
Medical Policy



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***Current Policy Effective Date: 5/1/20**
(See policy history boxes for previous effective dates)

Title: Telemedicine Services

Description/Background

Telehealth and telemedicine are terms that are frequently used interchangeably. Telehealth is an umbrella term used to describe all the possible variations of healthcare services and health care education using telecommunications. Telehealth includes health care services such as telemedicine, telemonitoring and store and forward, in addition to healthcare education for patients and professionals and related administrative services.

Telemedicine, a subset of telehealth, is the use of telecommunications technology for real-time, medical diagnostic and therapeutic purposes when distance separates the patient and healthcare provider. Many have advocated the use of telemedicine to improve health care in rural areas, in the home and in other places where medical personnel are not readily available. Telemedicine may substitute for a face-to-face, hands-on encounter between a patient and the healthcare provider when using the appropriate technology.

The use of telecommunications to support a clinical decision can incorporate patient data collected and reviewed immediately, such as clinician interactive; or reviewed later when the patient is no longer available, such as telemonitoring or store and forward.

- **Clinician Interactive Visit** – An electronically based, real-time clinician-patient encounter where the patient and healthcare provider are in different locations. This virtual encounter can either be audio only or audio visual. The virtual encounter can also be hosted. A hosted visit is a virtual consult with a remote health care provider hosted by a provider who is face-to-face with the patient. Certain clinical scenarios will dictate the use of a hosted visit, so as to minimize risk to the patient and maximize the clinical outcome. For example, when a patient presents to the emergency room with acute stroke symptoms and the neurology specialist is not on site, the emergency room physician hosts a consult with the remote neurologist in a real-time encounter.

- **Online Visit** – A type of low complexity clinician interactive visit that requires an audio visual online communication. The patient initiates the medical or behavioral health evaluation. The visit is typically straight forward decision making that addresses urgent but not emergent clinical conditions. At the point of making decisions regarding diagnosis and/or treatment, the provider does not require face-to-face contact to make an optimal decision. It is not anticipated that a follow-up encounter is required.

Examples of online visits include, but are not limited to: upper respiratory infections, such as sore throat, runny nose, sinus congestion, ear ache; mild gastrointestinal distress, such as GERD, diarrhea, nausea, constipation; skin disorders such as itching, rash, limited cuts; joint irritations such as aches, stiffness; headaches that are simple and uncomplicated; seasonal allergies, hay fever; urinary tract infections; acute situational anxiety.

- **Store and Forward** – The asynchronous transmission of medical information, where the information is reviewed at a later time by a physician or practitioner at the distant site. A store and forward process eliminates the need for the patient and clinician to be present at the same time and place. Data that is sent to a remote clinician and interpreted in real-time is not store and forward. For example, a radiologist reading a study for the emergency room remotely is not considered store and forward since the clinical decision is occurring in real-time. Store and Forward is not the subject of this policy.
- **Telemonitoring** – Services that enable providers to monitor test results, images and sounds that are usually obtained in a patient’s home or a care facility. Post-acute care patients, patients with chronic illnesses and patients with conditions that limit their mobility often require close monitoring and follow-up. These types of programs use various strategies to monitor patients while reducing the need for face-to-face visits. An example is remote blood pressure monitoring in the home reported electronically to the provider. Telemonitoring is not the subject of this policy.

Regulatory Status

NA

Medical Policy Statement

The safety and effectiveness of telemedicine has been established. It may be considered a useful diagnostic and therapeutic option when indicated.

Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder is considered experimental/ investigational when delivered by telemedicine. (Parent/guardian/caregiver adaptive behavior treatment training may be performed as a telemedicine service.)

Inclusionary and Exclusionary Guidelines (Clinically based guidelines that may support individual consideration and pre-authorization decisions)

Inclusions:

Clinician Interactive Visit

- The provider must be licensed, registered, or otherwise authorized to perform service in their health care profession in the state where the patient is located. Services must fall within their scope of practice.
- Telemedicine delivered services are available to all clinicians; however, this may not be the preferred method of delivery in certain clinical scenarios, for example chronic suicidal ideation or unstable angina. A hosted visit* or a face-to-face visit may be necessary due to the complexity of the clinical situation. The telemedicine provider may provide the face-to-face encounter.
- Telemedicine delivered services for ongoing treatment of a condition that is chronic and/or is expected to take more than 5 sessions before the condition resolves or stabilizes may require a hosted visit* or a face-to-face visit. The telemedicine provider may provide the face-to-face encounter.
- The service must be conducted over a secured channel*.
- The delivery of the service can be either audio only (telephone) or audio/video (a secured computer based system).

**see Policy Guidelines*

Online Visit

- An audio visual online communication
- The patient initiates the medical or behavioral health encounter
- The provider must be licensed, registered, or otherwise authorized to perform service in their health care profession in the state where the patient is located.
- A low complexity, straight forward decision making encounter that addresses urgent but not emergent clinical conditions
- A single encounter where a follow-up encounter is not anticipated
- Services must fall within the provider's scope of practice.

Exclusions:

- Email only communication
- Facsimile transmission
- Text only communication
- Request for medication refills
- Reporting of normal test results
- Provision of educational materials
- Scheduling of appointments and other healthcare related issues
- Registration or updating billing information
- Reminders for healthcare related issues
- Referrals to other providers
- An online or telemedicine visit resulting in an office visit, urgent care or emergency care encounter on the same day for the same condition

- An online visit for the same condition of an online visit within the previous seven days
- An online or telemedicine visit occurring during the post-operative period

Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder is considered experimental/investigational when delivered by telemedicine.*

*Exceptions:

- Parent/guardian/caregiver adaptive behavior treatment training (97156, 97157) may be performed as a telemedicine service.
- Program modification of ABA therapy (97155) may be used as a combination of face-to-face and telemedicine services up to 50% of the time – as long as a technician is present face-to-face.

Policy Guidelines

An eligible provider is any practitioner who is able to bill independently and receive direct reimbursement for services, such as, but not limited to:

- MD/DO
- Certified nurse midwife
- Clinical nurse practitioner
- Clinical psychologist
- Clinical social worker
- Physician assistant
- Licensed professional counselor

Any eligible provider is able to provide telemedicine services.

Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder requires direct observation, assessment and interaction based on subtle, complex behaviors. Therapists who provide direct care may be able to bill independently for these services; however, direct ABA therapy is excluded from telemedicine.

- Parent/guardian/caregiver adaptive behavior treatment training (97156, 97157) MAY be provided via telemedicine.
- Program modification of ABA therapy (97155) may be used as a combination of face-to-face and telemedicine services up to 50% of the time – as long as a technician is present face-to-face.

Hosted Visit

A hosted visit is a virtual consult with a remote (telehealth) health care provider, which is “hosted” by a provider who is face-to-face with the patient. The clinician providing telemedicine services is the consultant, and cannot be considered the host. The complexity of a hosted visit excludes it from being an online visit.

Modifiers / Place of Service

When the nomenclature of the code does not specify how the service is being delivered, then a modifier is required to clarify this. Use the modifier that is appropriate for the code.

GT – Via interactive audio and video telecommunications systems **OR**

95 – Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System

POS 02 – Telehealth – The location where health services and health related services are provided or received, through telecommunication technology.

Billing an originating site is **not** required, but may be used if clinically necessary.

Billing Requirements		
	Modifier GT or 95	Place of Service 02
Online Codes 98970-98972, 99421-99423	No	Yes
Telephone Codes 99441 – 99443 98966 – 98968	No	Yes
Crisis Codes (telephone) 90839 and 90840	Yes	Yes
CPT Codes (Appropriate for encounter and provider scope)	Yes	Yes

Billing Requirements Table

When care is delivered virtually (by telemedicine), the appropriate modifier and place of service must be billed.

1. When care is delivered through an online visit, and the appropriate CPT code is submitted, a place of service 02 should also be submitted. A modifier is not necessary.
2. When care is delivered using a secure telephone transmission, and the appropriate CPT code is submitted, a place of service 02 should also be submitted. A modifier is not necessary.
3. When care is delivered using a secure telephone transmission for crisis intervention, and the appropriate CPT code is submitted, a place of service 02 and the GT modifier should also be submitted. A modifier is needed because the nomenclature of the codes do not specify how the service is delivered.
4. When care is delivered using a secure audio and video transmission, and the appropriate CPT code to reflect the encounter is submitted, a place of service 02 and the GT modifier

should also be submitted. A modifier is needed because the nomenclature of the codes do not specify how the service is delivered.

Secured Communication

A secured electronic channel must include and support all of the following for audio and audio/visual encounters:

1. The electronic channel must be secure, with provisions for privacy and security, including encryption, in accordance with HIPAA guidelines.
2. A mechanism must be in place to authenticate the identity of correspondent(s) in electronic communication and to ensure that recipients of information are authorized to receive it.
3. The patient's informed consent to participate in the consultation must be obtained, including discussing appropriate expectations, disclaimers and service terms, and any fees that may be imposed. Expectations for appropriate use must be specified as part of the consent process including use of specific written guidelines and protocols, avoiding emergency use, heightened consideration of use for highly sensitive medical topics relevant to privacy issues.
4. The name and patient identification number is contained in the body of the message, when applicable.
5. A standard block of text is contained in the provider's response that contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies, when applicable.
6. The medical record of the telemedicine visit should include, if applicable, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record.⁸

The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records.⁸

Finally, the documentation should adequately support the billing code used for the visit.

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.)*

Established codes:

Online codes: 98970-98972, 99421-99423

Telephone codes: 99441-99443, 98966-98969

Crisis codes: 90839, 90840

CPT code: any CPT code that is appropriate for both the encounter and provider scope

Other codes (investigational, not medically necessary, etc.):

97151	97152	97153	97154	97158
0362T	0373T			
H0031	H0032	H2014	H2019	S5108

Note: Individual policy criteria determine the coverage status of the CPT/HCPCS code(s) on this policy. Codes listed in this policy may have different coverage positions (such as established or experimental/investigational) in other medical policies.

Rationale

The State of Michigan Insurance Code of 1956, Act 218 (2012)¹ was enacted to prohibit an insurance policy or certificate from requiring “face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine”. It also provided a definition of the term “telemedicine” and delineated requirements.

“Telemedicine means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine, the health care professional must be able to examine the patient via a real time, interactive audio or video or both, telecommunications system and the patient must be able to interact with the off-site health care professional at the time the services are provided.”

Public Act 359 of 2016 amended Michigan’s Public Health Code to establish initial standards for the use of telehealth in medical practice. It defines telehealth as “the use of electronic information and telecommunication technologies to support or promote long-distance clinical health care, patient and professional health-related education, public health, or health administration.”²

The Center for Connected Health Policy reports that all 50 states and the District of Columbia provide reimbursement for some form of live video in Medicaid fee-for-service. Thirty-nine states and the District of Columbia currently have a law that governs private payer telehealth reimbursement policy. No two states are alike in the scope and administration of telehealth.³ Grigsby et al (1995) reported that data concerning the costs, effects and effectiveness of telemedicine are limited. The authors identify the need for studies of efficacy and effectiveness, the evaluation of cost-effectiveness, and the identification of specific processes of telemedicine that are associated with optimal health outcomes.⁴ Although there is more information than was available when this article was published, research is still lacking, most specifically in the area of randomized clinical trials.

Kruse et al (2017) reported on patient satisfaction of telehealth services in regard to effectiveness and efficiency. The researchers filtered 2193 articles for suitability, and performed a systematic review of 44. Findings reported: “Providers and patients should embrace telehealth modalities because of its ease of use, its tendency to improve outcomes and communications, and its low cost. It can decrease travel time and increased communications with providers. Telehealth can provide a high-quality services, increase access to care, increase self-awareness and it empowers patients to manage their chronic conditions. Healthcare organisations should embrace telehealth because it decreases missed appointments, is a good modality for education, decreases wait times, decreases readmissions and improves medication adherence. But most importantly, policymakers need to help legislation catch up with the technology by enabling additional means of reimbursement for telehealth because the modality improves outcomes, which improves public health.” Limitations of the literature review included utilizing only two databases and the relatively young age of the telehealth modality of care.⁵

Langarizadeh et al (2017) performed a systematic review on the applications, technologies, advantages and challenges associated with telemental health care published since the year 2000. From four databases, 156 articles were identified. Of these, 25 met all inclusion criteria and were used in the review. Materials derived from 55 credible articles were used as further support and complementary facts. The findings revealed that telemental health care is an extended domain supportive of conventional mental health services. Currently, telemental health care has multiple capabilities and technologies for providing effective interventions to patients with various mental illnesses. It provides clinicians with a wide variety of innovative choices and strategies for mental interventions, in addition to significant future potential. The reviewers concluded that telemental health care can provide effective and adaptable solutions to the care of mental illnesses universally. While being comparable to in-person services, telemental health care is particularly advantageous and inexpensive through the use of current technologies and adaptable designs, especially in isolated communities.⁶

Lee TC, et al (2019) reported on a study of the impact of a telemedicine-based home management program (THMP) on patient adherence, hospital readmissions and quality of life after liver transplantation. One hundred six consecutive liver transplantation recipients were randomized (1:1) to 1 of 2 posttransplant care strategies: standard of care or THMP. The THMP included an electronic tablet and bluetooth devices to support daily text messages, education videos, and video FaceTime capability; data was cyber-delivered into our electronic medical record daily. Endpoints were THMP participation, 90-day hospital readmission rate, and quality of life. One hundred patients completed the study with 50 enrolled in each arm. Participation and adherence with telemedicine was 86% for basic health sessions (vital sign recording), but only 45% for using messaging or FaceTime. The THMP group had a lower 90-day readmission rate compared to SOC (28% vs 58%; $P = 0.004$). The THMP cohort also showed improved quality of life in regard to physical function ($P = 0.02$) and general health ($P = 0.05$) at 90 days. The authors concluded that the magnitude of effect on liver transplant outcomes, hospital readmissions, and quality of life suggests that the adoption of telemedicine has great potential for other major surgeries.⁷

Supplemental Information

The American Telemedicine Association, which is focused on advancing telehealth, has developed numerous clinical and administrative Practice Guidelines. A sample of these follows. In addition, the ATA offers accreditation to organizations that provide telehealth services.

- Practice Guidelines for Telemental Health with Children and Adolescents (2017)

- Practice Guidelines for Telestroke (2017)

- Guidelines for TeleICU (2016)

- Clinical Guidelines for Telepathology (2014)

- Telehealth Practice Recommendations for Diabetic Retinopathy (2011)

- Practice Guidelines for Live, On Demand, Primary and Urgent Care (2015)

- Practice Guidelines for Teleburn Care (2014)

- Practice Guidelines for TeleDermatology (2016)

(At the time of this policy update, the Guidelines are only available to ATA members)

The Federation of State Medical Boards (2014) developed “Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine”.⁸ The policy provides guidance to state medical boards for regulating the use of telemedicine and also educates licensees as

to the appropriate standards of care in delivery of services to patients via telemedicine technologies. The guidelines discuss ten areas of responsibility, including the following topics:

Licensure: a physician must be licensed in the state where the patient is located.

Establishment of a Physician-Patient Relationship: a physician must take appropriate steps to establish a physician-patient relationship, where the physician recognizes the obligations, responsibilities and patient rights associated with the establishment of the relationship.

Evaluation and Treatment of the Patient: there is to be a documented medical evaluation and collection of relevant clinical history. Treatment recommendations will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings.

Privacy and Security of Patient Records: compliance with HIPPA and state privacy, confidentiality, security and medical record retention rules.

The Agency for Healthcare Research and Quality (AHRQ) (2016) issued a technical brief, “Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews” in which it evaluated 58 systematic reviews.

“The largest volume of research reported that telehealth interventions have produced positive results when used in the clinical areas of chronic conditions and behavioral health and when telehealth is used for providing communication/ counseling and monitoring/management ... In areas where we did not find sufficient synthesized research, such as telehealth for consultation, in ICU and surgery, and in maternal and child health new systematic reviews may be able to organize primary research (some of which is new and some of which has been included in reviews in the past) into better reviews designed to address practice and policy considerations related to these issues.”⁹

The American Academy of Family Physicians in its policy Telehealth and Telemedicine (1994, 2016) states:

“The AAFP supports expanded use of telehealth and telemedicine as an appropriate and efficient means of improving health, when conducted within the context of appropriate standards of care. The appropriateness of a telemedicine service should be dictated by the standard of care and not by arbitrary policies. Available technology capabilities as well as an existing physician-patient relationship impact whether the standard of care can be achieved for a specific patient encounter type.”¹⁰

Government Regulations

National:

Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

190.1 Background (Rev.1635, Issued: 11-14-08, Effective: 01-01-19)

190.2 Eligibility Criteria (Rev.2848, Issued 12-30-13; Effective 01-01-14)

190.3 List of Medicare Telehealth Services (Rev.3476, Issued: 03-11-16, Effective: 01-01-15)

190.4 Conditions of Payment (Rev.1, 10-01-03)

190.5 Originating Site Facility Fee Payment Methodology (Rev.3476, Issued: 03-11-16, Effective: 01-01-15)

190.6 Payment Methodology for Physician/Practitioner at the Distant Site (Rev.3586, Issued: 08-12-16, Effective: 01-01-17)
190.7 AB MAC (B) Editing of Telehealth Claims (Rev.3817, Issued: 07-28-18, Effective: 01-01-18)

CMS 42 CFR Part 410 Supplementary Medical Insurance (SMI) Benefits
Subpart B – Medical and Other Health Services
§ 410.78 - Telehealth services
Origination Date 1/1/01, Last Update 11/23/2018

CMS mIn Booklet Telehealth Services, January 2019

Local:

NA

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

NA

References

1. State of Michigan, The Insurance Code of 1956 (Excerpt), Act 218 of 1956, 500.3476 Telemedicine Services; provisions; definitions. Effective 6/28/12, updated effective date 12/20/17.
2. State of Michigan, 98th Legislature Regular Session of 2016, Act No. 359, Public Acts of 2016, <http://www.legislature.mi.gov/documents/2015-2016/publicact/pdf/2016-PA-0359.pdf> Accessed 7/31/19.
3. The Center for Connected Health Policy, State Telehealth Laws & Reimbursement Policies Report, <https://www.cchpca.org/telehealth-policy/state-telehealth-laws-and-reimbursement-policies-report> Accessed 7/31/19.
4. Grigsby J et al. Effects and Effectiveness of Telemedicine. Health Care Finance Rev. 1995 Fall; 17(1):115-131.
5. Kruse CS, et al. Telehealth and patient satisfaction: a systematic review and narrative analysis. BMJ Open 2017;7:e016242. June 23, 2017.
6. Langarizadeh M, et al. Telemental health care, an effective alternative to conventional mental care: a systematic review. ACTA INFORM MED. 2017 Dec; 25(4): 240-246.
7. Lee TC, et al. Telemedicine based remote home monitoring after liver transplantation: results of a randomized prospective trial. Ann Surg 2019, Jul 25. PMID: 31356267.
8. Federation of State Medical Boards, Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine, Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup, https://www.fsmb.org/siteassets/advocacy/policies/fsmb_telemedicine_policy.pdf Accessed 7/31/19.

9. AHRQ, Issue #525, Telehealth: mapping the evidenced for patient outcomes from systematic reviews, Technical Brief Number 26, July 16, 2016, <https://www.ahrq.gov/news/newsletters/e-newsletter/525.html#link1> Accessed 7/31/19.
10. American Academy of Family Physicians, Telehealth and Telemedicine. <https://www.aafp.org/about/policies/all/telemedicine.html> Accessed 7/31/19.
11. CMS, 42 CFR, Part 410 Supplementary Medical Insurance (SMI) Benefits, Subpart B Medical and Other Health Services, § 410.78 Telehealth Services, 1/1/2001, last update 11/23/2018.
12. CMS mIn Booklet, Telehealth Services, January 2019, <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/telehealthsrvcfsctst.pdf> Accessed 7/31/19.

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 7/31/19, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
6/12/02	6/12/02	7/19/02	Joint policy established
3/21/06	3/21/06	4/14/06	Routine maintenance, policy retired
9/1/09	6/1/09	6/16/09	Unretired, routine maintenance
11/1/10	8/28/10	8/17/10	Routine maintenance
5/1/11	2/15/11	3/3/11	Routine maintenance
5/1/12	2/21/12	2/21/12	Routine maintenance
11/1/13	8/20/13	9/3/13	Routine maintenance
N/A	N/A	N/A	Blue Cross and BCN policies established, see Pre-Consolidation Medical Policy History below
5/1/20	2/7/20	N/A	Joint policy re-established Combined the following: Blue Cross and BCN Telemedicine policies; and BCN eVisits policy. Direct ABA therapy for autism spectrum disorder is excluded from telemedicine.

Next Review Date: 2nd Qtr, 2021

Pre-Consolidation Medical Policy History

Original Policy Date	Comments
BCN: 1/1/16	Revised: 11/16/16, 11/15/19, 11/14/18
BCBSM: 1/1/16	Revised: 1/19/17, 1/25/18, 5/14/18, 3/19/19

**BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: TELEMEDICINE SERVICES**

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered
BCNA (Medicare Advantage)	See Government Regulations section.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.