

Telemedicine Services Professional Payment Policy

Applies to the following Tufts Health Plan products:

- Tufts Health Plan Commercial (including Tufts Health Freedom Plan)¹
- Tufts Medicare Preferred HMO (a Medicare Advantage product)
- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting providers who render telemedicine services for members of Tufts Health Freedom Plan products and Rhode Island-based employer groups.

Effective for dates of service on or after July 1, 2019, this policy will also apply to providers rendering services for members of Massachusetts-based employer groups.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the [Professional Services and Facilities Payment Policy](#).

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

POLICY

Tufts Health Plan covers medically necessary telemedicine services consistent with applicable state mandates² and in accordance with the member's benefit plan document. Some self-insured groups may choose to voluntarily elect to offer coverage.

DEFINITIONS

"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 asynchronous or "store-and-forward" technology (e.g., audio-only telephone conversation, email or fax between the provider and member, or an automated computer program used to diagnose and/or treat ocular or refractive conditions).

Services must be provided by a contracting provider with the member present on the receiving end and must occur in real time. All technology used must meet or exceed HIPAA requirements to maintain privacy.

Note: New Hampshire legislation states that in order to prescribe non-opioid Level II-IV controlled substances via telemedicine, the provider must have an established in-person relationship with the patient.³

GENERAL BENEFIT INFORMATION

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

Visit limits may apply. Coverage is not provided for devices that may be provided to members to assist in interactive communications, including, but not limited to, robotic devices, laptop computers, desktop computers, personal assistive devices (PDAs), tablets, and smartphones, as well as all accessories for multi-purpose general electronic devices and internet and modem connection/access.

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.

² Per N.H. RSA § 415-J:1 and R.I.G.L. § 27-81.

³ Per N.H. RSA § 318-B:2, 329:1-d and 326: B-2

BILLING INSTRUCTIONS

Modifier GT is required and should be appended to all applicable CPT and/or HCPCS procedure code(s). Claims submitted without the GT modifier will deny.

COMPENSATION/REIMBURSEMENT INFORMATION

Telemedicine services are compensated at 80 percent of the in-office rate.

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.

Tufts Health Plan does not routinely compensate for the following:

- Specialist services from the onsite specialist if a same or similar specialist performs the telehealth visit. Services may be subject to a duplicate denial if the same or similar service(s) have already been provided by an onsite provider.
- Telemedicine services associated with G0406-G0408 or G0425-G0427
- Telemedicine services submitted with modifier GQ

ADDITIONAL RESOURCES

- Rhode Island § 27-81: "[The Telemedicine Coverage Act](#)"
- NH RSA, Chapter 415-J: "[New Hampshire Telemedicine Act](#)"

DOCUMENT HISTORY

- May 2019: Combined existing policies for members of Tufts Health Freedom Plan and Commercial Massachusetts-based employer groups; added Commercial Massachusetts-based employer group applicability effective for dates of service on or after July 1, 2019
- September 2018: Updated definition of telemedicine, per New Hampshire HB 1471
- June 2018: Template updates
- April 2018: Policy reviewed by committee; template updates
- March 2018: Removed place of service table
- January 2018: Template update
- January 2017: Template updates
- December 2016: Added new place of service 02 (telehealth) effective January 1, 2017
- August 2016: Added clarification of NH law regarding telemedicine prescription requirements effective June 2016.
- January 2016: Policy created, added compensation change to 80% of in office rate, effective for date of service on or after April 1, 2016.

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure 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, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's [audit policies](#), refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. 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. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLinkSM for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.