



**EFFECTIVE DATE:** 01|01|2019

**POLICY LAST UPDATED:** 11|06|2018

### OVERVIEW

Telemedicine is a broad term used to describe an array of electronic communications between medical personnel and patients at different locations. It can also be referred to as telehealth. For purposes of this payment policy, “telemedicine services” shall mean healthcare services delivered by means of real time, two-way electronic audiovisual communications, which facilitate the assessment, diagnosis, treatment, and care management of a patient’s health care while such patient is at an originating site and the health-care provider is at a distant site, consistent with applicable state and federal laws and regulations.

The Centers for Medicare and Medicaid Services (CMS) promote telemedicine as a tool to improve primary and preventive care to Medicare beneficiaries who live in underserved and rural areas. Additionally, in 2016, the Rhode Island General Assembly enacted a mandate that health insurers cover telemedicine services.

While many existing services may be performed as telemedicine services, not all will meet BCBSRI’s requirements for payment. This policy is intended to define BCBSRI payment policies and criteria for reimbursement for telemedicine services.

### MEDICAL CRITERIA

Not applicable

### PRIOR AUTHORIZATION

Not applicable

### POLICY STATEMENT

**BlueCHiP for Medicare** (for member residing in a county outside of a Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HPSA) located in a rural census tract

Telemedicine services are reimbursed when all of the following criteria are met:

1. Member is from an originating site located in either a rural HPSA or in a county outside of an MSA as defined by the following:  
*Bureau of Health Professions website at: <https://datavarehouse.brsa.gov/tools/analyzers/geo/Telehealth.aspx>*
2. The patient is present at the time of service.
3. Services must be equivalent or similar to in-person services with a patient.
4. Services are limited to Telemedicine that involves Health Insurance Portability and Accountability Act (HIPAA) compliant secure electronic communication of which both audio and video components are utilized. These services are typically for the purpose of evaluations, follow-up care, or treatment of a specific condition.
5. A permanent record of online communications relevant to the ongoing medical care and follow-up of the patient is maintained as part of the patient’s medical record.
6. The provider’s services must be rendered in one of the following medical/behavioral health locations:
  - Hospital
  - Critical access hospital (CAH)
  - Rural health clinic (RHC)
  - Federally qualified health center (FQHC)

- Hospital-based or critical access hospital-based renal dialysis center (including satellites)
- Skilled nursing facility (SNF)
- Community mental health center (CMHC)
- Provider's office

7. Telemedicine services are limited to the following providers:

- Physician
- Nurse practitioner
- Physician assistant
- Nurse midwife
- Certified Registered Nurse Anesthetist (CRNAs)
- Clinical nurse specialist
- Clinical psychologist
- Clinical social worker
- Registered dietitian or nutrition professional

**BC for Medicare Members (Effective 01 | 01 | 2019) not meeting above requirements and Commercial Products**

Telemedicine services are covered when all of the following criteria are met:

1. The patient is present at the time of service.
  2. Services must be equivalent or similar to in-person services with a patient.
  3. Services must be medically necessary and otherwise covered under the member's benefit booklet or subscriber agreement
  4. Services must be within the provider's scope of license
  5. The extent of any evaluation and management services (E&M) provided over the telemedicine technology is an appropriate substitute for a face-to-face encounter for the service that is being rendered.
  6. Services must involve HIPAA-compliant secure electronic communication, which involves both audio and video components.
  7. A permanent record of online communications relevant to the ongoing medical care and follow-up of the patient must be maintained as part of the patient's medical record.
  8. Telemedicine services are limited to the following providers, which are able to file for E&M services, Behavioral Health Services, or Medical Nutrition Services:
    - Physician
    - Nurse practitioner
    - Physician assistant
    - Nurse Midwife
    - Clinical nurse specialist
    - Psychiatrist
    - Psychologist
    - Clinical social worker
    - Licensed Marriage and Family Therapist (not allowed for BC for Medicare)
    - Licensed Mental Health Counselor (not allowed for BC for Medicare)
    - Registered dietician
7. Only the Provider rendering the services via telemedicine may submit for reimbursement for telemedicine services

## BlueCHiP for Medicare and Commercial Products

The following services are excluded from reimbursement:

- Services rendered by non-secure electronic communication.
- The technical and overhead component of the facility fee associated with telemedicine services. These costs are included in the maximum allowable benefit paid to the professional provider for professional telemedicine Services and are not separately billed or reimbursed.
- Services rendered over the telephone (audio-only), email or by fax.
- Telemedicine that occurs the same day as a face-to-face visit, when performed by the same provider and for the same condition.
- Services that consist of triage solely to assess the appropriate place of service and/or appropriate provider type
- Patient communications incidental to E&M services, including, but not limited to: reporting of test results, or provision of educational materials.
- Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.

## COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for applicable telemedicine services benefits/coverage.

## BACKGROUND

Formally defined, telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. Telemedicine includes a growing variety of applications and services using two-way video, smart phones, wireless tools, and other forms of audio-visual telecommunications technology.

Starting out over 40 years ago with demonstrations of hospitals extending care to patients in remote areas, the use of telemedicine has spread rapidly and is now becoming integrated into the ongoing operations of hospitals, specialty departments, home health agencies, private physician offices, as well as consumers' homes and workplaces.

Telemedicine is not a separate medical specialty. Telemedicine can be provided by an array of physicians and other medical personnel including many different specialists. It is used as a tool to provide better access to patients where a physician may not be available due to such reasons as distance, wait for an appointment, or lack of geographic specialty access.

Effective October 1, 2001, coverage and payment for Medicare telehealth services includes consultation, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system.

Eligible geographic areas include rural HPSAs and counties not classified as an MSA. Additionally, federal telemedicine demonstration projects as of December 31, 2000, may serve as the originating site regardless of geographic location.

For Medicare payment to occur, HIPAA-compliant interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit.

In 2016, the Rhode Island General Assembly enacted the Telemedicine Coverage Act, requiring health insurers to cover telemedicine services in all plans with effective dates of January 1, 2018 or later.

### **§ 27-81-1 Title.**

This act shall be known as, and may be cited as, the "Telemedicine Coverage Act".

### **§ 27-81-2 Purpose.**

The general assembly hereby finds and declares that:

- (1) The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery, cost, and accessibility of health care, particularly in the area of telemedicine.
- (2) Geography, weather, availability of specialists, transportation, and other factors can create barriers to accessing the appropriate health care, including behavioral health care, and one way to provide, ensure, or enhance access to health care given these barriers is through the appropriate use of technology to allow health-care consumers access to qualified health-care providers.
- (3) There is a need in this state to embrace efforts that will encourage health insurers and health-care providers to support the use of telemedicine, and that will also encourage all state agencies to evaluate and amend their policies and rules to remove any regulatory barriers prohibiting the use of telemedicine services.

### **§ 27-81-3 Definitions.**

As used in this chapter:

- (1) "Distant site" means a site at which a health-care provider is located while providing health-care services by means of telemedicine.
- (2) "Health-care facility" means an institution providing health-care services or a health-care setting, including, but not limited to: hospitals and other licensed, inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory and imaging centers; and rehabilitation and other therapeutic-health settings.
- (3) "Health-care professional" means a physician or other health-care practitioner licensed, accredited, or certified to perform specified health-care services consistent with state law.
- (4) "Health-care provider" means a health-care professional or a health-care facility.
- (5) "Health-care services" means any services included in the furnishing to any individual of medical, podiatric, or dental care, or hospitalization, or incident to the furnishing of that care or hospitalization, and the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.
- (6) "Health insurer" means any person, firm, or corporation offering and/or insuring health-care services on a prepaid basis, including, but not limited to, a nonprofit service corporation, a health-maintenance organization, or an entity offering a policy of accident and sickness insurance.
- (7) "Health-maintenance organization" means a health-maintenance organization as defined in chapter 41 of this title.
- (8) "Nonprofit service corporation" means a nonprofit, hospital-service corporation as defined in chapter 19 of this title, or a nonprofit, medical-service corporation as defined in chapter 20 of this title.
- (9) "Originating site" means a site at which a patient is located at the time health-care services are provided to them by means of telemedicine, which can be a patient's home where medically appropriate; provided,

however, notwithstanding any other provision of law, health insurers and health-care providers may agree to alternative siting arrangements deemed appropriate by the parties.

(10) “Policy of accident and sickness insurance” means a policy of accident and sickness insurance as defined in chapter 18 of this title.

(11) “Store-and-forward technology” means the technology used to enable the transmission of a patient's medical information from an originating site to the health-care provider at the distant site without the patient being present.

(12) “Telemedicine” means the delivery of clinical health-care services by means of real time, two-way electronic audiovisual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health-care delivery, which facilitate the assessment, diagnosis, treatment, and care management of a patient's health care while such patient is at an originating site and the health-care provider is at a distant site, consistent with applicable federal laws and regulations. Telemedicine does not include an audio-only telephone conversation, email message, or facsimile transmission between the provider and patient, or an automated computer program used to diagnose and/or treat ocular or refractive conditions.

#### **§ 27-81-4 Coverage of telemedicine services.**

(a) Each health insurer that issues individual or group accident-and-sickness insurance policies for health-care services and/or provides a health-care plan for health-care services shall provide coverage for the cost of such covered health-care services provided through telemedicine services, as provided in this section.

(b) A health insurer shall not exclude a health-care service for coverage solely because the health-care service is provided through telemedicine and is not provided through in-person consultation or contact, so long as such health-care services are medically appropriate to be provided through telemedicine services and, as such, may be subject to the terms and conditions of a telemedicine agreement between the insurer and the participating health-care provider or provider group.

(c) Benefit plans offered by a health insurer may impose a deductible, copayment, or coinsurance requirement for a health-care service provided through telemedicine.

(d) The requirements of this section shall apply to all policies and health plans issued, reissued, or delivered in the state of Rhode Island on and after January 1, 2018.

(e) This chapter shall not apply to: short-term travel, accident-only, limited or specified disease; or individual conversion policies or health plans; nor to policies or health plans designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare; or any other similar coverage under state or federal governmental plans.

#### **§ 27-81-5 Severability.**

If any provision of this chapter or of any rule or regulation made under this chapter, or its application to any person or circumstance is held invalid by a court of competent jurisdiction, the remainder of the chapter, rule, or regulation and the application of the provision to other persons or circumstances shall not be affected by this invalidity. The invalidity of any section or sections or parts of any section or sections shall not affect the validity of the remainder of the chapter.

#### **CODING**

**BlueCHiP for Medicare** (for member residing in a county outside of a Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HPSA) located in a rural census tract

BCBSRI will reimburse for Telemedicine services, which are recognized by CMS when filed with the modifier GT and place of service 02. Any other service reported with that modifier is not recognized by CMS. The service will be provider liability and not reimbursable.

For specific details regarding Telemedicine coverage please refer to the Medicare Benefit Policy Manual The Medicare Claims Processing Manual (Pub.100-04), Chapter 12, §190.3 List of Medicare Telehealth Services at:

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

### **BC for Medicare Members (Effective 01|01|2019) not meeting above requirements and Commercials Products and**

The following codes are covered as telemedicine services when filed with GT modifier and place of service 02 and the telemedicine criteria set forth in this policy are met:

**Place of Service (POS) 02:** Telehealth: The location where health services and health related services are provided or received, through telehealth telecommunication technology.

**Note: Any claim filed with a code NOT listed below with place of service 02 will deny as invalid place of service**

- 90791 Psychiatric diagnostic evaluation
- 90792 Psychiatric diagnostic evaluation with medical services
- 90832 Psychotherapy, 30 minutes with patient
- 90833 Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
- 90834 Psychotherapy, 45 minutes with patient
- 90836 Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
- 90837 Psychotherapy, 60 minutes with patient
- 90838 Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
- 90839 Psychotherapy for crisis; first 60 minutes
- 90840 Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)
- 97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- 97803 Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- 99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
- 99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
- 99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's

- and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
- 99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
- 99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
- 99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
- 99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
- 99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
- 99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
- 99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

## RELATED POLICIES

None

## PUBLISHED

Provider Update, January 2019

Provider Update, February 2018

Provider Update, December 2017

## REFERENCES

1. Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15 § 270 Telehealth Services at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>. (Accessed February 4, 2015)
2. The Medicare Claims Processing Manual (Pub.100-04), Chapter 12, §190.3 List of Medicare Telehealth Services at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>. (Accessed February 4, 2015)
3. Telehealth Services, MLN Matters  
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf>
4. Rhode Island General Laws The Telemedicine Coverage Act  
<http://webserver.rilin.state.ri.us/Statutes/TITLE27/27-81/INDEX.HTM>

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