit documentation. All relevant visit documentation is subject to Highmark post-payment review.

Delaware Telemedicine Mandate - House Bill 69

Effective January 1, 2016, Delaware law requires all individual and group policies subject to Delaware insurance law to provide coverage for health-care services provided through telemedicine and telehealth deemed covered services by the Plan. Eligible Delaware practitioners include most physicians and many other providers practicing within the scope of their license.

"Telehealth" is the use of information and communications technologies consisting of telephones, store and forward transfers, remote patient monitoring devices, or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, and health administration services.

"Telemedicine" is a form of telehealth, which is the delivery of clinical health-care services by means of real time two-way audio, visual, or other telecommunications or electronic communications. This includes the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health-care provider practicing within his or her scope of license as would be practiced in-person with a patient, and legally allowed to practice in the State.

The following are applicable to Delaware providers ONLY:

Distant Site

The distant site is the location where the provider (legally allowed to practice in the state) is rendering the service by means of telemedicine or telehealth. The Plan will not reimburse claims submitted for an access fee by the distant site.

Originating Site

The originating medical site (i.e., provider's office, outpatient facility, etc.) is a site in Delaware at which an eligible member is located at the time the service is performed by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties. The Plan will accept only one claim for the originating site access fee per visit that involves both an originating medical site and a distant site. Only the originating medical site will receive payment for an access fee.

Note: An access fee is not applicable for non-medical sites (e.g. member's home).

Professional service claims (1500/837P) should be billed using CMS Level 2 code Q3014, indicating the telehealth origination site fee, when applicable.

Outpatient facility claims (UB-04/837I) should be billed using CMS Level 2 code Q3014 and revenue code 780, when applicable.

Real-time Audio

Professional services (1500/837P) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968.

Outpatient facility claims (UB-04/837I) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968 with the appropriate revenue code.

Real-time Audio & Visual

Professional services claims (1500/837P) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT or 95 modifier indicating the use of an interactive audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT and 95 modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: Place of Service "02" (Telehealth) must be used when reporting the GT or 95 modifier on professional (1500 form) claims.

Store and Forward

Professional service claims (1500/837P) should be billed using existing E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier indicating the use of asynchronous telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: Place of Service "02" (Telehealth) must be used when reporting the GQ modifier on professional (1500 form) claims.

Telehealth Transmission

Professional service claims (1500/837P) should be billed using CMS Level 2 code T1014 indicating telehealth transmission, if appropriate.

Outpatient facility claims (UB04/837I) should be billed using CMS Level 2 code T1014 and the appropriate revenue code.

Note: The Plan will accept only one telehealth transmission code per encounter, per provider; if both a medical Originating and Distant site were involved, the Plan will accept one from each site, when applicable.

Services Not Covered

Services that the Plan **does not** reimburse include, but are not limited to, the following:

- Unsecured and unstructured services such as, but not limited to, skype and instant messaging unless such service is within the scope of practice of the provider
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements above and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: In accordance with the telehealth waiver issued by the Governor of the State of Delaware through the Second Modification to the Declaration of the State of Emergency for the State of Delaware due to a Public Health Threat ("PHT") ("Declaration"), effective March 18, 2020 at 8:00 p.m., some of the requirements throughout this policy may also be waived or altered during the PHT and until such time as the Declaration remains in effect. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by the Declaration.

West Virginia Telemedicine Mandate - House Bill 4003

Effective July 1, 2020, West Virginia law requires all individual and group policies subject to West Virginia insurance law to provide coverage for health-care services, deemed covered services by the Plan, provided through telehealth services if those same services are covered through face-to-face consultation by the policy. Telehealth services shall not be subject to annual or lifetime dollar maximum; copayment, coinsurance or deductible amounts; policy year, calendar year or other duration benefit limitation or maximum that is not equally imposed on all terms and services covered under the policy, contract or plan. Eligible West Virginia practitioners include most physicians and many other providers practicing within the scope of their license.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS or applicable state waiver. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Telehealth Services

Telehealth services means the use of synchronous or asynchronous telecommunications technology by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and services; and

health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

Distant Site

The distant site means the telehealth site where the health care practitioner is seeing the patient at a distance or consulting with a patient's health care practitioner. The Plan will not reimburse claims submitted for an access fee by the distant site.

Health Care Practitioner

The health care practitioner means a person licensed under §30-1-1 *et seq.* of this code who provides health care services.

Originating Site

The originating site means the location where the patient is located, whether or not accompanied by a health care practitioner, at the time services are provided by a health care practitioner through telehealth, including, but not limited to, a health care practitioner's office, hospital, critical access hospital, rural health clinic, federally qualified health center, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

Note: Providers/facility at the Originating Site should bill procedure code Q3014.

Remote Patient Monitoring Services

Remote patient monitoring services means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows CMS guidelines for Telemedicine and Telehealth services.

Note: In accordance with the telehealth waiver issued by CMS, certain services are now permitted to be conducted via Telehealth. Please reference the Medicare Telemedicine Health Care Provider Fact Sheet located in the reference section of this policy. Below is a summary of the expanded services.

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: <ul style="list-style-type: none"> • 99201-99215 (Office or other outpatient visits) • G0425-G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	<ul style="list-style-type: none"> • HCPCS code G2012 • HCPCS code G2010 	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	<ul style="list-style-type: none"> • 99421 • 99422 • 99423 • G2061 • G2062 • G2063 	For established patients.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

More information on telehealth can be found in the Highmark Provider Manual on the Provider Resource Center. Also, the Provider Resource Center has additional guidelines on the PHE.

RELATED POLICIES:

Refer to the following Medical Policies for additional information:

- Commercial Policy Z-65: Telestroke Services
- Medicare Advantage Policy N-4: Nutrition Therapy

Refer to the following Reimbursement Policies for related information:

- Reimbursement Policy RP-043: Care Management

REFERENCES:

- American Medical Association, *Current Procedure Terminology* CPT® Manual
- CMS Medicare Claims Processing Manual, Chapter 12
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>

- Delaware Telemedicine Mandate, House Bill 69 (Codified as 18 Del. C. §§ 3770 & 3571R; 18 Del. Admin. Code 1409) <http://delcode.delaware.gov/sessionlaws/ga148/chp080.pdf>
- U.S. Department of Health and Human Services: Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus
<https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html>
- CMS Medicare Telemedicine Health Care Provider Fact Sheet.
<https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>
- Second Modification of the Declaration of a State of Emergency for the State of Delaware due to a Public Health Threat
<https://governor.delaware.gov/wp-content/uploads/sites/24/2020/03/Second-Modification-to-the-State-of-Emergency.pdf>

POLICY UPDATE HISTORY INFORMATION:

07 / 2019	Implementation
01 / 2020	Replaced code 99444 with 99421, 99422 and 99423
03 / 2020	Added information related to the PHE issued by HHS and the PHT Declaration issued by the Governor of the State of Delaware. Added policy to be applicable to Medicare Advantage.