If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSNM may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSNM has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Telemedicine and Telehealth Services

Policy Number: CPCP033

Version 12.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: 3/28/2022

Plan Effective Date: 3/28/2022

Description

The Plan recognizes federal and state mandates regarding Telehealth and Telemedicine.

The purpose of the Telemedicine Services and Telehealth Services policy is to provide guidance on payment and coding for services that are provided by an eligible health care professional to a member when neither is present at the same physical location. These services can be performed through various delivery methods.

Term Descriptions:

Health care professional - A physician or an individual who is licensed, certified or authorized in the Plan's state to perform a health care service; and is authorized to perform a telemedicine service or is authorized to assist a provider in performing a telemedicine service that is delegated and supervised by the physician or a licensed or certified health care professional acting within the scope of the license or certification who does not perform the telemedicine service. Note, eligible providers performing telemedicine services must possess the necessary license to treat members of the Plan's state. Licensed providers must meet the health plans definition of eligible provider.

Physician - A person who is licensed to practice medicine in the Plan's state. Note, eligible providers performing telemedicine services must possess the necessary license to treat members of the Plan's state. Licensed providers must meet the health plans definition of eligible provider.

Telehealth service - 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. Typically, telehealth describes provider to provider interaction, or indirect provider to patient interaction.

Telemedicine service - 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.

Delivery Methods:

Interactive electronic telecommunications equipment includes, audio and video equipment permitting two-way, or live video interactive communication between the member and physician or practitioner. Qualified physicians or health care professionals should utilize the appropriate communication service described below depending on the type of service needed and as allowed by state and federal laws.

- **Synchronous:** 2-way, live interactive audio and video communications
- **Asynchronous telecommunication** - Via image and video not provided in real-time (a service is recorded as video or captured as an image; the provider evaluates it later)
    - **Store and forward** - Technology that stores and transmits or grants access to a member's clinical information for review by a health care professional at a different physical location than the person.
    - **Remote Monitoring Services -** Remote monitoring is a service that enables member's health monitoring as well as transfers the health data to an eligible physician or other qualified health care professional.
- Other methods allowed by state and federal laws, which can allow members to connect with physicians while reducing the risk of contagion.

Providers can find the latest guidance on acceptable Health Insurance Portability and Accountability Act (HIPAA) compliant remote technologies issued by the U.S. Department of Health and Human Services' Office for Civil Rights in Action.

Reimbursement Information:

For services appropriately provided through telemedicine, in addition to the requirements applicable to the service being rendered, the following requirements must be met for eligible reimbursement unless otherwise agreed upon:

- The provider must maintain complete and accurate medical records including but not limited to start and end times of the telemedicine service or telehealth service; Method of communication must be documented.
- Ensure HIPAA compliant and federal and state privacy laws are implemented for member communications, recordings and member's records.
- Qualified providers providing telemedicine services must possess the necessary license to treat members of the Plan's state.

Note: Our self-funded employer group customers make decisions for their employee benefit plans. Check eligibility and benefits for any variations in member benefit plans.

Billing/Coding:

Modifiers

Modifiers **G0**, **GT**, **GQ** and **95** are used to describe a telemedicine service and telehealth service. The appropriate modifiers must be appended to the HCPCS or CPT code when the telehealth or telemedicine claims are submitted.

Note: If a claim is submitted using a telemedicine procedure code, the modifier is not necessary. Only codes that are not traditional telemedicine procedure codes require the modifier. Additionally, modifier G0 will only be accepted by the Plan when modifier GQ, GT and/or 95 are appended to the service.

Modifier G0: Telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke.
Modifier GT: Via interactive audio and video telecommunications system
Modifier GQ: Via asynchronous telecommunications system.
Modifier 95: Synchronous telemedicine services rendered via real-time interactive audio and video telecommunications system. Modifier 95 is applicable to certain codes that can be found in AMA, CPT documents. Check current CPT documents for the appendix on **CPT Codes That May Be Used for Synchronous Telemedicine Services**. These procedures codes are billed when electronic communication using interactive telecommunications equipment include, at a minimum, audio and video. In addition, codes that are appropriate for use with modifier 95 are indicated with a star (★) throughout the AMA, CPT codebook.

Place of Service (POS) Codes

Telehealth or telemedicine professional claims submitted on a CMS 1500 form must be submitted with Place of Service (POS) Code '**02**'. POS 02 does **not** apply to originating site facilities when billing a facility fee.

***NOTE:** Providers should continue to use POS 02 in place of POS 10 even when telehealth is provided in a member's home. Providers should check the Plan's website for updates on when the Plan will begin accepting POS 10.

Place of Service (POS) Code 02 (Telehealth Provided Other than in Patient's Home): 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.
***Place of Service (POS) Code 10 (Telehealth Provided in Patient's Home):** The location where health services and health related services are provided or received, through telecommunications 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 telecommunications technology.

The following is used to determine eligibility for HCPCS Q3014 ***"Telehealth originating site facility fee"***:

- Appropriate billing of Q3014 (To transmit data between providers): The provider who is supplying the room and telecommunication equipment would bill Q3014
- Patient visits their PCP's office and the PCP helps to initiate a telehealth appointment with a specialist located in another office location.
- PCP's office can submit **Q3014 – Telehealth originating site facility fee** for physically hosting the patient.
- The specialist located in another office location may not bill code Q3014 since they aren't the originating site.

Inappropriate billing of Q3014 (Not to be used for virtual visits or use of equipment for those purposes):

- Patient is in their home and initiates telehealth visit with their PCP.
- Since the PCP is not physically hosting the patient, they cannot bill **Q3014 – Telehealth originating site facility fee** as the patient is not present at their facility.
- The PCP is acting as a "distant site provider" to the patient who is at home.

Codes referenced in this policy do not guarantee reimbursement for claims. Providers must follow all Plan rules regarding reimbursement.

The plan reserves the right to request supporting documentation. Claim(s) that do not adhere to coding and billing guidelines may be denied. Claims may be reviewed on a case-by-case basis.

For additional information on telemedicine services or telehealth services or procedures, please check the Plan's website or contact your Network Management Office.

References:

registered trademark of the AMA.

Centers for Medicare and Medicaid Services (CMS) permanent telemedicine codes and/or the American Medical Association (AMA) telemedicine codes may be eligible for coverage.

www.cms.gov

Policy Update History:

Approval Date	Description
11/9/2020	New policy
12/24/2020	CMS footnote added
02/04/2021	Annual Review, added IOP coverage
03/18/2021	Temporary expanded coverage of telemedicine services effective 1/1/2021 to 12/31/21, language update
3/28/2022	Annual review, updated state specific verbiage, extended coverage date
Correction date 4/27/2022	Correction made to effective date of 3/28/2022