Manual:	Reimbursement Policy		
Policy Title:	**Telehealth And Telemedicine**		
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COVID-19 Update

Due to the COVID-19 public health emergency (PHE) this policy has been temporarily supplemented by RPM073, "Telehealth and Telemedicine Expanded Services for COVID-19." which can be viewed here on our provider website.

- RPM073 outlines Moda Health's temporarily expanded telehealth coverage and changes for all lines of business. It will be updated as further information and changes develop.

- Please continue to use this policy for more extensive and in-depth telehealth topics. Examples include but are not limited to:
  - Definitions of specific telehealth terminology.
  - Use of modifier G0.
  - Services which are included in the telehealth service and may not be separately billed.

Scope

This policy applies to Oregon insured Commercial medical benefit plans, any ASO plans which adopt the Oregon telehealth mandate, Alaska group and individual medical plans issued or renewing 10/1/2016 and after, any Alaska ASO plans which adopt the Alaska telehealth mandate, Medicare Advantage plans, and Oregon Medicaid plans.

The policy applies to professional and other qualified healthcare professionals and facilities providing telemedicine services to a member on one of our plans.

This policy does not apply to:

- Dental-only plans.
- Vision-only plans.

This policy is intended to define telehealth and telemedicine terminology for our company, plans, and claims, provide clarification of which services are and are not eligible for reimbursement, and specify the criteria and requirements which must be met.

Reimbursement Guidelines

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A. All Lines of Business, New Patient versus Established Patient Determinations

1. Telemedicine visit services are performed as the remote/technology equivalent of an in-person service.
2. Telemedicine services count the same as an in-office visit for the purposes of determining if the patient is a new patient or an established patient when they are receiving future visits and services.
3. If a provider is seeing a new patient for the first time via telemedicine using audio/video capabilities, select and report the appropriate new patient E/M code with POS 02 for the telemedicine visit (and any telemedicine modifier if needed).
4. If for some reason a new patient E/M code is not reported for that initial telemedicine visit, the patient is still considered an established patient for the next visit and any future E/M visits which occur in person.

B. Commercial Oregon plans

Moda Health Oregon Commercial plans comply with OR SB 144 / ORS 743A.058 and ORS 743A.185.

1. Telemedicine services are eligible for reimbursement when:
   - The billed services must be within the provider's scope of license.
   - The billed services are a covered benefit under the member's plan.
   - The services can be safely and effectively performed as a telemedicine service.
   - Any applicable Medical Necessity Criteria are met.
   - Oregon licensed providers can provide telemedicine services to Oregon residents while the provider is out-of-state.

- The billing and coding guidelines in this policy are met.

  Note: CMS originating site (patient location) restrictions and geographic restrictions do not apply to Oregon Commercial plans.

2. Telemedicine services are not eligible for reimbursement when:
   - Email/online written communication only is used.
     - These are not considered "telemedicine services" and are not a covered benefit on our standard plans.
     - Exception: If the member's plan has a specific benefit addressing coverage for email or online communication.
   - The service is not covered under the member's plan.
   - Other criteria in # 1 are not met.

3. Telemedicine services performed by non-contracted providers will be eligible for available benefits at the member's out-of-network benefit level.

4. Billing and Coding Guidelines:
   a. Report the primary service(s) using the appropriate CPT or HCPCS code(s) for the professional service(s) performed.
      1) Report with place of service (POS) 02. (MLN[12], CMS[13])
      2) Append modifier GQ, modifier 95, or modifier GT to the procedure code to indicate the type of transmission technology used. Only one of these modifiers may be used per line item. Using more than one of these modifiers on the same line item will result in a denial for incorrect combination of modifiers.
      3) Use modifier G0 (G Zero) for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (MLN[17])
      4) Do not submit a telemedicine service or evaluation with CPT code 99499 (Unlisted evaluation and management service).
   b. Online evaluation and management service procedure codes include description wording of "… provided to an *established patient…"* or *"…for an established patient…"*
      1) Procedure codes 99444 *(DOS 2019 & prior)* or 99421-99423 *(DOS 1/1/2020 & following)* are used by providers in two distinct ways; to report:
         i. An audio/video real-time interactive telemedicine visit handled via a secure internet connection or app.
            a) This would be a telemedicine visit eligible for coverage if all criteria is met.
            b) Moda's guidelines instruct to report this service with the appropriate E/M procedure code and POS 02. However, some clinics are reporting with 99444 or 99421-99423 and cite their own internal policies.
         ii. A provider-patient exchange by written communication only online (e.g. email or private messaging), which is only a covered benefit for a few non-standard plans.

2) No matter if 99444 or 99421-99423 represent an email/written exchange or a real-time audio/visual internet visit, the code definitions for CPT codes 99444 or 99421-99423 require that the patient be an established patient.
   i. Codes 99444 or 99421-99423 may not be used to report a telemedicine visit to a new patient. Use the appropriate new patient E/M code with POS 02.
   ii. If 99444 or 99421-99423 are reported for a new patient member (with no previous billed services within the past 3 years), a clinical edit denial will be generated.
      a) A corrected claim will be needed.
      b) If the member is an established patient but previous services occurred before the member became effective on the Moda plan, submit a brief cover letter with explanation and attached medical record documentation and request a reconsideration using the provider inquiry/appeal process.

c. Originating site fee –
   1) An originating site fee may not be billed when the patient is located at home or at a self-service kiosk.
   2) The originating site (office or facility where the patient was located at the time of the telemedicine professional service) may submit an originating site facility fee for telemedicine services with HCPCS code Q3014 and one unit per provider of telemedicine services.
      a) Per Medically Unlikely Edits (MUE) unit limits for Q3014, Moda Health will reimburse a maximum of one unit per date of service to a professional provider or clinic, and a maximum of two units per date of service for facilities.
      b) The originating site fee (Q3014) may not be billed by the same provider or on the same claim as the telemedicine visit services performed by the provider at the distant site (where the patient is not located). Even if both office locations are within a large system of multi-location clinics or facilities and even if they share the same TIN, services where the patient is located (Q3014) and services where the patient is not located (e.g. 99213-GT/POS 02 or 99213-95/POS 02) need to be submitted under separate claims with separate NPIs and separate service addresses.
      c) A provider may do a face-to-face E/M, and then also be the originating site (space and equipment) for the patient to have a telemedicine visit with a second provider at another location, when a different specialty or more advanced care is needed. Both the face-to-face E/M visit and the Q3014 will be eligible for reimbursement.
      d) Moda Health does not reimburse for Q3014 for audio + visual telemedicine services utilizing ordinary non-secure smart phone or internet video phone call technology (e.g. Skype, FaceTime, etc.), applications, etcetera. These services are not HIPAA-compliant for a telemedicine service/PHI.

e) The originating site should keep a written record of the telemedicine session in the member's medical record, just as for any other patient service. The documentation should include the date, time, and duration of session; technology and equipment used; staff members present (name and licensure) at originating site; name, licensure, specialty, and location of the telemedicine provider at distant site; and reason for the telemedicine service.
f) The telemedicine session record must be provided for review upon request to substantiate the originating site facility fee.
g) Moda Health does not reimburse for T1014 (Telehealth transmission, per minute, professional services bill separately). T1014 is a HCPCS code specific to Medicaid services.

d. Telemedicine services are not reimbursed for the following:
   1) Telemedicine that occurs the same day as an in-person visit, when performed by the same provider.
   2) Online medical evaluations for evaluation and management services.
   3) Patient communications incidental to E/M, counseling, or other covered medical services, including, but not limited to:
      a) Reporting of test results.
      b) Further discussion of symptoms or care.
      c) Provision of educational materials.

e. Some services (such as home cardiac event monitoring) are routinely performed using asynchronous telecommunications technology, and do not normally involve face-to-face provider contact. These services do not need to be submitted with modifier GQ. See # 8 below for more information.

5. Telemedicine services include the following items which are not eligible to be separately billed or reimbursed:

   a. Pre-service activities include, but are not be limited to:
      1) Reviewing patient data (for example, diagnostic and/or imaging studies, interim lab work).
      2) Communicating with other professionals.
      3) Communicating with the family and/or further with the patient as needed.

   b. Intra-service activities include, but are not be limited to, the key elements for each procedure code.

   c. Post-service activities include, but are not limited to:
      1) Completing medical records or other documentation.
      2) Communicating results of the service and further care plans to other health care professionals.

6. Specific types of providers who are eligible to perform telemedicine services include but are not limited to the following:
    - Physician (MD, DO)
    - Naturopathic physicians (ND)
    - Nurse practitioner (NP)
    - Physician assistant (PA)
    - Certified Nurse-midwife (CNM)
    - Nurse Practitioner Midwife (NPM)
    - Clinical nurse specialist (CNS), Registered Nurse Clinical Specialist (RNCS)
    - Certified registered nurse anesthetist (CRNA), for pain management services only.
    - Clinical psychologists (CP, LCP, PhD.) *(See Coding Guidelines and MLN[5] for code restrictions.)*
    - Clinical social worker (LCSW, CSW) *(See Coding Guidelines and MLN[5] for code restrictions.)*
    - Board Certified Behavior Analyst (BCBA)
    - Other contracted mental health or chemical dependency providers
    - Registered dietitian (RD)
    - Speech Therapists, Speech-Language Pathologists (SLP).
    - Optometrists. (ORS[16])
    - Other provider types who meet the requirements in section A.1.

7. Providers are expected to:
    - Verify the member's identity and eligibility.
    - Ensure that all data transmission and recording is secure and HIPAA-compliant.
    - Comply with all state and federal laws governing privacy and security of protected health information (PHI), including laws in the state where the patient is located.
    - Utilize and follow community standards, best practices, prevailing technology, etc. for recording consent, security, encryption, transmission, storage, and storage disclosure.
    - Document the service in the patient's record in the same manner as if it were performed in-person. The written record is in addition to any stored recording of the data transmission of the service.
        - Include additional notations indicating the service was performed as a telemedicine service and document any relevant impacts this had on the encounter or service.
        - Specify the type of transmission utilized (e.g. real-time or delayed, telephonic, audio + video, encrypted transmission of diagnostic test data, etc.).
        - Identify and note participation of any additional staff present at the member's location to assist with the telemedicine service.
        - The medical record must be available and provided to the health plan upon request for review at any time (pre-payment or post-payment).

- Care provided via telemedicine will be evaluated according to the clinical standard of care applicable to the relevant area of specialty for more traditional in-person medical care (e.g. pertinent physical exam findings, etc.). Additionally, telemedicine providers are expected to adhere to current standards for practice improvement and monitoring of outcomes.
- For ESRD-related services, a physician, NP, PA, or CNS must furnish at least one "hands on" in-person visit (not telehealth) each month to examine the vascular access site.

8. Services are eligible to be covered as telemedicine services if they are a covered benefit when performed in-person and can be safely and effectively performed as a telemedicine service. Examples include but are not limited to:
   - Treatment of diabetes and/or Diabetes Self-Management Training (DSMT) (individual, or group).
   - Most evaluation and management (E/M) services are eligible to be performed as telemedicine services.
   - Most behavioral health services are eligible to be performed as telemedicine services.
   - Medical nutrition therapy assessment, individual, or group.
   - Other covered condition-specific assessments or patient education (mandated benefits or verify each member's plan benefits).

9. Services not eligible to be performed as telemedicine services (common examples, list not all-inclusive):

Service	**Why not eligible for telemedicine**
Anesthesia services	Requires member and provider to be in the same physical location to be performed safely and effectively.
Consultation between two physicians or providers	Does not require the presence of the patient for an in-person service.
Laboratory tests	Not performed as an in-person service.
Radiology interpretation and report services	Not performed as an in-person service.
Surgery	Requires member and provider to be in the same physical location to be performed safely and effectively.
Telephone calls with member(s).	When/if covered, a telephone call is not considered a telemedicine service, as telephone calls have always supplemented face-to-face services, and do not include video interaction.

10. Services not considered covered telemedicine services, but which may be otherwise covered as non-telemedicine services.

Some professional services do not require the patient to be present in-person with the practitioner when they are furnished and are commonly furnished using some form of telecommunications technology. These services are part of the broader scope of telehealth, but are not considered *telemedicine* service(s), and do not need to be reported with modifier GQ to signify asynchronous technology was used. They are processed as usual under the member's benefits and reimbursed under the usual fee schedule.

Examples of such services include:

- Real-time remote intraoperative neurophysiologic monitoring.
- Radiology interpretations. Claims should be billed with modifier 26.
- Home cardiac event monitoring.
    - May utilize real-time or asynchronous transmission technology.
    - Duration of monitoring and monitor technology utilized must be documented, as proper code selection relies on a combination of both factors.

Beginning in 2017, the current CPT book Appendix P includes some procedure codes of this nature. Modifier 95 will be considered valid for these codes (based upon the CPT book information only), but modifier GT and GQ will not be considered valid for these procedure codes.

Code	Code Definition
92227	Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional
93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional

Code	Code Definition
93268	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional
93270	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection)
93271	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis
93272	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional
93298	Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results

11. Services and activities not considered telemedicine services which are not eligible to be separately reported:
    - Sending e-mail, facsimile transmission, secure messaging, etc. to another provider, office, or facility containing clinical information.
    - Installation or maintenance of any telecommunication devices or systems to support telemedicine services.
    - Home health or safety monitoring (e.g. Medical Guardian Alert, VueZone, QuietCare Plus, LifeFone).
    - Advice-nurse lines, poison center, or other "health line" type services provided by nurses and other non-physician, non-nurse practitioner providers.
    - Triage to assess the appropriate place of service and/or appropriate provider type to render needed care.
    - Administrative services, 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.

C. Commercial Alaska plans

Moda Health Alaska Commercial plans comply with Alaska Statute 21.42.422.

1. Telemedicine services are eligible for reimbursement when:
   a. The billing provider is licensed in the state of Alaska. Billing providers outside the state of Alaska need to be registered with the Alaska telemedicine business registry.
   b. The billed services are a covered benefit under the member's plan.
   c. The services can be safely and effectively performed as a telemedicine service.
   d. Any applicable Medical Necessity Criteria are met.
   e. The billing and coding guidelines in this policy are met.
   f. Synchronous two-way interactive audio + video (A/V) conferencing is used.
      i. The A/V conferencing the application and technology used meet all state and federal standards for privacy and security of protected health information (HIPAA).
      ii. The billing provider is responsible to ensure these HIPAA privacy protection standards are met.
   g. The same benefit cost-sharing (deductible, copayment, co-insurance) applies to the telemedicine service as would apply if the service were performed in person.
   h. Effective for dates of service March 17, 2020 and following, telehealth services may be provided to new patients; there is no requirement for the provider and the member to have had prior contact in person before the telehealth service.
   i. Effective for dates of service March 17, 2020 and following, telephone visits and online medical evaluations for evaluation and management services are covered benefits for Alaska plans.

      Note: CMS originating site (patient location) restrictions and geographic restrictions <u>do not apply to Alaska Commercial plans.</u>

2. Telemedicine services are not eligible for reimbursement when:
   a. The provider is not either licensed in the state of Alaska or registered with the Alaska telemedicine business registry.
   b. Asynchronous transmission is used (time-delay).
   c. Audio-only conferencing or audio-web conferencing without person-to-person video abilities is used.
   d. Other criteria in # 1 are not met.

3. Billing and Coding Guidelines:

   a. <u>Report the primary service(s)</u> using the appropriate CPT or HCPCS code(s) for the professional service(s) performed.
      1) Report with place of service 02. (MLN[12], CMS[13]) Do not report with POS 99 (Other place of service not identified above).
      2) Append modifier GQ, modifier 95, or modifier GT to the procedure code to indicate the type of transmission technology used.

3) Use modifier G0 (G Zero) for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (MLN[17])
4) Do not submit a telemedicine service or evaluation with CPT code 99499 (Unlisted evaluation and management service).
5) CPT codes 99444 and 99421-99423 all have descriptions which require that the patient be an established patient. Codes 99444 and/or 99421-99423 may not be used to report a telemedicine visit to a new patient. Use the appropriate new patient E/M code with POS 02.

b. Originating site fee –
1) An originating site fee may not be billed when the patient is located at home or at a self-service kiosk.
2) The originating site (office or facility where the patient was located at the time of the telemedicine professional service) may submit an originating site facility fee for telemedicine services with HCPCS code Q3014 and one unit per provider of telemedicine services.
   a) Per Medically Unlikely Edits (MUE) unit limits for Q3014, Moda Health will reimburse a maximum of one unit per date of service to a professional provider or clinic, and a maximum of two units per date of service for facilities.
   b) The originating site fee (Q3014) may not be billed by the same provider or on the same claim as the telemedicine visit services performed by the provider at the distant site (where the patient is not located). Even if both office locations are within a large system of multi-location clinics or facilities and even if they share the same TIN, services where the patient is located (Q3014) and services where the patient is not located (e.g. 99213-95/POS 02 or 99213-GT/POS 02) need to be submitted under separate claims with separate NPIs and separate service addresses.
   c) A provider may do a face-to-face E/M, and then also be the originating site (space and equipment) for the patient to have a telemedicine visit with a second provider at another location, when a different specialty or more advanced care is needed. Both the face-to-face E/M visit and the Q3014 will be eligible for reimbursement.
   d) Moda Health does not reimburse for Q3014 for audio + visual telemedicine services utilizing ordinary non-secure smart phone or internet video phone call technology (e.g. Skype, FaceTime, etc.), applications, etcetera. These services are not HIPAA-compliant for a telemedicine service/PHI.
   e) The originating site should keep a written record of the telemedicine session in the member's medical record, just as for any other patient service. The documentation should include the date, time, and duration of session; technology and equipment used; staff members present (name and licensure) at originating site; name, licensure, specialty, and location of the telemedicine provider at distant site; and reason for the telemedicine service.

f) The telemedicine session record must be provided for review upon request to substantiate the originating site facility fee.
g) Moda Health does not reimburse for T1014 (Telehealth transmission, per minute, professional services bill separately). T1014 is a HCPCS code specific to Medicaid services.

c. Telemedicine services are not reimbursed for the following:
   1) Telemedicine that occurs the same day as an in-person visit, when performed by the same provider.
   2) Patient communications incidental to E/M, counseling, or other covered medical services, including, but not limited to:
      a) Reporting of test results.
      b) Further discussion of symptoms or care.
      c) Provision of educational materials.

d. Some services (such as home cardiac event monitoring) are routinely performed using asynchronous telecommunications technology, and do not normally involve face-to-face provider contact. These services do not need to be submitted with modifier GQ. See # 8 below for more information.

4. Telemedicine services include the following items which are not eligible to be separately billed or reimbursed:

   a. Pre-service activities include, but are not be limited to:
      1) Reviewing patient data (for example, diagnostic and/or imaging studies, interim lab work).
      2) Communicating with other professionals.
      3) Communicating with the family and/or further with the patient as needed.

   b. Intra-service activities include, but are not be limited to, the key elements for each procedure code.

   c. Post-service activities include, but are not be limited to:
      1) Completing medical records or other documentation.
      2) Communicating results of the service and further care plans to other health care professionals.

5. Providers are expected to:
   a. Verify the member's identity and eligibility.
   b. Ensure that all data transmission and recording is secure and HIPAA-compliant.
   c. Comply with all state and federal laws governing privacy and security of protected health information (PHI), including laws in the state where the patient is located.
   d. Utilize and follow community standards, best practices, prevailing technology, etc. for recording consent, security, encryption, transmission, storage, and storage disclosure.

e. Document the service in the patient's record in the same manner as if it were performed in-person. The written record is in addition to any stored recording of the data transmission of the service.
    1) Include additional notations indicating the service was performed as a telemedicine service and document any relevant impacts this had on the encounter or service.
    2) Specify the type of transmission utilized (e.g. real-time or delayed, telephonic, audio + video, encrypted transmission of diagnostic test data, etc.).
    3) Identify and note participation of any additional staff present at the member's location to assist with the telemedicine service.
    4) The medical record must be available and provided to the health plan upon request for review at any time (pre-payment or post-payment).
f. Care provided via telemedicine will be evaluated according to the standard of care applicable to the relevant area of specialty for more traditional in-person medical care. Additionally, telemedicine providers are expected to adhere to current standards for practice improvement and monitoring of outcomes.

6. Services and activities not considered telemedicine services which are not eligible to be separately reported:
    a. Sending e-mail, facsimile transmission, secure messaging, etc. containing clinical information.
    b. Installation or maintenance of any telecommunication devices or systems to support telemedicine services.
    c. Home health or safety monitoring (e.g. Medical Guardian Alert, VueZone, QuietCare Plus, LifeFone).
    d. Advice-nurse lines, poison center, or other "health line" type services provided by nurses and other non-physician, non-nurse practitioner providers.
    e. Triage to assess the appropriate place of service and/or appropriate provider type to render needed care.
    f. Administrative services, 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.

D. Moda Health Medicare Advantage plans

1. CMS covers a limited number of Part B telemedicine services furnished by a physician or practitioner to an eligible beneficiary when specific criteria are met.
2. Moda Health Medicare Advantage plans follow CMS telemedicine guidelines and requirements.
    a. Services must be provided using real-time, interactive audio and video telecommunications system.

The physician/provider and the beneficiary/member are in different locations. They must be able to both see and hear each other and talk to each other without any time-delay or lag.

b. Moda Health Medicare Advantage plans do not participate in the Federal telemedicine demonstration programs in Alaska or Hawaii for the use of asynchronous "store and forward" technology for telemedicine services. Services billed with modifier GQ are denied to provider write-off.

c. Specific locations must be used.

   i. The member must be in a geographic location designated by CMS as a qualifying rural area.

   ii. While receiving telemedicine services, the member must be located at one of the following Medicare-approved "originating sites" (MLN[5]):
      1) Physician or practitioner's office
      2) Hospital
      3) Critical Access Hospital (CAH)
      4) Rural Health Clinic (RHC)
      5) Federally Qualified Health Center (FQHC)
      6) Hospital-based or CAH-based Renal Dialysis Center (including satellites)
      7) Skilled Nursing Facility (SNF)
      8) Community Mental Health Center (CMHC)
      9) Renal Dialysis Facility
      10) Home of beneficiaries with End-Stage Renal Disease (ESRD) receiving home dialysis
      11) Mobile Stroke Units
      12) Beginning date of service July 1, 2019: Home of beneficiaries receiving treatment of a substance use disorder or a co-occurring mental health disorder.

d. The following types of providers are defined by CMS as eligible to perform and receive reimbursement for covered telemedicine services (subject to state law and scope of license restrictions) (MLN[5]):
   i. Physicians
   ii. Nurse practitioners (NPs)
   iii. Physician assistants (PAs)
   iv. Nurse-midwives (CNMs)
   v. Clinical nurse specialists (CNSs)
   vi. Certified registered nurse anesthetists
   vii. Clinical psychologists (CPs) and clinical social workers (CSWs).

      Note: CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.

viii. Registered dietitians or nutrition professionals.

e. The services provided must otherwise be a benefit under the Medicare Advantage plan. Any benefit periods, limitations, or quantities exhausted will apply.

f. The services must be on the list of Medicare-approved telemedicine procedure codes applicable for the date of service year.
   i. Medicare publishes a list of procedure codes approved for telemedicine/telehealth services which is updated annually and effective for the calendar year.
      1) This list of codes is available for download on the CMS website and is published in the MedLearn Matters Telehealth Services Fact Sheet annual update.
      2) Covered telemedicine procedure codes must be submitted with place of service 02. The use telehealth POS 02 certifies that the service meets the telehealth requirements. (CMS[14])
      3) The rules for modifier GT have changed for Medicare Advantage claims.
         a) For distant site services billed under Critical Access Hospital (CAH) method II on institutional claims, the GT modifier will still be required. (CMS[14])
         b) For non-CAH facilities with dates of service January 1, 2017 through September 30, 2018, the optional use of modifier GT will not result in denial as an inappropriate modifier.
         c) For non-CAH facilities with dates of service October 1, 2018 and following, claims billed with modifier GT will be denied to provider liability. (CMS15) Per CMS, for dates of service October 1, 2018 and following, modifier GT is only allowed on institutional claims billed under CAH Method II billing. (CMSX)
         d) For professional claims, POS 02 is sufficient; modifier GT is not required. There is currently no known CMS guidance to deny professional claims submitted with modifier GT, however Moda Health requests modifier GT no longer be used on Medicare Advantage non-CAH professional claims.
      4) The GQ modifier is still required when applicable.
      5) Do not use modifier 95 for Medicare Advantage telemedicine services.
      6) Use modifier G0 (G Zero) for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (MLN[17])
   ii. Services not on the list of approved CMS telemedicine procedure codes will not be allowed as telemedicine services under Moda Health Medicare Advantage plans.
   iii. Non-covered telemedicine services (those which do not meet Medicare requirements for any reason) will be denied to provider liability. See RPM036 for pre-service requirements to seek any payment. (Moda [B])

3. PHE impacts.
    a. During the PHE, CMS was authorized to waive or modify telehealth payment requirements on an interim basis through emergency rulemaking, waivers, and flexibilities. For further information on these PHE flexibilities, see RPM073, "Telehealth and Telemedicine Expanded Services for COVID-19." (Moda[C])
    b. At the conclusion of the PHE for COVID-19, these waivers and interim policies will expire, and payment for Medicare telehealth services will once again be limited by the previous requirements. However, to avoid abruptly eliminating the full range of expanded telehealth services available during the PHE and potentially jeopardizing member access to telemedicine services that have been clinically beneficial, CMS: (CMS[18], CMS[19])
        i. Has identified a subset of procedure codes from the temporary PHE expansion list which will remain on the Medicare telehealth services list for an additional period through the end of the calendar year in which the PHE for COVID-19 ends.
        ii. Is adding a provision to the Medicare telehealth services list for a new category of codes, "Category 3."
            1) Codes will be added to Category 3 on a temporary, provisional basis while additional evidence is gathered for possible permanent addition to the Medicare telehealth services list.
            2) Procedure codes added as part of the temporary PHE expansion list will be considered for Category 3 provisional status.
            3) Adding services to the Medicare telehealth services list on a Category 3 basis will give the public the opportunity to gather data and generate requests to add certain services to the Medicare telehealth services list permanently, which would then be adjudicated on a Category 1 or Category 2 basis during future PFS annual rulemaking, while maintaining access during the study and research process.
    c. At the conclusion of the PHE for COVID-19, there will be no separate payment for audio-only E/M visit codes (99441 – 99443). These procedure codes will be assigned a status of "bundled," although RUC-recommended RVU values will be posted for informational purposes.

E. Oregon Medicaid plans

Moda Health Medicaid plans cover telemedicine services to an eligible beneficiary when specific criteria are met. The CMS Medicare/Medicaid Telemedicine requirements are followed.

1. Services must be provided using real-time, interactive audio and video telecommunications system.

   The physician/provider and the beneficiary/member are in different locations. They must be able to both see and hear each other and talk to each other without any time-delay or lag.

2. Moda Health Medicaid plans do not cover telemedicine services performed using asynchronous "store and forward" technology. Services billed with modifier GQ are denied to provider write-off.

3. Specific locations must be used. The member must be located at one of the following Medicare-approved "originating sites" (MLN[5]):
   a. Physician or practitioner's office
   b. Hospital
   c. Critical Access Hospital (CAH)
   d. Rural Health Clinic (RHC)
   e. Federally Qualified Health Center (FQHC)
   f. Hospital-based or CAH-based Renal Dialysis Center (including satellites)
   g. Skilled Nursing Facility (SNF)
   h. Community Mental Health Center (CMHC)

4. The following types of providers are defined by CMS as eligible to perform and receive reimbursement for covered telemedicine services (subject to state law and scope of license restrictions) (MLN[5]):
   a. Physicians
   b. Nurse practitioners (NPs)
   c. Physician assistants (PAs)
   d. Nurse-midwives (CNMs)
   e. Clinical nurse specialists (CNSs)
   f. Certified registered nurse anesthetists
   g. Clinical psychologists (CPs) and clinical social workers (CSWs).

      Note: CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.

   h. Registered dietitians or nutrition professionals.

5. The provider may be contracted with Moda Health Community Health, Inc. on behalf of EOCCO or out of network.

6. The provider may be located outside of the state of Oregon.

7. The services provided must otherwise be a benefit under the Medicaid plan. Any benefit periods, limitations, or quantities exhausted will apply.
8. The services must be either:
    a. On the list of Medicare-approved telemedicine procedure codes applicable for the date of service year.
        i. Medicare publishes a list of procedure codes approved for telemedicine/telehealth services which is updated annually and effective for the calendar year.
            1) This list of codes is available for download on the CMS website and is published in the MedLearn Matters Telehealth Services Fact Sheet annual update.
            2) Covered telemedicine procedure codes must be submitted with place of service 02. The use telehealth POS 02 certifies that the service meets the telehealth requirements. (CMS[14])
            3) The use of modifier GT is optional and no longer required for Moda Health Medicaid claims. POS 02 is sufficient.
            4) The GQ modifier is still required when applicable.
            5) Do not use modifier 95 for Moda Health Medicaid telemedicine services.
            6) Use modifier G0 (G Zero) for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (MLN[17])
        ii. Services not on the list of approved CMS telemedicine procedure codes will not be allowed as telemedicine services under Moda Health Medicaid plans.
    b. On the OHA Behavioral Health fee schedule with modifier GT listed as appropriate. This applies for procedure codes in any Service Type category on the Behavioral Health fee schedule. See https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx .

Codes, Terms, and Definitions

Acronyms Defined

Acronym		Definition
ASO	=	Administrative Services Only
ATA	=	American Telemedicine Association
CAH	=	Critical Access Hospital
CMHC	=	Community Mental Health Center
CMS	=	Centers for Medicare and Medicaid Services
DSMT	=	Diabetes self-management training
E/M	=	Evaluation and management (service)

Acronym		Definition
ESRD	=	End-stage renal disease
FQHC	=	Federally Qualified Health Center
HealthIT.gov	=	A federal government resource website maintained by ONC.
HHS	=	U.S. Department of Health and Human Services
HIPAA	=	Health Insurance Portability and Accountability Act
HITECH	=	Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009
NPI	=	National Provider Identifier
NRTRC	=	Northwest Regional Telehealth Resource Center
ONC	=	Office of the National Coordinator for Health Information Technology (ONC)
PHI	=	Protected Health Information
POS	=	Place of Service
RHC	=	Rural Health Clinic
RPM	=	Remote patient monitoring
RPM	=	Reimbursement Policy Manual (e.g. in context of “RPM052” policy number, etc.)
SBIRT	=	Screening, Brief Intervention and Referral to Treatment
SNF	=	Skilled Nursing Facility
TIN	=	Tax ID Number
VoIP	=	Voice over Internet Protocol

Definition of Terms

Sorting-out "Tele-" Terminology	
Term	**Definition**

Telehealth	Telehealth is the use of technology to deliver health care, health information or health education at a distance. Telehealth is a broad term that includes:
	• Telemedicine clinical services
	• Other clinical services. Examples include:
	  ○ Provider-to-provider consultations which are not face-to-face
	  ○ Remote patient monitoring
	  ○ Remote patient health education (e.g. webinars on specific health issues), prescribed or voluntary.
	• Non-clinical services. Examples include:
	  ○ Physician teleconference about new best practices in treating angina
	  ○ Provider training (medical students or licensed staff)
	  ○ Administrative meetings
	  ○ Continuing medical education
	• Technology –
	  ○ Audio plus video
	  ○ Audio-only (telephone)
	  ○ Data-only (remote intraoperative monitoring)
	  ○ Audio plus data or webinar, no person-to-person video
	  ○ Instant messaging
	  ○ Email contact
	• Timing –
	  ○ Immediate, real-time, interactive exchanges.
	  ○ Delayed data transmission and/or delayed interpretation and results.
	"Telehealth is different from telemedicine because it refers to a *broader scope of remote healthcare services* than telemedicine." (ONC/HealthIT.gov[1])

Sorting-out "Tele-" Terminology	
Term	**Definition**
Telemedicine	Remote clinical services which are typically or traditionally delivered in-person with the provider and patient in the same location. Telemedicine services are delivered via technology because the patient and the provider are in two different locations (remote services). **Note 1 (Commercial plans):** Services performed via synchronous two-way interactive audio + video secure conferencing by a contracted provider are considered ***covered*** telemedicine services eligible for reimbursement, when all other requirements are met. Services performed by a non-contracted provider or by contracted providers via asynchronous technology are ***not considered covered*** telemedicine services and are not eligible for reimbursement under a Moda Health Commercial plan. **Note 2 (Medicare Advantage plans):** Medicare and Medicaid (CMS) considers Telemedicine to **only** include: Remote, face-to-face clinical services with real-time, two-way, interactive communication using both audio and video transmission. (CMS[2, 3]) This CMS definition is very strict. Any communication or data exchange which is time-delayed or does not include video (visual) transmission of information and data is not considered a telemedicine service by CMS. For Moda Health Commercial plans, there are covered telemedicine services and non-covered telemedicine services; but for CMS and Medicare Advantage, if the service does not meet the coverage requirements, it may not be called a "telemedicine service."
Telemonitoring	The use of telecommunications and information technology to provide patient monitoring (real-time or delayed store and transmit) to a separate monitoring and interpretation site.
Telepresenter	An individual, at the same location as the member who provides support to the patient and the telemedicine consulting provider, in completing the physical examination and/or telemedicine activity. The telepresenter is trained to use specialized telemedicine technology, such as digital stethoscope, otoscope, ophthalmoscope and examination camera, to facilitate comprehensive exams under physician guidance. (ATA[7], NRTRC[8])

Telehealth-related Terms	
Term	**Definition**
Asynchronous (also called "Store and Forward")	Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image or information data that is sent (forwarded) via telecommunication to another site for consultation.
Distant site (also called "Hub site")	Site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.
E-visit	An exchange of emails between member and provider asking and addressing clinical concerns are sometimes referred to as an "e-visit." Most groups do not provide benefits for email exchanges between member and provider or "e-visits;" a few select plans may specifically have an additional benefit for this service.
Hub site (also called "Distant site")	Site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.
In-person	Face to face interaction when the member and provider are physically in the same location.
Originating site (or Spoke site)	Location of the patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.
Remote patient monitoring	Remote patient monitoring (RPM) is using technology to enable monitoring of patients outside of conventional clinical settings (e.g. monitoring the patient in the home instead of in the clinic or the hospital).
Remote services	Services which occur when the member and provider are not physically in the same location. The amount of distance between the member's location and the provider's location is not significant; the member and provider may be located in the same city but different buildings and communicating via technology. The member may be in a rural or urban location and does not need to be in a Health Professional Shortage Area (HPSA).

Telehealth-related Terms	
Term	**Definition**
Secondary Provider Network AKA: "Rented Network" or "Travel Network."	A group of providers contracted directly with another company. Moda Health then contracts with that other company to use their network of providers for specific member plans under specific circumstances. The secondary network company has control over the list of participating providers, fee schedule, and other contract terms. Moda Health pays for the additional provider access and hold-harmless protection for our members. Claims are processed as in-network when criteria is met. Different plans/groups may use different secondary networks. Examples include: Private Healthcare Services (PHCS), First Choice Health Network, Idaho Physician's Network (IPN), and First Health Network. Sometimes also called "rented network" or "travel network."
Spoke site (or Originating site)	Location of the patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.
"Store and Forward" (also called Asynchronous)	Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation.
Virtual Care	A wide-ranging term that includes telemedicine, virtual visits, and other non-telemedicine benefits and/or services. May include a nurse-advice line, emailing a physician, etc. which are not considered telemedicine.
Virtual Visit	A telemedicine visit that uses real-time, audio-visual technology and special equipment to accomplish a visit that is virtual or "the same as being there in person." Qualifies for modifier GT or 95.

Procedure codes:

Online evaluation and management service procedure codes		
Code	**Code Description**	**Applicable DOS**
99444	Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network	Terminated 12/31/2019. **Do not use for 2020 dates of service.**
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Effective 1/1/2020
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Effective 1/1/2020
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Effective 1/1/2020

Note: These are originating site fees. They do not represent the primary service performed.	
Code	**Code Description**
Q3014	Telehealth originating site facility fee
T1014	Telehealth transmission, per minute, professional services bill separately

Modifier Definitions:

Modifier	**Modifier Definition**
G0	Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke
GQ	Via asynchronous telecommunications system
GT	Via interactive audio and video telecommunication systems

Modifier	Modifier Definition
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System: Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Modifier 95 may only be appended to the services listed in Appendix P. Appendix P is the list of CPT codes for services that are typically performed face-to-face but may be rendered via a real-time (synchronous) interactive audio and video telecommunications system.

Place of Service code:

Note: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service. (CMS MM9726[12])

Code	Short Description	Place of Service Code Long Description
02	Telehealth	The location where health services and health related services are provided or received, through telecommunication technology. (Does not apply to originating site facilities billing a facility fee.) (Effective for claims submitted 1/1/2017 and following, regardless of date of service.)

National Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"Submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, "via interactive audio and video telecommunications systems" (for example,99201 GT). By coding and billing the GT modifier with a covered telehealth procedure code, you are certifying that the beneficiary was present at an eligible originating site when you furnished the telehealth service. By coding and billing the GT modifier with a covered ESRD-related service telehealth code, you are certifying that you furnished one "hands on" visit per month to examine the vascular access site." (MLN[5])

"Clinical psychologists (CPs) and clinical social workers (CSWs). CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838…" (MLN[5])

"The originating site facility fee is a separately billable Part B payment. The contractor pays it outside of other payment methodologies. This fee is subject to post payment verification." (CMS[10])

Cross References

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B. "Modifiers GA, GX, GY, and GZ." Moda Health Reimbursement Policy Manual, RPM036.

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11. ONC. "About ONC." June 16, 2016. https://www.healthit.gov/newsroom/about-onc

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Background Information

Telehealth and telemedicine are terms which are defined in multiple ways by multiple entities and organizations. The terms "telemedicine" and "telehealth" are often used interchangeably, although "telehealth" typically refers to a broader range of services, and "telemedicine" is generally a specific subset of "telehealth" services.

In general, the terms "telehealth" and "telemedicine" refer to the use of technology to deliver health care, health information or health education at a distance. Some of these applications involve the patient directly, others are professional-to-professional consultations regarding patient care, and yet others are professional education which is not connected to the care of a patient. Some of these telehealth applications are covered and eligible for reimbursement and others are not. Telemedicine and telehealth comprise a significant and rapidly growing component of health care in the United States. (ATA[6]) The boundaries of telehealth are limited only by the technology available - new applications are being invented and tested every day. (ONC[1])

Telehealth is a potentially useful tool that, if employed appropriately, can provide important benefits to patients and improve healthcare. A wide variety of services may be performed as telemedicine services; some may meet the requirements for coverage, and others may not. The basic service is reported with the normal procedure code(s) for the service performed. The fact that the services were performed as a telemedicine service may be identified with a modifier.

The Centers for Medicare and Medicaid Services (CMS) promotes telemedicine as beneficial and useful to improve primary and preventative care to Medicare beneficiaries who live in underserved and rural areas. CMS states that telemedicine provides remote access for face to face services when beneficiaries and providers are geographically separated and offers great promise for reducing access barriers for chronically ill Medicare beneficiaries.

In addition, there are legislative mandates for coverage of some specific telehealth and telemedicine services. Oregon state law mandates certain specific telemedicine services. OR SB 144 modified an existing telemedicine mandate, ORS 743A.058. The modified mandate of OR SB 144 applies to Oregon commercial insured medical benefit plans which are issued or renewed on and after 1/1/2016. Alaska HB 234 incorporated telehealth coverage for mental health benefits in Alaska Statute 21.42.422 for new and renewing plans on and after 10/1/2016.

This policy is intended to define telehealth and telemedicine terminology for our company, plans, and claims, provide clarification of which services are and are not eligible for reimbursement, and specify the criteria and requirements which must be met.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document Moda Health's payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Moda Health Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Providers are expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between the Moda Health Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and Moda Health Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; Moda Health strives to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****