Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-046		
Subject:	Telemedicine and Telehealth Services		
Effective Date:	July 15, 2019	**End Date:**	
Issue Date:	January 1, 2025	**Revised Date:**	January 2025
Date Reviewed:	December 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy outlines the Plan's reimbursement for telemedicine, telehealth, virtual-care, or eVisit services. The term "telehealth" is often used in conjunction with telemedicine and is intended to include a broader range of services using telecommunication technologies, including videoconferencing. Unless otherwise provided herein and unless as specifically set forth in the Delaware Telemedicine Mandate – House Bill 69 Section of this Policy, "telehealth" shall include telemedicine, telehealth, virtual care, and eVisit services deemed covered services by the Plan or its affiliates.

DEFINITIONS:

Term	Definition
Distant Site	The location of an appropriately licensed health care provider while furnishing health care services by means of telecommunication.
Originating Site	The location of the patient at the time a telecommunication service is furnished.
Place of Service "02"	The 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 "10"	The location where health services and health related services are provided or received, through telecommunication 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 telecommunication technology.

Modifier	Definition
GQ	Via asynchronous telecommunications system.
GT	Via interactive audio and video telecommunications systems.
95	Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system.
93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system.
FQ	Service was furnished using audio-only communication technology.
FR	The supervising practitioner was present through two-way audio/video communication technology.

Note: Effective January 30, 2023, the Plan will require providers to use all telehealth modifiers appropriately as defined by correct coding and CMS guidelines.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Reimbursement for telehealth services is determined according to individual, group, or customer benefits. Coverage for telehealth is limited to the types of services already considered a covered benefit under the member's specific plan. Coverages and reimbursements for telehealth services are limited to those services performed between a licensed clinician and a member/patient.

Note: In accordance with post-Public Health Emergency telehealth guidance issued by CMS or state mandates, some of the requirements throughout this policy may be waived or altered.

IMPORTANT – To assist with timely processing of claims, if services are delivered outside the patients Home in a manner other than face-to-face, claims should always be billed using the place of service (POS) "02", including telephonic only codes. If services are delivered in the patients Home, use POS "10". Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g. electronic portal) by a provider to deliver care, POS 02 or POS 10 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

Note: Diagnostic services that are patient worn or activated devices such as Holter monitoring (i.e., 93224, 93225, 93226, 93227) should continue to be billed in their historically appropriate POS.

When a covered benefit, evaluation and management services delivered through telehealth for new and established patients may be reimbursed under the following conditions:

1. Professional services rendered via an interactive telecommunication system are only eligible for reimbursement to the provider rendering the telehealth services. A provider rendering face-to-face care should report the appropriate codes for the in-person services.
2. The patient must be present at the time of all billed services unless the billed code is for exclusive use with *asynchronous* services or as specifically allowed under state law. If state law requires a face-to-face examination PRIOR to the delivery of telehealth services, the face-to-face services must be concluded and documented in the medical record prior to the initiation of any related telehealth visits.

3. All services provided must be medically appropriate and necessary in accordance with Highmark Medical Policy Z-11: Definition of Medical Necessity.
4. The consultation/evaluation and management service must take place via an interactive audio/ video telecommunications system, unless exceptions are allowed by applicable laws, post-PHE CMS guidance, or, unless the service is for mental health as described in this policy. Interactive telecommunications systems must be multi-media communication which, at minimum, includes audio and video equipment permitting real-time (synchronous) consultation among the patient and practitioner at the Originating Site and the practitioner at the Distant Site, unless the service is for mental health or other service as described in this policy.
5. The technology platform used by the provider must meet technology security requirements, including being both HIPAA and HITECH compliant.
6. Thorough, appropriate documentation of telehealth services and other communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

For audio only codes, a patient visit performed through telehealth should be documented to the same extent as an in-person visit, reflecting what occurred during the visit. The provider must also document that the visit was done through audio only telecommunications.

Note: Effective January 1, 2022, telehealth services performed with audio only communication are eligible for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes when the patient is not capable of, or does not consent to, the use of two-way audio/video technology. Modifier FQ or 93 must be appended to the claim line for these services.

Note: Provider should consult published guidance from the Office of Civil Rights (OCR) of HHS related to HIPAA and HITECH compliance for telehealth services.

Eligible Providers

Providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face to face service.

Note: The requirement above may be waived or altered as declared by HHS pursuant to state requirements or as directed by CMS.

Virtual PCP and Retail Clinic Visits

When billing professional services (1500/837P), Virtual PCP Visits and Virtual Retail Clinic Visits should be billed with Evaluation & Management (E&M) CPT codes (99201-99205; 99211-99215) applicable to the services provided and with the GT, 93, or 95 modifiers, indicating the use of interactive audio and video telecommunications technology.

POS “02” should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS “10” for services furnished in the patient’s Home. OP facility claims must also use the GT, 93, or 95 modifiers, as appropriate and applicable.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code (99201-99205; 99211-99215 or *G0463) with the GT, 93, or 95 modifiers, and the revenue code 780.

***Note**: If mandated by your OPPS payment methodology for reporting clinic visits.

Note: Revenue code 780 should be used when billing Q3014.

Virtual visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy***** (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits) or treatment.
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan. See section below for more information on Virtual Behavioral Health Visits.

Note: More information on telehealth virtual visits, including annual wellness visits, can be found on the Provider Resource Center and in the Highmark Provider Manual.

Virtual Behavioral Health Visits

When billing professional services (1500/837P), virtual behavioral health services should be billed with existing mental health CPT codes applicable to the services provided with a GT, 93, or 95 modifiers, indicating the use of an interactive (synchronous) audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code with the GT, 93, or 95 modifiers, and the appropriate behavioral health revenue code (900-919).

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home. OP Facility claims must also use the GT, 93, or 95 modifiers, as appropriate and applicable.

Note: Revenue code 780 should be used when billing Q3014.

Virtual behavioral health visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Telephone conversations, facsimile, or email communications

Note: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan. Effective January 1, 2022, telehealth services performed with audio only communication are eligible for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes when the patient is not capable of, or does not consent to, the use of two-way audio/video technology. Modifier FQ must be appended to the claim line for these services.

Specialist Virtual Visit

The Originating Site can be either a medical site or an approved non-medical site. Only a medical Originating Site (i.e., PCP's office, outpatient facility, etc.) is eligible for reimbursement of an access fee. The Plan will accept HCPCS code Q3014 ("telehealth Originating Site facility fee") for the service. Claims for the medical Originating Site's access fee will be accepted as either professional (1500/837P) or outpatient facility (UB-04/837I using revenue code 780).

Note: No other service reported on the medical Originating Site claim will be eligible for payment by the Plan or the member.

Providers/facility at the Originating Site should bill procedure code Q3014.

Note: Code Q3014 is not covered if billed with a non-covered professional service.

The access fee is an all-inclusive fee that includes all medical Originating Site fees including, without limitation, providing a physical location for the virtual visit as well as providing all equipment to be utilized for the secure connection. No other fees may be billed to either the Plan or to the member by the medical Originating Site and all contractual member hold harmless requirements shall apply.

Note: The Plan will reimburse only one claim per encounter for the medical Originating Site access fee.

The Plan will accept only a professional claim (1500/837P) for the provider's evaluation/assessment services provided at the Distant Site.

Evaluation and management (E&M) visits (99201-99205; 99211-99215) are eligible codes for the specialist's services rendered at the Distant Site. The procedure code(s) representing the specialist's services must be billed with GT, 93, or 95 modifiers. The service appended with one of these modifiers is only billed by the specialty practitioner.

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home. OP Facility claims must also use the GT, 93, and 95 modifiers, as appropriate and applicable.

Note: Revenue code 780 should be used when billing Q3014.

Specialist Virtual Visit services that the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan. See section above for more information on Virtual Behavioral Health Visits.

Encounter Documentation Requirements

All telehealth encounter documentation in the medical record is expected to meet the same minimum standards as required by face-to-face visit documentation**.** All relevant visit documentation is subject to post-payment review.

Delaware Telemedicine Mandate - House Bill 69

Effective January 1, 2016, Delaware law requires all individual and group policies subject to Delaware insurance law to provide coverage for health-care services provided through telemedicine and telehealth deemed covered services by the Plan. Eligible Delaware practitioners include most physicians and many other providers practicing within the scope of their license.

"Telehealth" is the use of information and communications technologies consisting of telephones, store and forward transfers, remote patient monitoring devices, or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, and health administration services.

"Telemedicine" is a form of telehealth, which is the delivery of clinical health-care services by means of real time two-way audio, visual, or other telecommunications or electronic communications. This includes the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health-care provider practicing within his or her scope of license as would be practiced in-person with a patient, and legally allowed to practice in the State.

The following are applicable to Delaware providers only:

Distant Site

The distant site is the location where the provider (legally allowed to practice in the state) is rendering the service by means of telemedicine or telehealth. The Plan will not reimburse claims submitted for an access fee by the distant site.

Originating Site

The originating medical site (i.e., provider's office, outpatient facility, etc.) is a site in Delaware at which an eligible member is located at the time the service is performed by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties. The Plan will accept only one claim for the originating site access fee per visit that involves both an originating medical site and a distant site. Only the originating medical site will receive payment for an access fee.

Note: An access fee is not applicable for non-medical sites (e.g., member's home).

Professional service claims (1500/837P) should be billed using CMS Level 2 code Q3014, indicating the telehealth origination site fee, when applicable.

Outpatient facility claims (UB-04/837I) should be billed using CMS Level 2 code Q3014 and revenue code 780, when applicable.

Real-time Audio

Professional services (1500/837P) should be billed using CPT codes 98966, 98967, and 98968.

Outpatient facility claims (UB-04/837I) should be billed using CPT codes 98966, 98967, and 98968 with the appropriate revenue code.

Real-time Audio & Visual

Professional services claims (1500/837P) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT, 93, or 95 modifiers, indicating the use of an interactive audio and video telecommunications system. Modifier FQ should be used for services furnished using audio-only communication technology.

Outpatient facility claims (UB-04/837I) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT, 93, and 95 modifiers, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home.

Note: Revenue code 780 should be used when billing Q3014.

Store and Forward

Professional service claims (1500/837P) should be billed using existing E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier indicating the use of asynchronous telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home.

Telehealth Transmission

Professional service claims (1500/837P) should be billed using CMS Level 2 code T1014 indicating telehealth transmission, if appropriate.

Outpatient facility claims (UB04/837I) should be billed using CMS Level 2 code T1014 and the appropriate revenue code.

Note: The Plan will accept only one telehealth transmission code per encounter, per provider; if both a medical Originating and Distant site were involved, the Plan will accept one from each site, when applicable.

Services Not Covered

Services that the Plan **does not** reimburse include, but are not limited to, the following:

- Unsecured and unstructured services such as, but not limited to, skype and instant messaging unless such service is within the scope of practice of the provider.

Services Not Separately Reimbursed

The Plan does not separately reimburse for codes 98000-98016.

West Virginia Telemedicine Mandate - W. Va. Code § 33-57-1

West Virginia law requires all individual and group policies subject to West Virginia insurance law to provide coverage for health-care services, deemed covered services by the Plan, provided through telehealth services if those same services are covered through face-to-face consultation by the policy. Telehealth services shall not be subject to annual or lifetime dollar maximum; copayment, coinsurance or deductible amounts; policy year, calendar year or other duration benefit limitation or maximum that is not equally

imposed on all terms and services covered under the policy, contract or plan. Eligible West Virginia practitioners include most physicians and many other providers practicing within the scope of their license. Required coverage includes the use of telehealth technologies as it pertains to medically necessary remote patient monitoring services to the full extent that those services are available.

Telehealth Services

Telehealth services means the use of synchronous or asynchronous telecommunications technology or audio only telephone calls by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

Distant Site

The distant site means the telehealth site where the health care practitioner is seeing the patient at a distance or consulting with a patient's health care practitioner. The Plan will not reimburse claims submitted for an access fee by the distant site.

Health Care Practitioner

The health care practitioner means a person licensed under §30-1-1 *et seq*. of this code who provides health care services.

Originating Site

The originating site means the location where the patient is located, whether or not accompanied by a health care practitioner, at the time services are provided by a health care practitioner through telehealth, including, but not limited to, a health care practitioner's office, hospital, critical access hospital, rural health clinic, federally qualified health center, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

Note: Providers/facility at the Originating Site should bill procedure code Q3014.

Remote Patient Monitoring Services

Remote patient monitoring services means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

New York Telehealth Mandate

Telehealth Services

"Telehealth" means the use of electronic information and communication technologies by a health care provider to deliver health care services to an insured individual while such individual is located at a site that is different from the site where the health care provider is located. Telehealth includes audio-only visits.

Mandated Telehealth Benefit:

New York law requires that insurers and HMOs shall not exclude from coverage a service that is otherwise covered under a contract that provides comprehensive coverage for hospital, medical or surgical care

because the service is delivered via "telehealth"; provided, however, that a service by a health care provider may be excluded where the provider is not otherwise covered under the contract. The coverage of a service delivered via telehealth may be subject to co-payments, coinsurance or deductibles provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth. A service delivered via telehealth may be subject to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

Effective until April 1, 2024, covered services delivered by means of telehealth shall be reimbursed on the same basis, at the same rate, and to the same extent that such services are reimbursed when delivered in person; provided that reimbursement of covered services delivered via telehealth shall not require reimbursement of costs not actually incurred in the provision of the telehealth services, including charges related to the use of a clinic or other facility when neither the originating site nor the distant site occur within the clinic or other facility.

Effective until April 1, 2024, a corporation that provides comprehensive coverage for hospital, medical, or surgical care with a network of health care providers shall ensure that such network is adequate to meet the telehealth needs of insured individuals for services covered under the policy when medically appropriate.

An insurer may engage in reasonable fraud, waste and abuse detection efforts, including to prevent payments for telehealth services that do not warrant separate reimbursement.

[NY Insurance Law §3217-h & §4306-g)][NY Public Health Law §4406-g] [11 NYCRR §52.17(d) & §52.18(h)]

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows CMS guidelines for Telemedicine and Telehealth services.

IMPORTANT – To assist with timely processing of claims, if services are delivered outside the patients Home in a manner other than face-to-face, claims should always be billed using the place of service (POS) "02", including telephonic only codes. If services are delivered in the patients Home, use POS "10". Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g., electronic portal) by a provider to deliver care, POS 02 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

More information on telehealth can be found on the Provider Resource Center and in the Highmark Provider Manual.

RELATED POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- Z-65: Telestroke Services

- Z-11: Definition of Medical Necessity
- Z-27: Eligible Providers

Refer to the following Medicare Advantage Medical Policies for additional information:

- N-4: Nutrition Therapy
- Z-11: Definition of Medical Necessity

Refer to the following Reimbursement Policies for related information:

- RP-035: Correct Coding Guidelines
- RP-043: Care Management
- RP-057: Evaluation and Management Services

REFERENCES:

- American Medical Association, *Current Procedure Terminology* CPT® Manual
- CMS Medicare Claims Processing Manual, Chapter 12 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- Delaware Telemedicine Mandate, House Bill 69 (Codified as 18 Del. C. §§ 3770 & 3571R; 18 Del. Admin. Code 1409) http://delcode.delaware.gov/sessionlaws/ga148/chp080.pdf
- U.S. Department of Health and Human Services: Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html
- CMS Medicare Telemedicine Health Care Provider Fact Sheet. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- Second Modification of the Declaration of a State of Emergency for the State of Delaware due to a Public Health Threat https://governor.delaware.gov/wp-content/uploads/sites/24/2020/03/Second-Modification-to-the-State-of-Emergency.pdf
- CMS COVID-19 National Stakeholder Call, March 31, 2020. https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts
- CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19. https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf
- MLN Connects; 2020-04-03-MLNC-SE. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-03-mlnc-se
- American Medical Association; CPT Appendix A audio only Modifier 93 for reporting medical services: https://www.ama-assn.org/practice-management/cpt/cpt-appendix-audio-only-modifier-93-reporting-medical-services
- NY Insurance Law §3217-h & §4306-g; NY Public Health Law §4406-g;11 NYCRR §52.17(d) & §52.18(h)

POLICY UPDATE HISTORY INFORMATION:

7 / 2019	Implementation
1 / 2020	Replaced code 99444 with 99421, 99422 and 99423

3 / 2020	Added information related to the PHE issued by HHS and the PHT Declaration issued by the Governor of the State of Delaware. Added policy to be applicable to Medicare Advantage.
4 / 2020	Added information on reporting services per National Stakeholder Call. Added note for G0463.
7 / 2020	Added direction for mandatory use of POS 02 for Medicare Advantage and Commercial
8 / 2020	Added note below codes that do not include both audio and video communication
11 / 2021	Added NY region applicable to the policy. Removed Tele-dermatology section. Added note for NY variation of direction for codes 98966, 98967, 98968, 99441, 99442, and 99443.
1 / 2022	Added Delaware MA applicable to the policy. Added new POS 10 and mental health audio only communication direction. Added modifier FR, FQ and 93.
1 / 2023	Direction change on codes 99446, 99447, 99448, 99449, 98966, 98967 and 98968.
2 / 2023	Direction reversal on codes 99446, 99447, 99448, 99449.
7 / 2023	Updated with post-PHE direction
1 / 2025	Removed codes 99441-99443. Added codes 98000-98016.

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DEFINITIONS:

Term	Definition
Distant Site	The location of an appropriately licensed health care provider while furnishing health care services by means of telecommunication.
Originating Site	The location of the patient at the time a telecommunication service is furnished.
Place of Service "02"	The 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 "10"	The location where health services and health related services are provided or received, through telecommunication 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 telecommunication technology.

Modifier	Definition
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Note: Effective January 30, 2023, the Plan will require providers to use all telehealth modifiers appropriately as defined by correct coding and CMS guidelines.

COMMERCIAL REIMBURSEMENT GUIDELINES:

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Note: In accordance with post-Public Health Emergency telehealth guidance issued by CMS or state mandates, some of the requirements throughout this policy may be waived or altered.

IMPORTANT – To assist with timely processing of claims, if services are delivered outside the patients Home in a manner other than face-to-face, claims should always be billed using the place of service (POS) "02", including telephonic only codes. If services are delivered in the patients Home, use POS "10". Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g. electronic portal) by a provider to deliver care, POS 02 or POS 10 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

Note: Diagnostic services that are patient worn or activated devices such as Holter monitoring (i.e., 93224, 93225, 93226, 93227) should continue to be billed in their historically appropriate POS.

When a covered benefit, evaluation and management services delivered through telehealth for new and established patients may be reimbursed under the following conditions:

1. Professional services rendered via an interactive telecommunication system are only eligible for reimbursement to the provider rendering the telehealth services. A provider rendering face-to-face care should report the appropriate codes for the in-person services.
2. The patient must be present at the time of all billed services unless the billed code is for exclusive use with *asynchronous* services or as specifically allowed under state law. If state law requires a face-to-face examination PRIOR to the delivery of telehealth services, the face-to-face services

must be concluded and documented in the medical record prior to the initiation of any related telehealth visits.

3. All services provided must be medically appropriate and necessary in accordance with Highmark Medical Policy Z-11: Definition of Medical Necessity.
4. The consultation/evaluation and management service must take place via an interactive audio/ video telecommunications system, unless exceptions are allowed by applicable laws, post-PHE CMS guidance, or, unless the service is for mental health as described in this policy. Interactive telecommunications systems must be multi-media communication which, at minimum, includes audio and video equipment permitting real-time (synchronous) consultation among the patient and practitioner at the Originating Site and the practitioner at the Distant Site, unless the service is for mental health or other service as described in this policy.
5. The technology platform used by the provider must meet technology security requirements, including being both HIPAA and HITECH compliant.
6. Thorough, appropriate documentation of telehealth services and other communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

For audio only codes, a patient visit performed through telehealth should be documented to the same extent as an in-person visit, reflecting what occurred during the visit. The provider must also document that the visit was done through audio only telecommunications.

Note: Effective January 1, 2022, telehealth services performed with audio only communication are eligible for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes when the patient is not capable of, or does not consent to, the use of two-way audio/video technology. Modifier FQ or 93 must be appended to the claim line for these services.

Note: Provider should consult published guidance from the Office of Civil Rights (OCR) of HHS related to HIPAA and HITECH compliance for telehealth services.

Eligible Providers

Providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face to face service.

Note: The requirement above may be waived or altered as declared by HHS pursuant to state requirements or as directed by CMS.

Virtual PCP and Retail Clinic Visits

When billing professional services (1500/837P), Virtual PCP Visits and Virtual Retail Clinic Visits should be billed with Evaluation & Management (E&M) CPT codes (99201-99205; 99211-99215) applicable to the services provided and with the GT, 93, or 95 modifiers, indicating the use of interactive audio and video telecommunications technology.

POS “02” should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS “10” for services furnished in the patient’s Home. OP facility claims must also use the GT, 93, or 95 modifiers, as appropriate and applicable.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code (99201-99205; 99211-99215 or *G0463) with the GT, 93, or 95 modifiers, and the revenue code 780.

***Note**: If mandated by your OPPS payment methodology for reporting clinic visits.

Note: Revenue code 780 should be used when billing Q3014.

Virtual visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits) or treatment.
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan. See section below for more information on Virtual Behavioral Health Visits.

Note: More information on telehealth virtual visits, including annual wellness visits, can be found on the Provider Resource Center and in the Highmark Provider Manual.

Virtual Behavioral Health Visits

When billing professional services (1500/837P), virtual behavioral health services should be billed with existing mental health CPT codes applicable to the services provided with a GT, 93, or 95 modifiers, indicating the use of an interactive (synchronous) audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code with the GT, 93, or 95 modifiers, and the appropriate behavioral health revenue code (900-919).

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home. OP Facility claims must also use the GT, 93, or 95 modifiers, as appropriate and applicable.

Note: Revenue code 780 should be used when billing Q3014.

Virtual behavioral health visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Telephone conversations, facsimile, or email communications

Note: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan. Effective January 1, 2022, telehealth services performed with audio only communication are eligible for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes when the patient is not capable of, or does not consent to, the use of two-way audio/video technology. Modifier FQ must be appended to the claim line for these services.

Specialist Virtual Visit

The Originating Site can be either a medical site or an approved non-medical site. Only a medical Originating Site (i.e., PCP's office, outpatient facility, etc.) is eligible for reimbursement of an access fee. The Plan will accept HCPCS code Q3014 ("telehealth Originating Site facility fee") for the service. Claims

for the medical Originating Site's access fee will be accepted as either professional (1500/837P) or outpatient facility (UB-04/837I using revenue code 780).

Note: No other service reported on the medical Originating Site claim will be eligible for payment by the Plan or the member.

Providers/facility at the Originating Site should bill procedure code Q3014.

Note: Code Q3014 is not covered if billed with a non-covered professional service.

The access fee is an all-inclusive fee that includes all medical Originating Site fees including, without limitation, providing a physical location for the virtual visit as well as providing all equipment to be utilized for the secure connection. No other fees may be billed to either the Plan or to the member by the medical Originating Site and all contractual member hold harmless requirements shall apply.

Note: The Plan will reimburse only one claim per encounter for the medical Originating Site access fee.

The Plan will accept only a professional claim (1500/837P) for the provider's evaluation/assessment services provided at the Distant Site.

Evaluation and management (E&M) visits (99201-99205; 99211-99215) are eligible codes for the specialist's services rendered at the Distant Site. The procedure code(s) representing the specialist's services must be billed with GT, 93, or 95 modifiers. The service appended with one of these modifiers is only billed by the specialty practitioner.

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home. OP Facility claims must also use the GT, 93, and 95 modifiers, as appropriate and applicable.

Note: Revenue code 780 should be used when billing Q3014.

Specialist Virtual Visit services that the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan. See section above for more information on Virtual Behavioral Health Visits.

Encounter Documentation Requirements

All telehealth encounter documentation in the medical record is expected to meet the same minimum standards as required by face-to-face visit documentation**.** All relevant visit documentation is subject to post-payment review.

Delaware Telemedicine Mandate - House Bill 69

Effective January 1, 2016, Delaware law requires all individual and group policies subject to Delaware insurance law to provide coverage for health-care services provided through telemedicine and telehealth deemed covered services by the Plan. Eligible Delaware practitioners include most physicians and many other providers practicing within the scope of their license.

"Telehealth" is the use of information and communications technologies consisting of telephones, store and forward transfers, remote patient monitoring devices, or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, and health administration services.

"Telemedicine" is a form of telehealth, which is the delivery of clinical health-care services by means of real time two-way audio, visual, or other telecommunications or electronic communications. This includes the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health-care provider practicing within his or her scope of license as would be practiced in-person with a patient, and legally allowed to practice in the State.

The following are applicable to Delaware providers only:

Distant Site

The distant site is the location where the provider (legally allowed to practice in the state) is rendering the service by means of telemedicine or telehealth. The Plan will not reimburse claims submitted for an access fee by the distant site.

Originating Site

The originating medical site (i.e., provider's office, outpatient facility, etc.) is a site in Delaware at which an eligible member is located at the time the service is performed by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties. The Plan will accept only one claim for the originating site access fee per visit that involves both an originating medical site and a distant site. Only the originating medical site will receive payment for an access fee.

Note: An access fee is not applicable for non-medical sites (e.g., member's home).

Professional service claims (1500/837P) should be billed using CMS Level 2 code Q3014, indicating the telehealth origination site fee, when applicable.

Outpatient facility claims (UB-04/837I) should be billed using CMS Level 2 code Q3014 and revenue code 780, when applicable.

Real-time Audio

Professional services (1500/837P) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968.

Outpatient facility claims (UB-04/837I) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968 with the appropriate revenue code.

Real-time Audio & Visual

Professional services claims (1500/837P) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT, 93, or 95 modifiers, indicating the use of an interactive audio and video telecommunications system. Modifier FQ should be used for services furnished using audio-only communication technology.

Outpatient facility claims (UB-04/837I) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT, 93, and 95 modifiers, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home.

Note: Revenue code 780 should be used when billing Q3014.

Store and Forward

Professional service claims (1500/837P) should be billed using existing E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier indicating the use of asynchronous telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home.

Telehealth Transmission

Professional service claims (1500/837P) should be billed using CMS Level 2 code T1014 indicating telehealth transmission, if appropriate.

Outpatient facility claims (UB04/837I) should be billed using CMS Level 2 code T1014 and the appropriate revenue code.

Note: The Plan will accept only one telehealth transmission code per encounter, per provider; if both a medical Originating and Distant site were involved, the Plan will accept one from each site, when applicable.

Services Not Covered

Services that the Plan **does not** reimburse include, but are not limited to, the following:

- Unsecured and unstructured services such as, but not limited to, skype and instant messaging unless such service is within the scope of practice of the provider.

West Virginia Telemedicine Mandate - W. Va. Code § 33-57-1

West Virginia law requires all individual and group policies subject to West Virginia insurance law to provide coverage for health-care services, deemed covered services by the Plan, provided through telehealth services if those same services are covered through face-to-face consultation by the policy. Telehealth services shall not be subject to annual or lifetime dollar maximum; copayment, coinsurance or deductible

amounts; policy year, calendar year or other duration benefit limitation or maximum that is not equally imposed on all terms and services covered under the policy, contract or plan. Eligible West Virginia practitioners include most physicians and many other providers practicing within the scope of their license. Required coverage includes the use of telehealth technologies as it pertains to medically necessary remote patient monitoring services to the full extent that those services are available.

Telehealth Services

Telehealth services means the use of synchronous or asynchronous telecommunications technology or audio only telephone calls by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

Distant Site

The distant site means the telehealth site where the health care practitioner is seeing the patient at a distance or consulting with a patient's health care practitioner. The Plan will not reimburse claims submitted for an access fee by the distant site.

Health Care Practitioner

The health care practitioner means a person licensed under §30-1-1 *et seq*. of this code who provides health care services.

Originating Site

The originating site means the location where the patient is located, whether or not accompanied by a health care practitioner, at the time services are provided by a health care practitioner through telehealth, including, but not limited to, a health care practitioner's office, hospital, critical access hospital, rural health clinic, federally qualified health center, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

Note: Providers/facility at the Originating Site should bill procedure code Q3014.

Remote Patient Monitoring Services

Remote patient monitoring services means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

New York Telehealth Mandate

Telehealth Services

"Telehealth" means the use of electronic information and communication technologies by a health care provider to deliver health care services to an insured individual while such individual is located at a site that is different from the site where the health care provider is located. Telehealth includes audio-only visits.

Mandated Telehealth Benefit:

New York law requires that insurers and HMOs shall not exclude from coverage a service that is otherwise covered under a contract that provides comprehensive coverage for hospital, medical or surgical care because the service is delivered via "telehealth"; provided, however, that a service by a health care provider may be excluded where the provider is not otherwise covered under the contract. The coverage of a service delivered via telehealth may be subject to co-payments, coinsurance or deductibles provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth. A service delivered via telehealth may be subject to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

Effective until April 1, 2024, covered services delivered by means of telehealth shall be reimbursed on the same basis, at the same rate, and to the same extent that such services are reimbursed when delivered in person; provided that reimbursement of covered services delivered via telehealth shall not require reimbursement of costs not actually incurred in the provision of the telehealth services, including charges related to the use of a clinic or other facility when neither the originating site nor the distant site occur within the clinic or other facility.

Effective until April 1, 2024, a corporation that provides comprehensive coverage for hospital, medical, or surgical care with a network of health care providers shall ensure that such network is adequate to meet the telehealth needs of insured individuals for services covered under the policy when medically appropriate.

An insurer may engage in reasonable fraud, waste and abuse detection efforts, including to prevent payments for telehealth services that do not warrant separate reimbursement.

[NY Insurance Law §3217-h & §4306-g)][NY Public Health Law §4406-g] [11 NYCRR §52.17(d) & §52.18(h)]

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows CMS guidelines for Telemedicine and Telehealth services.

IMPORTANT – To assist with timely processing of claims, if services are delivered outside the patients Home in a manner other than face-to-face, claims should always be billed using the place of service (POS) "02", including telephonic only codes. If services are delivered in the patients Home, use POS "10". Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g., electronic portal) by a provider to deliver care, POS 02 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

More information on telehealth can be found on the Provider Resource Center and in the Highmark Provider Manual.

RELATED POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- Z-65: Telestroke Services
- Z-11: Definition of Medical Necessity
- Z-27: Eligible Providers

Refer to the following Medicare Advantage Medical Policies for additional information:

- N-4: Nutrition Therapy
- Z-11: Definition of Medical Necessity

Refer to the following Reimbursement Policies for related information:

- RP-035: Correct Coding Guidelines
- RP-043: Care Management
- RP-057: Evaluation and Management Services

REFERENCES:

- American Medical Association, *Current Procedure Terminology* CPT® Manual
- CMS Medicare Claims Processing Manual, Chapter 12 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- Delaware Telemedicine Mandate, House Bill 69 (Codified as 18 Del. C. §§ 3770 & 3571R; 18 Del. Admin. Code 1409) http://delcode.delaware.gov/sessionlaws/ga148/chp080.pdf
- U.S. Department of Health and Human Services: Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html
- CMS Medicare Telemedicine Health Care Provider Fact Sheet. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- Second Modification of the Declaration of a State of Emergency for the State of Delaware due to a Public Health Threat https://governor.delaware.gov/wp-content/uploads/sites/24/2020/03/Second-Modification-to-the-State-of-Emergency.pdf
- CMS COVID-19 National Stakeholder Call, March 31, 2020. https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts
- CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19. https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf
- MLN Connects; 2020-04-03-MLNC-SE. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-03-mlnc-se

- American Medical Association; CPT Appendix A audio only Modifier 93 for reporting medical services: https://www.ama-assn.org/practice-management/cpt/cpt-appendix-audio-only-modifier-93-reporting-medical-services

- NY Insurance Law §3217-h & §4306-g; NY Public Health Law §4406-g;11 NYCRR §52.17(d) & §52.18(h)

POLICY UPDATE HISTORY INFORMATION:

7 / 2019	Implementation
1 / 2020	Replaced code 99444 with 99421, 99422 and 99423
3 / 2020	Added information related to the PHE issued by HHS and the PHT Declaration issued by the Governor of the State of Delaware. Added policy to be applicable to Medicare Advantage.
4 / 2020	Added information on reporting services per National Stakeholder Call. Added note for G0463.
7 / 2020	Added direction for mandatory use of POS 02 for Medicare Advantage and Commercial
8 / 2020	Added note below codes that do not include both audio and video communication
11 / 2021	Added NY region applicable to the policy. Removed Tele-dermatology section. Added note for NY variation of direction for codes 98966, 98967, 98968, 99441, 99442, and 99443.
1 / 2022	Added Delaware MA applicable to the policy. Added new POS 10 and mental health audio only communication direction. Added modifier FR, FQ and 93.
1 / 2023	Direction change on codes 99446, 99447, 99448, 99449, 98966, 98967 and 98968.
2 / 2023	Direction reversal on codes 99446, 99447, 99448, 99449.
7 / 2023	Updated with post-PHE direction

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-046		
Subject:	Telemedicine and Telehealth Services		
Effective Date:	July 15, 2019	**End Date:**	
Issue Date:	February 20, 2023	**Revised Date:**	February 2023
Date Reviewed:	February 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy outlines the Plan's reimbursement for telemedicine, telehealth, virtual-care, or eVisit services. The term "telehealth" is often used in conjunction with telemedicine and is intended to include a broader range of services using telecommunication technologies, including videoconferencing. Unless otherwise provided herein and unless as specifically set forth in the Delaware Telemedicine Mandate – House Bill 69 Section of this Policy, "telehealth" shall include telemedicine, telehealth, virtual care, and eVisit services deemed covered services by the Plan or its affiliates.

DEFINITIONS:

Distant Site: The location of an appropriately licensed health care provider while furnishing health care services by means of telecommunication.

Originating Site: The location of the patient at the time a telecommunication service is furnished.

Place of Service "02": The 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 "10": The location where health services and health related services are provided or received, through telecommunication 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 telecommunication technology.

Modifier GQ: Via asynchronous telecommunications system.

Modifier GT: Via interactive audio and video telecommunications systems.

Modifier 95: Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system.

Modifier 93: Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system.

Modifier FQ**:** Service was furnished using audio-only communication technology.

Modifier FR: The supervising practitioner was present through two-way audio/video communication technology.

Note: Effective January 30, 2023, the Plan will require providers to use all telehealth modifiers appropriately as defined by correct coding and CMS guidelines.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Reimbursement for telehealth services is determined according to individual, group, or customer benefits. Coverage for telehealth is limited to the types of services already considered a covered benefit under the member's specific plan. Coverages and reimbursements for telehealth services are limited to those services performed between a licensed clinician and a member/patient.

IMPORTANT – To assist with timely processing of claims, if services are delivered outside the patients Home in a manner other than face-to-face, claims should always be billed using the place of service (POS) "02", including telephonic only codes. If services are delivered in the patients Home, use POS "10". Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g. electronic portal) by a provider to deliver care, POS 02 or POS 10 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

Note: Diagnostic services that are patient worn or activated devices such as Holter monitoring (i.e., 93224, 93225, 93226, 93227) should continue to be billed in their historically appropriate POS.

When a covered benefit, evaluation and management services delivered through telehealth for *new and established patients may be reimbursed under the following conditions:

***Note**: In accordance with the telehealth waiver issued by CMS related to the 2019 novel coronavirus, new patients will be permitted to receive telehealth services beginning March 6, 2020, until the PHE declared by the Department of Health and Human Services (HHS) expires. Also, some of

the requirements below and throughout this policy may also be waived or altered during the PHE period. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

1. Professional services rendered via an interactive telecommunication system are only eligible for reimbursement to the provider rendering the telehealth services. A provider rendering face-to-face care should report the appropriate codes for the in-person services.
2. The patient must be present at the time of all billed services unless the billed code is for exclusive use with *asynchronous* services or as specifically allowed under state law. If state law requires a face-to-face examination PRIOR to the delivery of telehealth services, the face-to-face services must be concluded and documented in the medical record prior to the initiation of any related telehealth visits.
3. All services provided must be medically appropriate and necessary in accordance with Highmark Medical Policy Z-11: Definition of Medical Necessity.
4. The consultation/evaluation and management service must take place via an interactive audio AND video telecommunications system, unless exceptions are allowed by applicable laws, or, unless the service is for mental health as described in this policy. Interactive telecommunications systems must be multi-media communication which, at minimum, includes audio and video equipment permitting real-time (synchronous) consultation among the patient and practitioner at the Originating Site and the practitioner at the Distant Site, unless the service is for mental health as described in this policy.
5. The technology platform used by the provider must meet technology security requirements, including being both HIPAA and HITECH compliant.
6. Thorough, appropriate documentation of telehealth services and other communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

Note: Provider should consult published guidance from the Office of Civil Rights (OCR) of HHS related to HIPAA and HITECH compliance during the PHE.

Codes 99441, 99442 and 99443 have regional variations (below) on reimbursement.

For audio only codes, a patient visit performed through Telehealth should be documented to the same extent as an in-person visit, reflecting what occurred during the visit. The provider must also document that the visit was done through audio only telecommunications.

PA/WV/DE: Codes 98966, 98967, 98968, are <u>not</u> separately reimbursed as they do not include both audio and video communication.

PA/WV/DE/NY: Codes 99441, 99442, 99443 are eligible during the PHE and for 151 days after it ends.

NY: Codes 98966, 98967, 98968, are eligible during the PHE and for 151 days after it ends.

Note: Effective January 1, 2022, telehealth services performed with audio only communication are eligible for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes when the patient is not capable of, or does not consent to, the

use of two-way audio/video technology. Modifier FQ or 93 must be appended to the claim line for these services.

Eligible Providers

Providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face to face service.

Note: The requirement above may be waived or altered during the PHE declared by HHS pursuant to state requirements.

Virtual PCP and Retail Clinic Visits

When billing professional services (1500/837P), Virtual PCP Visits and Virtual Retail Clinic Visits should be billed with Evaluation & Management (E&M) CPT codes (99201-99205; 99211-99215) applicable to the services provided and with the GT, 93, or 95 modifiers, indicating the use of interactive audio and video telecommunications technology.

POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home. OP facility claims must also use the GT, 93, or 95 modifiers, as appropriate and applicable.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code (99201-99205; 99211-99215 or *G0463) with the GT, 93, or 95 modifiers, and the revenue code 780.

***Note**: If mandated by your OPPS payment methodology for reporting clinic visits.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits) or treatment.
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations*, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan. See section below for more information on Virtual Behavioral Health Visits.

Virtual Behavioral Health Visits

When billing professional services (1500/837P), virtual behavioral health services should be billed with existing mental health CPT codes applicable to the services provided with a GT, 93, or 95 modifiers, indicating the use of an interactive (synchronous) audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code with the GT, 93, or 95 modifiers, and the appropriate behavioral health revenue code (900-919).

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home. OP Facility claims must also use the GT, 93, or 95 modifiers, as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual behavioral health visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

Note: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan. Effective January 1, 2022, telehealth services performed with audio only communication are eligible for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes when the patient is not capable of, or does not consent to, the use of two-way audio/video technology. Modifier FQ must be appended to the claim line for these services.

Specialist Virtual Visit

The Originating Site can be either a medical site or an approved non-medical site. Only a medical Originating Site (i.e., PCP's office, outpatient facility, etc.) is eligible for reimbursement of an access fee. The Plan will accept HCPCS code Q3014 ("telehealth Originating Site facility fee") for the service. Claims for the medical Originating Site's access fee will be accepted as either professional (1500/837P) or outpatient facility (UB-04/837I using revenue code 780).

Note: No other service reported on the medical Originating Site claim will be eligible for payment by the Plan or the member.

Providers/facility at the Originating Site should bill procedure code Q3014.

Note: Code Q3014 is not covered if billed with a non-covered professional service.

The access fee is an all-inclusive fee that includes all medical Originating Site fees including, without limitation, providing a physical location for the virtual visit as well as providing all equipment to be utilized for the secure connection. No other fees may be billed to either the Plan or to the member by the medical Originating Site and all contractual member hold harmless requirements shall apply.

Note: The Plan will reimburse only one claim per encounter for the medical Originating Site access fee.

The Plan will accept only a professional claim (1500/837P) for the provider's evaluation/assessment services provided at the Distant Site.

Evaluation and management (E&M) visits (99201-99205; 99211-99215) are eligible codes for the specialist's services rendered at the Distant Site. The procedure code(s) representing the specialist's services must be billed with GT, 93, or 95 modifiers. The service appended with one of these modifiers is only billed by the specialty practitioner.

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home. OP Facility claims must also use the GT, 93, and 95 modifiers, as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Specialist Virtual Visit services that the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan. See section above for more information on Virtual Behavioral Health Visits.

Encounter Documentation Requirements

All telehealth encounter documentation in the medical record is expected to meet the same minimum standards as required by face-to-face visit documentation**.** All relevant visit documentation is subject to Highmark post-payment review.

Delaware Telemedicine Mandate - House Bill 69

Effective January 1, 2016, Delaware law requires all individual and group policies subject to Delaware insurance law to provide coverage for health-care services provided through telemedicine and telehealth deemed covered services by the Plan. Eligible Delaware practitioners include most physicians and many other providers practicing within the scope of their license.

"Telehealth" is the use of information and communications technologies consisting of telephones, store and forward transfers, remote patient monitoring devices, or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, and health administration services.

"Telemedicine" is a form of telehealth, which is the delivery of clinical health-care services by means of real time two-way audio, visual, or other telecommunications or electronic communications. This includes the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health-care provider practicing within his or her scope of license as would be practiced in-person with a patient, and legally allowed to practice in the State.

The following are applicable to Delaware providers ONLY:

Distant Site

The distant site is the location where the provider (legally allowed to practice in the state) is rendering the service by means of telemedicine or telehealth. The Plan will not reimburse claims submitted for an access fee by the distant site.

Originating Site

The originating medical site (i.e., provider's office, outpatient facility, etc.) is a site in Delaware at which an eligible member is located at the time the service is performed by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties. The Plan will accept only one claim for the originating site access fee per visit that involves both an originating medical site and a distant site. Only the originating medical site will receive payment for an access fee.

Note: An access fee is not applicable for non-medical sites (e.g., member's home).

Professional service claims (1500/837P) should be billed using CMS Level 2 code Q3014, indicating the telehealth origination site fee, when applicable.

Outpatient facility claims (UB-04/837I) should be billed using CMS Level 2 code Q3014 and revenue code 780, when applicable.

Real-time Audio

Professional services (1500/837P) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968.

Outpatient facility claims (UB-04/837I) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968 with the appropriate revenue code.

Real-time Audio & Visual

Professional services claims (1500/837P) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT, 93, or 95 modifiers, indicating the use of an interactive audio and video telecommunications system. Modifier FQ should be used for services furnished using audio-only communication technology.

Outpatient facility claims (UB-04/837I) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT, 93, and 95 modifiers, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Store and Forward

Professional service claims (1500/837P) should be billed using existing E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier indicating the use of asynchronous telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home.

Telehealth Transmission

Professional service claims (1500/837P) should be billed using CMS Level 2 code T1014 indicating telehealth transmission, if appropriate.

Outpatient facility claims (UB04/837I) should be billed using CMS Level 2 code T1014 and the appropriate revenue code.

Note: The Plan will accept only one telehealth transmission code per encounter, per provider; if both a medical Originating and Distant site were involved, the Plan will accept one from each site, when applicable.

Services Not Covered

Services that the Plan **does not** reimburse include, but are not limited to, the following:

- Unsecured and unstructured services such as, but not limited to, skype and instant messaging unless such service is within the scope of practice of the provider.
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements above and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: In accordance with the telehealth waiver issued by the Governor of the State of Delaware through the Second Modification to the Declaration of the State of Emergency for the State of Delaware due to a Public Health Threat ("PHT") ("Declaration"), effective March 18, 2020, at 8:00 p.m., some of the requirements throughout this policy may also be waived or altered during the PHT and until such time as the Declaration remains in effect. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by the Declaration.

West Virginia Telemedicine Mandate - House Bill 4003

Effective July 1, 2020, West Virginia law requires all individual and group policies subject to West Virginia insurance law to provide coverage for health-care services, deemed covered services by the Plan, provided through telehealth services if those same services are covered through face-to-face consultation by the policy. Telehealth services shall not be subject to annual or lifetime dollar maximum; copayment, coinsurance or deductible amounts; policy year, calendar year or other duration benefit limitation or maximum that is not equally imposed on all terms and services covered under the policy, contract or plan. Eligible West Virginia practitioners include most physicians and many other providers practicing within the scope of their license. Required coverage includes the use of telehealth technologies as it pertains to medically necessary remote patient monitoring services to the full extent that those services are available.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS or applicable state waiver. Services will be allowed to pay on initial processing, and any post-pay

audits will **not** penalize providers for waived requirements, as defined by CMS.

Telehealth Services

Telehealth services means the use of synchronous or asynchronous telecommunications technology by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

Distant Site

The distant site means the telehealth site where the health care practitioner is seeing the patient at a distance or consulting with a patient's health care practitioner. The Plan will not reimburse claims submitted for an access fee by the distant site.

Health Care Practitioner

The health care practitioner means a person licensed under §30-1-1 *et seq*. of this code who provides health care services.

Originating Site

The originating site means the location where the patient is located, whether or not accompanied by a health care practitioner, at the time services are provided by a health care practitioner through telehealth, including, but not limited to, a health care practitioner's office, hospital, critical access hospital, rural health clinic, federally qualified health center, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

Note: Providers/facility at the Originating Site should bill procedure code Q3014.

Remote Patient Monitoring Services

Remote patient monitoring services means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows CMS guidelines for Telemedicine and Telehealth services.

Note: In accordance with the telehealth waiver issued by CMS, certain services are now permitted to be conducted via Telehealth. Please reference the CMS Physicians and Other Clinicians: CMS

Flexibilities to Fight COVID-19 and the MLN Connects 2020-04-03-MLNC-SE documents at the links located in the reference section of this policy.

IMPORTANT – To assist with timely processing of claims, if services are delivered outside the patients Home in a manner other than face-to-face, claims should always be billed using the place of service (POS) "02", including telephonic only codes. If services are delivered in the patients Home, use POS "10". Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g., electronic portal) by a provider to deliver care, POS 02 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

More information on telehealth can be found in the Highmark Provider Manual on the Provider Resource Center. Also, the Provider Resource Center has additional guidelines on the PHE.

RELATED POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- Z-65: Telestroke Services
- Z-11: Definition of Medical Necessity

Refer to the following Medicare Advantage Medical Policies for additional information:

- N-4: Nutrition Therapy
- Z-11: Definition of Medical Necessity

Refer to the following Reimbursement Policies for related information:

- RP-043: Care Management
- RP-057: Evaluation and Management Services

REFERENCES:

- American Medical Association, *Current Procedure Terminology* CPT® Manual

- CMS Medicare Claims Processing Manual, Chapter 12 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

- Delaware Telemedicine Mandate, House Bill 69 (Codified as 18 Del. C. §§ 3770 & 3571R; 18 Del. Admin. Code 1409) http://delcode.delaware.gov/sessionlaws/ga148/chp080.pdf

- U.S. Department of Health and Human Services: Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus

https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html

- CMS Medicare Telemedicine Health Care Provider Fact Sheet. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

- Second Modification of the Declaration of a State of Emergency for the State of Delaware due to a Public Health Threat https://governor.delaware.gov/wp-content/uploads/sites/24/2020/03/Second-Modification-to-the-State-of-Emergency.pdf

- CMS COVID-19 National Stakeholder Call, March 31, 2020. https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

- CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19. https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

- MLN Connects; 2020-04-03-MLNC-SE. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-03-mlnc-se

- American Medical Association; CPT Appendix A audio only Modifier 93 for reporting medical services: https://www.ama-assn.org/practice-management/cpt/cpt-appendix-audio-only-modifier-93-reporting-medical-services

POLICY UPDATE HISTORY INFORMATION:

7 / 2019	Implementation
1 / 2020	Replaced code 99444 with 99421, 99422 and 99423
3 / 2020	Added information related to the PHE issued by HHS and the PHT Declaration issued by the Governor of the State of Delaware. Added policy to be applicable to Medicare Advantage.
4 / 2020	Added information on reporting services per National Stakeholder Call. Added note for G0463.
7 / 2020	Added direction for mandatory use of POS 02 for Medicare Advantage and Commercial
8 / 2020	Added note below codes that do not include both audio and video communication
11 / 2021	Added NY region applicable to the policy. Removed Tele-dermatology section. Added note for NY variation of direction for codes 98966, 98967, 98968, 99441, 99442, and 99443.
1 / 2022	Added Delaware MA applicable to the policy. Added new POS 10 and mental health audio only communication direction. Added modifier FR, FQ and 93.
1 / 2023	Direction change on codes 99446, 99447, 99448, 99449, 98966, 98967 and 98968.
2 / 2023	Direction reversal on codes 99446, 99447, 99448, 99449.

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-046		
Subject:	Telemedicine and Telehealth Services		
Effective Date:	July 15, 2019	**End Date:**	
Issue Date:	October 31, 2022	**Revised Date:**	October 2022
Date Reviewed:	September 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy outlines the Plan's reimbursement for telemedicine, telehealth, virtual-care, or eVisit services. The term "telehealth" is often used in conjunction with telemedicine and is intended to include a broader range of services using telecommunication technologies, including videoconferencing. Unless otherwise provided herein and unless as specifically set forth in the Delaware Telemedicine Mandate – House Bill 69 Section of this Policy, "telehealth" shall include telemedicine, telehealth, virtual care, and eVisit services deemed covered services by the Plan or its affiliates.

DEFINITIONS:

Distant Site: The location of an appropriately licensed health care provider while furnishing health care services by means of telecommunication.

Originating Site: The location of the patient at the time a telecommunication service is furnished.

Place of Service "02": The 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 "10": The location where health services and health related services are provided or received, through telecommunication 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 telecommunication technology.

Modifier GQ: Via asynchronous telecommunications system.

Modifier GT: Via interactive audio and video telecommunications systems.

Modifier 95: Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system.

Modifier 93: Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system.

Modifier FQ**:** Service was furnished using audio-only communication technology.

Modifier FR: The supervising practitioner was present through two-way audio/video communication technology.

Note: Effective January 30, 2023, the Plan will require providers to use all telehealth modifiers appropriately as defined by correct coding and CMS guidelines.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Reimbursement for telehealth services is determined according to individual, group, or customer benefits. Coverage for telehealth is limited to the types of services already considered a covered benefit under the member's specific plan. Coverages and reimbursements for telehealth services are limited to those services performed between a licensed clinician and a member/patient.

IMPORTANT – To assist with timely processing of claims, if services are delivered outside the patients Home in a manner other than face-to-face, claims should always be billed using the place of service (POS) "02", including telephonic only codes. If services are delivered in the patients Home, use POS "10". Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g. electronic portal) by a provider to deliver care, POS 02 or POS 10 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

Note: Diagnostic services that are patient worn or activated devices such as Holter monitoring (i.e., 93224, 93225, 93226, 93227) should continue to be billed in their historically appropriate POS.

When a covered benefit, evaluation and management services delivered through telehealth for *new and established patients may be reimbursed under the following conditions:

***Note**: In accordance with the telehealth waiver issued by CMS related to the 2019 novel coronavirus, new patients will be permitted to receive telehealth services beginning March 6, 2020, until the PHE declared by the Department of Health and Human Services (HHS) expires. Also, some of

the requirements below and throughout this policy may also be waived or altered during the PHE period. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

1. Professional services rendered via an interactive telecommunication system are only eligible for reimbursement to the provider rendering the telehealth services. A provider rendering face-to-face care should report the appropriate codes for the in-person services.
2. The patient must be present at the time of all billed services unless the billed code is for exclusive use with *asynchronous* services or as specifically allowed under state law. If state law requires a face-to-face examination PRIOR to the delivery of telehealth services, the face-to-face services must be concluded and documented in the medical record prior to the initiation of any related telehealth visits.
3. All services provided must be medically appropriate and necessary in accordance with Highmark Medical Policy Z-11: Definition of Medical Necessity.
4. The consultation/evaluation and management service must take place via an interactive audio AND video telecommunications system, unless exceptions are allowed by applicable laws, or, unless the service is for mental health as described in this policy. Interactive telecommunications systems must be multi-media communication which, at minimum, includes audio and video equipment permitting real-time (synchronous) consultation among the patient and practitioner at the Originating Site and the practitioner at the Distant Site, unless the service is for mental health as described in this policy.
5. The technology platform used by the provider must meet technology security requirements, including being both HIPAA and HITECH compliant.
6. Thorough, appropriate documentation of telehealth services and other communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

Note: Provider should consult published guidance from the Office of Civil Rights (OCR) of HHS related to HIPAA and HITECH compliance during the PHE.

Effective January 30, 2023, codes 99446, 99447, 99448, 99449 are not eligible for reimbursement.

Codes 99441, 99442 and 99443 have regional variations (below) on reimbursement.

For audio only codes, a patient visit performed through Telehealth should be documented to the same extent as an in-person visit, reflecting what occurred during the visit. The provider must also document that the visit was done through audio only telecommunications.

PA/WV/DE: Codes 98966, 98967, 98968, are not separately reimbursed as they do not include both audio and video communication.

PA/WV/DE/NY: Codes 99441, 99442, 99443 are eligible during the PHE and for 151 days after it ends.

NY: Codes 98966, 98967, 98968, are eligible during the PHE and for 151 days after it ends.

Note: Effective January 1, 2022, telehealth services performed with audio only communication are eligible for the diagnosis, evaluation, or treatment of mental health disorders furnished to

established patients in their homes when the patient is not capable of, or does not consent to, the use of two-way audio/video technology. Modifier FQ or 93 must be appended to the claim line for these services.

Eligible Providers

Providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face to face service.

Note: The requirement above may be waived or altered during the PHE declared by HHS pursuant to state requirements.

Virtual PCP and Retail Clinic Visits

When billing professional services (1500/837P), Virtual PCP Visits and Virtual Retail Clinic Visits should be billed with Evaluation & Management (E&M) CPT codes (99201-99205; 99211-99215) applicable to the services provided and with the GT, 93, or 95 modifiers, indicating the use of interactive audio and video telecommunications technology.

POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home. OP facility claims must also use the GT, 93, or 95 modifiers, as appropriate and applicable.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code (99201-99205; 99211-99215 or *G0463) with the GT, 93, or 95 modifiers, and the revenue code 780.

***Note**: If mandated by your OPPS payment methodology for reporting clinic visits.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits) or treatment.
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations*, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan. See section below for more information on Virtual Behavioral Health Visits.

Virtual Behavioral Health Visits

When billing professional services (1500/837P), virtual behavioral health services should be billed with existing mental health CPT codes applicable to the services provided with a GT, 93, or 95 modifiers, indicating the use of an interactive (synchronous) audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code with the GT, 93, or 95 modifiers, and the appropriate behavioral health revenue code (900-919).

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home. OP Facility claims must also use the GT, 93, or 95 modifiers, as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual behavioral health visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

Note: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan. Effective January 1, 2022, telehealth services performed with audio only communication are eligible for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes when the patient is not capable of, or does not consent to, the use of two-way audio/video technology. Modifier FQ must be appended to the claim line for these services.

Specialist Virtual Visit

The Originating Site can be either a medical site or an approved non-medical site. Only a medical Originating Site (i.e., PCP's office, outpatient facility, etc.) is eligible for reimbursement of an access fee. The Plan will accept HCPCS code Q3014 ("telehealth Originating Site facility fee") for the service. Claims for the medical Originating Site's access fee will be accepted as either professional (1500/837P) or outpatient facility (UB-04/837I using revenue code 780).

Note: No other service reported on the medical Originating Site claim will be eligible for payment by the Plan or the member.

Providers/facility at the Originating Site should bill procedure code Q3014.

Note: Code Q3014 is not covered if billed with a non-covered professional service.

The access fee is an all-inclusive fee that includes all medical Originating Site fees including, without limitation, providing a physical location for the virtual visit as well as providing all equipment to be utilized for the secure connection. No other fees may be billed to either the Plan or to the member by the medical Originating Site and all contractual member hold harmless requirements shall apply.

Note: The Plan will reimburse only one claim per encounter for the medical Originating Site access fee.

The Plan will accept only a professional claim (1500/837P) for the provider's evaluation/assessment services provided at the Distant Site.

Evaluation and management (E&M) visits (99201-99205; 99211-99215) are eligible codes for the specialist's services rendered at the Distant Site. The procedure code(s) representing the specialist's services must be billed with GT, 93, or 95 modifiers. The service appended with one of these modifiers is only billed by the specialty practitioner.

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home. OP Facility claims must also use the GT, 93, and 95 modifiers, as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Specialist Virtual Visit services that the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan. See section above for more information on Virtual Behavioral Health Visits.

Encounter Documentation Requirements

All telehealth encounter documentation in the medical record is expected to meet the same minimum standards as required by face-to-face visit documentation**.** All relevant visit documentation is subject to Highmark post-payment review.

Delaware Telemedicine Mandate - House Bill 69

Effective January 1, 2016, Delaware law requires all individual and group policies subject to Delaware insurance law to provide coverage for health-care services provided through telemedicine and telehealth deemed covered services by the Plan. Eligible Delaware practitioners include most physicians and many other providers practicing within the scope of their license.

"Telehealth" is the use of information and communications technologies consisting of telephones, store and forward transfers, remote patient monitoring devices, or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, and health administration services.

"Telemedicine" is a form of telehealth, which is the delivery of clinical health-care services by means of real time two-way audio, visual, or other telecommunications or electronic communications. This includes the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health-care provider practicing within his or her scope of license as would be practiced in-person with a patient, and legally allowed to practice in the State.

The following are applicable to Delaware providers ONLY:

Distant Site

The distant site is the location where the provider (legally allowed to practice in the state) is rendering the service by means of telemedicine or telehealth. The Plan will not reimburse claims submitted for an access fee by the distant site.

Originating Site

The originating medical site (i.e., provider's office, outpatient facility, etc.) is a site in Delaware at which an eligible member is located at the time the service is performed by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties. The Plan will accept only one claim for the originating site access fee per visit that involves both an originating medical site and a distant site. Only the originating medical site will receive payment for an access fee.

Note: An access fee is not applicable for non-medical sites (e.g., member's home).

Professional service claims (1500/837P) should be billed using CMS Level 2 code Q3014, indicating the telehealth origination site fee, when applicable.

Outpatient facility claims (UB-04/837I) should be billed using CMS Level 2 code Q3014 and revenue code 780, when applicable.

Real-time Audio

Professional services (1500/837P) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968.

Outpatient facility claims (UB-04/837I) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968 with the appropriate revenue code.

Real-time Audio & Visual

Professional services claims (1500/837P) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT, 93, or 95 modifiers, indicating the use of an interactive audio and video telecommunications system. Modifier FQ should be used for services furnished using audio-only communication technology.

Outpatient facility claims (UB-04/837I) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT, 93, and 95 modifiers, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Store and Forward

Professional service claims (1500/837P) should be billed using existing E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier indicating the use of asynchronous telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home.

Telehealth Transmission

Professional service claims (1500/837P) should be billed using CMS Level 2 code T1014 indicating telehealth transmission, if appropriate.

Outpatient facility claims (UB04/837I) should be billed using CMS Level 2 code T1014 and the appropriate revenue code.

Note: The Plan will accept only one telehealth transmission code per encounter, per provider; if both a medical Originating and Distant site were involved, the Plan will accept one from each site, when applicable.

Services Not Covered

Services that the Plan **does not** reimburse include, but are not limited to, the following:

- Unsecured and unstructured services such as, but not limited to, skype and instant messaging unless such service is within the scope of practice of the provider.
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements above and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: In accordance with the telehealth waiver issued by the Governor of the State of Delaware through the Second Modification to the Declaration of the State of Emergency for the State of Delaware due to a Public Health Threat ("PHT") ("Declaration"), effective March 18, 2020, at 8:00 p.m., some of the requirements throughout this policy may also be waived or altered during the PHT and until such time as the Declaration remains in effect. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by the Declaration.

West Virginia Telemedicine Mandate - House Bill 4003

Effective July 1, 2020, West Virginia law requires all individual and group policies subject to West Virginia insurance law to provide coverage for health-care services, deemed covered services by the Plan, provided through telehealth services if those same services are covered through face-to-face consultation by the policy. Telehealth services shall not be subject to annual or lifetime dollar maximum; copayment, coinsurance or deductible amounts; policy year, calendar year or other duration benefit limitation or maximum that is not equally imposed on all terms and services covered under the policy, contract or plan. Eligible West Virginia practitioners include most physicians and many other providers practicing within the scope of their license. Required coverage includes the use of telehealth technologies as it pertains to medically necessary remote patient monitoring services to the full extent that those services are available.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS or applicable state waiver. Services will be allowed to pay on initial processing, and any post-pay

audits will **not** penalize providers for waived requirements, as defined by CMS.

Telehealth Services

Telehealth services means the use of synchronous or asynchronous telecommunications technology by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

Distant Site

The distant site means the telehealth site where the health care practitioner is seeing the patient at a distance or consulting with a patient's health care practitioner. The Plan will not reimburse claims submitted for an access fee by the distant site.

Health Care Practitioner

The health care practitioner means a person licensed under §30-1-1 *et seq*. of this code who provides health care services.

Originating Site

The originating site means the location where the patient is located, whether or not accompanied by a health care practitioner, at the time services are provided by a health care practitioner through telehealth, including, but not limited to, a health care practitioner's office, hospital, critical access hospital, rural health clinic, federally qualified health center, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

Note: Providers/facility at the Originating Site should bill procedure code Q3014.

Remote Patient Monitoring Services

Remote patient monitoring services means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows CMS guidelines for Telemedicine and Telehealth services.

Note: In accordance with the telehealth waiver issued by CMS, certain services are now permitted to be conducted via Telehealth. Please reference the CMS Physicians and Other Clinicians: CMS

Flexibilities to Fight COVID-19 and the MLN Connects 2020-04-03-MLNC-SE documents at the links located in the reference section of this policy.

IMPORTANT – To assist with timely processing of claims, if services are delivered outside the patients Home in a manner other than face-to-face, claims should always be billed using the place of service (POS) "02", including telephonic only codes. If services are delivered in the patients Home, use POS "10". Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g., electronic portal) by a provider to deliver care, POS 02 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

More information on telehealth can be found in the Highmark Provider Manual on the Provider Resource Center. Also, the Provider Resource Center has additional guidelines on the PHE.

RELATED POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- Z-65: Telestroke Services
- Z-11: Definition of Medical Necessity

Refer to the following Medicare Advantage Medical Policies for additional information:

- N-4: Nutrition Therapy
- Z-11: Definition of Medical Necessity

Refer to the following Reimbursement Policies for related information:

- RP-043: Care Management
- RP-057: Evaluation and Management Services

REFERENCES:

- American Medical Association, *Current Procedure Terminology* CPT® Manual

- CMS Medicare Claims Processing Manual, Chapter 12 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

- Delaware Telemedicine Mandate, House Bill 69 (Codified as 18 Del. C. §§ 3770 & 3571R; 18 Del. Admin. Code 1409) http://delcode.delaware.gov/sessionlaws/ga148/chp080.pdf

- U.S. Department of Health and Human Services: Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html

- CMS Medicare Telemedicine Health Care Provider Fact Sheet. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

- Second Modification of the Declaration of a State of Emergency for the State of Delaware due to a Public Health Threat https://governor.delaware.gov/wp-content/uploads/sites/24/2020/03/Second-Modification-to-the-State-of-Emergency.pdf

- CMS COVID-19 National Stakeholder Call, March 31, 2020. https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

- CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19. https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

- MLN Connects; 2020-04-03-MLNC-SE. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-03-mlnc-se

- American Medical Association; CPT Appendix A audio only Modifier 93 for reporting medical services: https://www.ama-assn.org/practice-management/cpt/cpt-appendix-audio-only-modifier-93-reporting-medical-services

POLICY UPDATE HISTORY INFORMATION:

7 / 2019	Implementation
1 / 2020	Replaced code 99444 with 99421, 99422 and 99423
3 / 2020	Added information related to the PHE issued by HHS and the PHT Declaration issued by the Governor of the State of Delaware. Added policy to be applicable to Medicare Advantage.
4 / 2020	Added information on reporting services per National Stakeholder Call. Added note for G0463.
7 / 2020	Added direction for mandatory use of POS 02 for Medicare Advantage and Commercial
8 / 2020	Added note below codes that do not include both audio and video communication
11 / 2021	Added NY region applicable to the policy. Removed Tele-dermatology section. Added note for NY variation of direction for codes 98966, 98967, 98968, 99441, 99442, and 99443.
1 / 2022	Added Delaware MA applicable to the policy. Added new POS 10 and mental health audio only communication direction. Added modifier FR, FQ and 93.
1 / 2023	Direction change on codes 99446, 99447, 99448, 99449, 98966, 98967 and 98968.

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-046		
Subject:	Telemedicine and Telehealth Services		
Effective Date:	July 15, 2019	**End Date:**	
Issue Date:	January 3, 2022	**Revised Date:**	January 2022
Date Reviewed:	December 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy outlines the Plan's reimbursement for telemedicine, telehealth, virtual-care, or eVisit services. The term "telehealth" is often used in conjunction with telemedicine and is intended to include a broader range of services using telecommunication technologies, including videoconferencing. Unless otherwise provided herein and unless as specifically set forth in the Delaware Telemedicine Mandate – House Bill 69 Section of this Policy, "telehealth" shall include telemedicine, telehealth, virtual care, and eVisit services deemed covered services by the Plan or its affiliates.

DEFINITIONS:

Distant Site: The location of an appropriately licensed health care provider while furnishing health care services by means of telecommunication.

Originating Site: The location of the patient at the time a telecommunication service is furnished.

Place of Service "02": The 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 "10": The location where health services and health related services are provided or received, through telecommunication 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 telecommunication technology.

Modifier GQ: Via asynchronous telecommunications system.

Modifier GT: Via interactive audio and video telecommunications systems.

Modifier 95: Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system.

Modifier 93: Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system.

Modifier FQ**:** Service was furnished using audio-only communication technology.

Modifier FR: The supervising practitioner was present through two-way audio/video communication technology.

Note: In accordance with the telehealth waiver issued by The Centers for Medicaid and Medicare Services (CMS) related to the 2019 novel coronavirus, some of the requirements for reporting the telehealth modifiers above, for example GQ, may also be waived or altered during the Public Health Emergency (PHE) period. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: Outpatient services delivered through an alternate medium (e.g. phone, e-visit, etc.) would not need the modifier, but all codes typically delivered face-to-face will require use of the appropriate modifier to indicate the alternate delivery method.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Reimbursement for telehealth services is determined according to individual, group, or customer benefits. Coverage for telehealth is limited to the types of services already considered a covered benefit under the member's specific plan. Coverages and reimbursements for telehealth services are limited to those services performed between a licensed clinician and a member/patient.

IMPORTANT – To assist with timely processing of claims, if services are delivered outside the patients Home in a manner other than face-to-face, claims should always be billed using the place of service (POS) "02", including telephonic only codes. If services are delivered in the patients Home, use POS "10". Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g. electronic portal) by a provider to deliver care, POS 02 or POS 10 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

Note: Diagnostic services that are patient worn or activated devices such as Holter monitoring (i.e., 93224, 93225, 93226, 93227) should continue to be billed in their historically appropriate POS.

When a covered benefit, evaluation and management and consultation services delivered through telehealth for *new and established patients may be reimbursed under the following conditions:

***Note**: In accordance with the telehealth waiver issued by CMS related to the 2019 novel coronavirus, new patients will be permitted to receive telehealth services beginning March 6, 2020, until the PHE declared by the Department of Health and Human Services (HHS) expires. Also, some of the requirements below and throughout this policy may also be waived or altered during the PHE period. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

1. Professional services rendered via an interactive telecommunication system are only eligible for reimbursement to the provider rendering the telehealth services. A provider rendering face-to-face care should report the appropriate codes for the in-person services.
2. The patient must be present at the time of all billed services unless the billed code is for exclusive use with *asynchronous* services or as specifically allowed under state law. If state law requires a face-to-face examination PRIOR to the delivery of telehealth services, the face-to-face services must be concluded and documented in the medical record prior to the initiation of any related telehealth visits.
3. All services provided must be medically appropriate and necessary in accordance with Highmark Medical Policy Z-11: Definition of Medical Necessity.
4. The consultation/evaluation and management service must take place via an interactive audio AND video telecommunications system, unless exceptions are allowed by applicable laws, or, unless the service is for mental health as described in this policy. Interactive telecommunications systems must be multi-media communication which, at minimum, includes audio and video equipment permitting real-time (synchronous) consultation among the patient and practitioner at the Originating Site and the practitioner at the Distant Site, unless the service is for mental health as described in this policy.
5. The technology platform used by the provider must meet technology security requirements, including being both HIPAA and HITECH compliant.
6. Thorough, appropriate documentation of telehealth services and other communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

Note: Provider should consult published guidance from the Office of Civil Rights (OCR) of HHS related to HIPAA and HITECH compliance during the PHE.

The following codes have regional variations on reimbursement:

98966 98967 98968 99441 99442 99443 99446 99447 99448 99449

For audio only codes, a patient visit performed through Telehealth should be documented to the same extent as an in-person visit, reflecting what occurred during the visit. The provider must also document that the visit was done through audio only telecommunications.

PA/WV/DE: Codes 98966, 98967, 98968, are <u>not</u> eligible as they do not include both audio and video communication. Codes 99441, 99442, 99443, 99446, 99447, 99448 and 99449 are <u>only</u> eligible during the PHE period.

NY: Codes 99441, 99442, 99443, 98966, 98967 and 98968 are eligible. Codes 99446, 99447, 99448, 99449 are only eligible during the PHE period.

Note: Effective January 1, 2022, telehealth services performed with audio only communication are eligible for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes when the patient is not capable of, or does not consent to, the use of two-way audio/video technology. Modifier FQ or 93 must be appended to the claim line for these services.

Eligible Providers

Providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face to face service.

Note: The requirement above may be waived or altered during the PHE declared by HHS pursuant to state requirements.

Virtual PCP and Retail Clinic Visits

When billing professional services (1500/837P), Virtual PCP Visits and Virtual Retail Clinic Visits should be billed with Evaluation & Management (E&M) CPT codes (99201-99205; 99211-99215) applicable to the services provided and with the GT, 93, or 95 modifiers, indicating the use of interactive audio and video telecommunications technology.

POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home. OP facility claims must also use the GT, 93, or 95 modifiers, as appropriate and applicable.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code (99201-99205; 99211-99215 or *G0463) with the GT, 93, or 95 modifiers, and the revenue code 780.

***Note**: If mandated by your OPPS payment methodology for reporting clinic visits.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits) or treatment.
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging

- Clinician-to-clinician consultations, telephone conversations*, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan. See section below for more information on Virtual Behavioral Health Visits.

Virtual Behavioral Health Visits

When billing professional services (1500/837P), virtual behavioral health services should be billed with existing mental health CPT codes applicable to the services provided with a GT, 93, or 95 modifiers, indicating the use of an interactive (synchronous) audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code with the GT, 93, or 95 modifiers, and the appropriate behavioral health revenue code (900-919).

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home. OP Facility claims must also use the GT, 93, or 95 modifiers, as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual behavioral health visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

Note: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan. Effective January 1, 2022, telehealth services performed with audio only communication are eligible for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes when the patient is not capable of, or does not consent to, the use of two-way audio/video technology. Modifier FQ must be appended to the claim line for these services.

Specialist Virtual Visit

The Originating Site can be either a medical site or an approved non-medical site. Only a medical Originating Site (i.e., PCP's office, outpatient facility, etc.) is eligible for reimbursement of an access fee. The Plan will accept HCPCS code Q3014 ("telehealth Originating Site facility fee") for the service. Claims for the medical Originating Site's access fee will be accepted as either professional (1500/837P) or outpatient facility (UB-04/837I using revenue code 780).

Note: No other service reported on the medical Originating Site claim will be eligible for payment by the Plan or the member.

Providers/facility at the Originating Site should bill procedure code Q3014.

Note: Code Q3014 is not covered if billed with a non-covered professional service.

The access fee is an all-inclusive fee that includes all medical Originating Site fees including, without limitation, providing a physical location for the virtual visit as well as providing all equipment to be utilized for the secure connection. No other fees may be billed to either the Plan or to the member by the medical Originating Site and all contractual member hold harmless requirements shall apply.

Note: The Plan will reimburse only one claim per encounter for the medical Originating Site access fee.

The Plan will accept only a professional claim (1500/837P) for the provider's evaluation/assessment services provided at the Distant Site.

Evaluation and management (E&M) visits (99201-99205; 99211-99215) are eligible codes for the specialist's services rendered at the Distant Site. The procedure code(s) representing the specialist's services must be billed with GT, 93, or 95 modifiers. The service appended with one of these modifiers is only billed by the specialty practitioner.

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home. OP Facility claims must also use the GT, 93, and 95 modifiers, as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Specialist Virtual Visit services that the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan. See section above for more information on Virtual Behavioral Health Visits.

Encounter Documentation Requirements

All telehealth encounter documentation in the medical record is expected to meet the same minimum standards as required by face-to-face visit documentation**.** All relevant visit documentation is subject to Highmark post-payment review.

Delaware Telemedicine Mandate - House Bill 69

Effective January 1, 2016, Delaware law requires all individual and group policies subject to Delaware insurance law to provide coverage for health-care services provided through telemedicine and telehealth deemed covered services by the Plan. Eligible Delaware practitioners include most physicians and many other providers practicing within the scope of their license.

"Telehealth" is the use of information and communications technologies consisting of telephones, store and forward transfers, remote patient monitoring devices, or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, and health administration services.

"Telemedicine" is a form of telehealth, which is the delivery of clinical health-care services by means of real time two-way audio, visual, or other telecommunications or electronic communications. This includes the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health-care provider practicing within his or her scope of license as would be practiced in-person with a patient, and legally allowed to practice in the State.

The following are applicable to Delaware providers ONLY:

Distant Site

The distant site is the location where the provider (legally allowed to practice in the state) is rendering the service by means of telemedicine or telehealth. The Plan will not reimburse claims submitted for an access fee by the distant site.

Originating Site

The originating medical site (i.e., provider's office, outpatient facility, etc.) is a site in Delaware at which an eligible member is located at the time the service is performed by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties. The Plan will accept only one claim for the originating site access fee per visit that involves both an originating medical site and a distant site. Only the originating medical site will receive payment for an access fee.

Note: An access fee is not applicable for non-medical sites (e.g., member's home).

Professional service claims (1500/837P) should be billed using CMS Level 2 code Q3014, indicating the telehealth origination site fee, when applicable.

Outpatient facility claims (UB-04/837I) should be billed using CMS Level 2 code Q3014 and revenue code 780, when applicable.

Real-time Audio

Professional services (1500/837P) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968.

Outpatient facility claims (UB-04/837I) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968 with the appropriate revenue code.

Real-time Audio & Visual

Professional services claims (1500/837P) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT, 93, or 95 modifiers, indicating the use of an interactive audio and video telecommunications system. Modifier FQ should be used for services furnished using audio-only communication technology.

Outpatient facility claims (UB-04/837I) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT, 93, and 95 modifiers, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Store and Forward

Professional service claims (1500/837P) should be billed using existing E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier indicating the use of asynchronous telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: POS "02" should be used when reporting professional telehealth services (1500 form) furnished outside of the Home and POS "10" for services furnished in the patient's Home.

Telehealth Transmission

Professional service claims (1500/837P) should be billed using CMS Level 2 code T1014 indicating telehealth transmission, if appropriate.

Outpatient facility claims (UB04/837I) should be billed using CMS Level 2 code T1014 and the appropriate revenue code.

Note: The Plan will accept only one telehealth transmission code per encounter, per provider; if both a medical Originating and Distant site were involved, the Plan will accept one from each site, when applicable.

Services Not Covered

Services that the Plan **does not** reimburse include, but are not limited to, the following:

- Unsecured and unstructured services such as, but not limited to, skype and instant messaging unless such service is within the scope of practice of the provider.
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements above and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: In accordance with the telehealth waiver issued by the Governor of the State of Delaware through the Second Modification to the Declaration of the State of Emergency for the State of Delaware due to a Public Health Threat ("PHT") ("Declaration"), effective March 18, 2020 at 8:00 p.m., some of the requirements throughout this policy may also be waived or altered during the PHT and until such time as the Declaration remains in effect. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by the Declaration.

West Virginia Telemedicine Mandate - House Bill 4003

Effective July 1, 2020, West Virginia law requires all individual and group policies subject to West Virginia insurance law to provide coverage for health-care services, deemed covered services by the Plan, provided through telehealth services if those same services are covered through face-to-face consultation by the policy. Telehealth services shall not be subject to annual or lifetime dollar maximum; copayment, coinsurance or deductible amounts; policy year, calendar year or other duration benefit limitation or maximum that is not equally imposed on all terms and services covered under the policy, contract or plan. Eligible West Virginia practitioners include most physicians and many other providers practicing within the scope of their license. Required coverage includes the use of telehealth technologies as it pertains to medically necessary remote patient monitoring services to the full extent that those services are available.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS or applicable state waiver. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Telehealth Services

Telehealth services means the use of synchronous or asynchronous telecommunications technology by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

Distant Site

The distant site means the telehealth site where the health care practitioner is seeing the patient at a distance or consulting with a patient's health care practitioner. The Plan will not reimburse claims submitted for an access fee by the distant site.

Health Care Practitioner

The health care practitioner means a person licensed under §30-1-1 *et seq.* of this code who provides health care services.

Originating Site

The originating site means the location where the patient is located, whether or not accompanied by a health care practitioner, at the time services are provided by a health care practitioner through telehealth, including, but not limited to, a health care practitioner's office, hospital, critical access hospital, rural health clinic, federally qualified health center, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

Note: Providers/facility at the Originating Site should bill procedure code Q3014.

Remote Patient Monitoring Services

Remote patient monitoring services means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows CMS guidelines for Telemedicine and Telehealth services.

Note: In accordance with the telehealth waiver issued by CMS, certain services are now permitted to be conducted via Telehealth. Please reference the CMS Physicians and Other Clinicians: CMS

Flexibilities to Fight COVID-19 and the MLN Connects 2020-04-03-MLNC-SE documents at the links located in the reference section of this policy.

IMPORTANT – To assist with timely processing of claims, if services are delivered outside the patients Home in a manner other than face-to-face, claims should always be billed using the place of service (POS) "02", including telephonic only codes. If services are delivered in the patients Home, use POS "10". Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g., electronic portal) by a provider to deliver care, POS 02 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

More information on telehealth can be found in the Highmark Provider Manual on the Provider Resource Center. Also, the Provider Resource Center has additional guidelines on the PHE.

RELATED POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- Z-65: Telestroke Services
- Z-11: Definition of Medical Necessity

Refer to the following Medicare Advantage Medical Policies for additional information:

- N-4: Nutrition Therapy
- Z-11: Definition of Medical Necessity

Refer to the following Reimbursement Policies for related information:

- RP-043: Care Management
- RP-057: Evaluation and Management Services

REFERENCES:

- American Medical Association, *Current Procedure Terminology* CPT® Manual

- CMS Medicare Claims Processing Manual, Chapter 12 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

- Delaware Telemedicine Mandate, House Bill 69 (Codified as 18 Del. C. §§ 3770 & 3571R; 18 Del. Admin. Code 1409) http://delcode.delaware.gov/sessionlaws/ga148/chp080.pdf

- U.S. Department of Health and Human Services: Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html

- CMS Medicare Telemedicine Health Care Provider Fact Sheet. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

- Second Modification of the Declaration of a State of Emergency for the State of Delaware due to a Public Health Threat https://governor.delaware.gov/wp-content/uploads/sites/24/2020/03/Second-Modification-to-the-State-of-Emergency.pdf

- CMS COVID-19 National Stakeholder Call, March 31, 2020. https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

- CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19. https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

- MLN Connects; 2020-04-03-MLNC-SE. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-03-mlnc-se

- American Medical Association; CPT Appendix A audio only Modifier 93 for reporting medical services: https://www.ama-assn.org/practice-management/cpt/cpt-appendix-audio-only-modifier-93-reporting-medical-services

POLICY UPDATE HISTORY INFORMATION:

7 / 2019	Implementation
1 / 2020	Replaced code 99444 with 99421, 99422 and 99423
3 / 2020	Added information related to the PHE issued by HHS and the PHT Declaration issued by the Governor of the State of Delaware. Added policy to be applicable to Medicare Advantage.
4 / 2020	Added information on reporting services per National Stakeholder Call. Added note for G0463.
7 / 2020	Added direction for mandatory use of POS 02 for Medicare Advantage and Commercial
8 / 2020	Added note below codes that do not include both audio and video communication
11 / 2021	Added NY region applicable to the policy. Removed Tele-dermatology section. Added note for NY variation of direction for codes 98966, 98967, 98968, 99441, 99442, and 99443.
1 / 2022	Added Delaware MA applicable to the policy. Added new POS 10 and mental health audio only communication direction. Added modifier FR, FQ and 93.

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-046		
Subject:	Telemedicine and Telehealth Services		
Effective Date:	July 15, 2019	**End Date:**	
Issue Date:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☐	**NY** ☒
Applicable Claim Type	**UB**	☒	**1500**	☒			

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy outlines the Plan's reimbursement for telemedicine, telehealth, virtual-care, or eVisit services. The term "telehealth" is often used in conjunction with telemedicine and is intended to include a broader range of services using telecommunication technologies, including videoconferencing. Unless otherwise provided herein and unless as specifically set forth in the Delaware Telemedicine Mandate – House Bill 69 Section of this Policy, "telehealth" shall include telemedicine, telehealth, virtual care, and eVisit services deemed covered services by the Plan or its affiliates.

DEFINITIONS:

Distant Site:	The location of an appropriately licensed health care provider while furnishing health care services by means of telecommunication.
Originating Site:	The location of the patient at the time a telecommunication service is furnished.
Place of Service "02":	The location where health services and health related services are provided or received, through a telecommunication system.
Modifier GQ:	Via asynchronous telecommunications system.
Modifier GT:	Via Interactive Audio and Video Telecommunications systems.
Modifier 95:	Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System.

Note: In accordance with the telehealth waiver issued by The Centers for Medicaid and Medicare Services (CMS) related to the 2019 novel coronavirus, some of the requirements for reporting the telehealth modifiers above, for example GQ, may also be waived or altered during the Public Health Emergency (PHE) period. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: Outpatient services delivered through an alternate medium (e.g. phone, e-visit, etc.) would not need the modifier, but all codes typically delivered face-to-face will require use of the appropriate modifier to indicate the alternate delivery method.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Reimbursement for telehealth services is determined according to individual, group, or customer benefits. Coverage for telehealth is limited to the types of services already considered a covered benefit under the member's specific plan. Coverages and reimbursements for telehealth services are limited to those services performed between a licensed clinician and a member/patient.

IMPORTANT – To assist with timely processing of claims, if services are being delivered in a manner other than face-to-face, claims should always be billed using the place of service "02", including telephonic only codes. Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g. electronic portal) by a provider to deliver care, POS 02 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

Note: Diagnostic services that are patient worn or activated devices such as Holter monitoring (i.e. 93224, 93225, 93226, 93227) should continue to be billed in their historically appropriate POS.

When a covered benefit, evaluation and management and consultation services delivered through telehealth for *new and established patients may be reimbursed under the following conditions:

***Note**: In accordance with the telehealth waiver issued by CMS related to the 2019 novel coronavirus, new patients will be permitted to receive telehealth services beginning March 6, 2020, until the PHE declared by the Department of Health and Human Services (HHS) expires. Also, some of the requirements below and throughout this policy may also be waived or altered during the PHE period. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

1. Professional services rendered via an interactive telecommunication system are only eligible for reimbursement to the provider rendering the telehealth services. A provider rendering face-to-face care should report the appropriate codes for the in-person services.
2. The patient must be present at the time of all billed services unless the billed code is for exclusive use with *asynchronous* services or as specifically allowed under state law. If state law requires a face-to-face examination PRIOR to the delivery of telehealth services, the face-to-face services

must be concluded and documented in the medical record prior to the initiation of any related telehealth visits.

3. All services provided must be medically appropriate and necessary in accordance with Highmark Medical Policy Z-11: Definition of Medical Necessity.
4. The consultation/evaluation and management service must take place via an interactive audio AND video telecommunications system (unless exceptions are allowed by applicable laws). Interactive telecommunications systems must be multi-media communication which, at minimum, includes audio and video equipment permitting real-time (synchronous) consultation among the patient and practitioner at the Originating Site and the practitioner at the Distant Site.
5. The technology platform used by the provider must meet technology security requirements, including being both HIPAA and HITECH compliant.
6. Thorough, appropriate documentation of telehealth services and other communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

Note: Provider should consult published guidance from the Office of Civil Rights (OCR) of HHS related to HIPAA and HITECH compliance during the PHE.

The following codes have regional variations on reimbursement:

98966 98967 98968 99441 99442 99443 99446 99447 99448 99449

PA/WV/DE: Codes 98966, 98967, 98968, are not eligible as they do not include both audio and video communication. Codes 99441, 99442, 99443, 99446, 99447, 99448 and 99449 are only eligible during the PHE period.

NY: Codes 99441, 99442, 99443, 98966, 98967 and 98968 are eligible. Codes 99446, 99447, 99448, 99449 are only eligible during the PHE period.

Eligible Providers

Providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face to face service.

Note: The requirement above may be waived or altered during the PHE declared by HHS pursuant to state requirements.

Virtual PCP and Retail Clinic Visits

When billing professional services (1500/837P), Virtual PCP Visits and Virtual Retail Clinic Visits should be billed with Evaluation & Management (E&M) CPT codes (99201-99205; 99211-99215) applicable to the services provided and with the GT or 95 modifier indicating the use of interactive audio and video telecommunications technology.

Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code (99201-99205; 99211-99215 or *G0463) with the GT or 95 modifiers and the revenue code 780.

***Note**: If mandated by your OPPS payment methodology for reporting clinic visits.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits) or treatment.
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Virtual Behavioral Health Visits

When billing professional services (1500/837P), virtual behavioral health services should be billed with existing mental health CPT codes applicable to the services provided with a GT or 95 modifiers indicating the use of an interactive (synchronous) audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code with the GT or 95 modifiers and the appropriate behavioral health revenue code (900-919).

Note: Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP Facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual behavioral health visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

Note: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Specialist Virtual Visit

The Originating Site can be either a medical site or an approved non-medical site. Only a medical Originating Site (i.e. PCP's office, outpatient facility, etc.) is eligible for reimbursement of an access fee. The Plan will accept HCPCS code Q3014 ("telehealth Originating Site facility fee") for the service. Claims for the medical Originating Site's access fee will be accepted as either professional (1500/837P) or outpatient facility (UB-04/837I using revenue code 780).

Note: No other service reported on the medical Originating Site claim will be eligible for payment by the Plan or the member.

Providers/facility at the Originating Site should bill procedure code Q3014.

Note: Code Q3014 is not covered if billed with a non-covered professional service.

The access fee is an all-inclusive fee that includes all medical Originating Site fees including, without limitation, providing a physical location for the virtual visit as well as providing all equipment to be utilized for the secure connection. No other fees may be billed to either the Plan or to the member by the medical Originating Site and all contractual member hold harmless requirements shall apply.

Note: The Plan will reimburse only one claim per encounter for the medical Originating Site access fee.

The Plan will accept only a professional claim (1500/837P) for the provider's evaluation/assessment services provided at the Distant Site.

Evaluation and management (E&M) visits (99201-99205; 99211-99215) are eligible codes for the specialist's services rendered at the Distant Site. The procedure code(s) representing the specialist's services must be billed with GT or 95 modifiers. The service appended with one of these modifiers is only billed by the specialty practitioner.

Note: Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP Facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing, and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Specialist Virtual Visit services that the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Encounter Documentation Requirements

All telehealth encounter documentation in the medical record is expected to meet the same minimum standards as required by face-to-face visit documentation**.** All relevant visit documentation is subject to Highmark post-payment review.

Delaware Telemedicine Mandate - House Bill 69

Effective January 1, 2016, Delaware law requires all individual and group policies subject to Delaware insurance law to provide coverage for health-care services provided through telemedicine and telehealth deemed covered services by the Plan. Eligible Delaware practitioners include most physicians and many other providers practicing within the scope of their license.

"Telehealth" is the use of information and communications technologies consisting of telephones, store and forward transfers, remote patient monitoring devices, or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, and health administration services.

"Telemedicine" is a form of telehealth, which is the delivery of clinical health-care services by means of real time two-way audio, visual, or other telecommunications or electronic communications. This includes the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health-care provider practicing within his

or her scope of license as would be practiced in-person with a patient, and legally allowed to practice in the State.

The following are applicable to Delaware providers ONLY:

Distant Site

The distant site is the location where the provider (legally allowed to practice in the state) is rendering the service by means of telemedicine or telehealth. The Plan will not reimburse claims submitted for an access fee by the distant site.

Originating Site

The originating medical site (i.e., provider's office, outpatient facility, etc.) is a site in Delaware at which an eligible member is located at the time the service is performed by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties. The Plan will accept only one claim for the originating site access fee per visit that involves both an originating medical site and a distant site. Only the originating medical site will receive payment for an access fee.

Note: An access fee is not applicable for non-medical sites (e.g. member's home).

Professional service claims (1500/837P) should be billed using CMS Level 2 code Q3014, indicating the telehealth origination site fee, when applicable.

Outpatient facility claims (UB-04/837I) should be billed using CMS Level 2 code Q3014 and revenue code 780, when applicable.

Real-time Audio

Professional services (1500/837P) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968.

Outpatient facility claims (UB-04/837I) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968 with the appropriate revenue code.

Real-time Audio & Visual

Professional services claims (1500/837P) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT or 95 modifiers indicating the use of an interactive audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT and 95 modifiers, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: Place of Service "02" (Telehealth) must be used when reporting the GT or 95 modifiers on professional (1500 form) claims.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Store and Forward

Professional service claims (1500/837P) should be billed using existing E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier indicating the use of asynchronous telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: Place of Service "02" (Telehealth) must be used when reporting the GQ modifier on professional (1500 form) claims.

Telehealth Transmission

Professional service claims (1500/837P) should be billed using CMS Level 2 code T1014 indicating telehealth transmission, if appropriate.

Outpatient facility claims (UB04/837I) should be billed using CMS Level 2 code T1014 and the appropriate revenue code.

Note: The Plan will accept only one telehealth transmission code per encounter, per provider; if both a medical Originating and Distant site were involved, the Plan will accept one from each site, when applicable.

Services Not Covered

Services that the Plan **does not** reimburse include, but are not limited to, the following:

- Unsecured and unstructured services such as, but not limited to, skype and instant messaging unless such service is within the scope of practice of the provider
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements above and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: In accordance with the telehealth waiver issued by the Governor of the State of Delaware through the Second Modification to the Declaration of the State of Emergency for the State of Delaware due to a Public Health Threat ("PHT") ("Declaration"), effective March 18, 2020 at 8:00 p.m., some of the requirements throughout this policy may also be waived or altered during the PHT and until such time as the Declaration remains in effect. Services will be allowed to pay on initial processing

and any post-pay audits will **not** penalize providers for waived requirements, as defined by the Declaration.

West Virginia Telemedicine Mandate - House Bill 4003

Effective July 1, 2020, West Virginia law requires all individual and group policies subject to West Virginia insurance law to provide coverage for health-care services, deemed covered services by the Plan, provided through telehealth services if those same services are covered through face-to-face consultation by the policy. Telehealth services shall not be subject to annual or lifetime dollar maximum; copayment, coinsurance or deductible amounts; policy year, calendar year or other duration benefit limitation or maximum that is not equally imposed on all terms and services covered under the policy, contract or plan. Eligible West Virginia practitioners include most physicians and many other providers practicing within the scope of their license. Required coverage includes the use of telehealth technologies as it pertains to medically necessary remote patient monitoring services to the full extent that those services are available.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS or applicable state waiver. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Telehealth Services

Telehealth services means the use of synchronous or asynchronous telecommunications technology by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

Distant Site

The distant site means the telehealth site where the health care practitioner is seeing the patient at a distance or consulting with a patient's health care practitioner. The Plan will not reimburse claims submitted for an access fee by the distant site.

Health Care Practitioner

The health care practitioner means a person licensed under §30-1-1 *et seq*. of this code who provides health care services.

Originating Site

The originating site means the location where the patient is located, whether or not accompanied by a health care practitioner, at the time services are provided by a health care practitioner through telehealth, including, but not limited to, a health care practitioner's office, hospital, critical access hospital, rural health

clinic, federally qualified health center, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

Note: Providers/facility at the Originating Site should bill procedure code Q3014.

Remote Patient Monitoring Services

Remote patient monitoring services means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows CMS guidelines for Telemedicine and Telehealth services.

Note: In accordance with the telehealth waiver issued by CMS, certain services are now permitted to be conducted via Telehealth. Please reference the CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19 and the MLN Connects 2020-04-03-MLNC-SE documents at the links located in the reference section of this policy.

IMPORTANT – To assist with timely processing of claims, if services are being delivered in a manner other than face-to-face, claims should always be billed using the place of service "02", including telephonic only codes. Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g. electronic portal) by a provider to deliver care, POS 02 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

More information on telehealth can be found in the Highmark Provider Manual on the Provider Resource Center. Also, the Provider Resource Center has additional guidelines on the PHE.

RELATED POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- Z-65: Telestroke Services
- Z-11: Definition of Medical Necessity

Refer to the following Medicare Advantage Medical Policies for additional information:

- N-4: Nutrition Therapy
- Z-11: Definition of Medical Necessity

Refer to the following Reimbursement Policies for related information:

- Reimbursement Policy RP-043: Care Management

REFERENCES:

- American Medical Association, *Current Procedure Terminology* CPT® Manual
- CMS Medicare Claims Processing Manual, Chapter 12 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- Delaware Telemedicine Mandate, House Bill 69 (Codified as 18 Del. C. §§ 3770 & 3571R; 18 Del. Admin. Code 1409) http://delcode.delaware.gov/sessionlaws/ga148/chp080.pdf
- U.S. Department of Health and Human Services: Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html
- CMS Medicare Telemedicine Health Care Provider Fact Sheet. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- Second Modification of the Declaration of a State of Emergency for the State of Delaware due to a Public Health Threat https://governor.delaware.gov/wp-content/uploads/sites/24/2020/03/Second-Modification-to-the-State-of-Emergency.pdf
- CMS COVID-19 National Stakeholder Call, March 31, 2020. https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts
- CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19. https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf
- MLN Connects; 2020-04-03-MLNC-SE. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-03-mlnc-se

POLICY UPDATE HISTORY INFORMATION:

7 / 2019	Implementation

1 / 2020	Replaced code 99444 with 99421, 99422 and 99423
3 / 2020	Added information related to the PHE issued by HHS and the PHT Declaration issued by the Governor of the State of Delaware. Added policy to be applicable to Medicare Advantage.
4 / 2020	Added information on reporting services per National Stakeholder Call. Added note for G0463.
7 / 2020	Added direction for mandatory use of POS 02 for MA and Commercial
8 / 2020	Added note below codes that do not include both audio and video communication
11 / 2021	Added NY region applicable to the policy. Removed Tele-dermatology section. Added note for NY variation of direction for codes 98966, 98967, 98968, 99441, 99442, and 99443.

Highmark Reimbursement Policy Bulletin

HISTORY VERSIONS

Bulletin Number:	RP-046		
Subject:	Telemedicine and Telehealth Services		
Effective Date:	July 15, 2019	**End Date:**	
Issue Date:	August 6, 2020	**Revised Date:**	August 5, 2020
Date Reviewed:	August 2020		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV** ☒		
Applicable Claim Type	**UB**	☒	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy outlines the Plan's reimbursement for telemedicine, telehealth, virtual-care, or eVisit services. The term "telehealth" is often used in conjunction with telemedicine and is intended to include a broader range of services using telecommunication technologies, including videoconferencing. Unless otherwise provided herein and unless as specifically set forth in the Delaware Telemedicine Mandate – House Bill 69 Section of this Policy, "telehealth" shall include telemedicine, telehealth, virtual care, and eVisit services deemed covered services by the Plan or its affiliates.

Definitions

Distant Site:	The location of an appropriately licensed health care provider while furnishing health care services by means of telecommunication.
Originating Site:	The location of the patient at the time a telecommunication service is furnished.
Place of Service "02":	The location where health services and health related services are provided or received, through a telecommunication system.
Modifier GQ:	Via asynchronous telecommunications system.

Modifier GT: Via Interactive Audio and Video Telecommunications systems.

Modifier 95: Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System.

Note: In accordance with the telehealth waiver issued by The Centers for Medicaid and Medicare Services (CMS) related to the 2019 novel coronavirus, some of the requirements for reporting the telehealth modifiers above, for example GQ, may also be waived or altered during the Public Health Emergency (PHE) period. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: Outpatient services delivered through an alternate medium (e.g. phone, e-visit, etc.) would not need the modifier, but all codes typically delivered face-to-face will require use of the appropriate modifier to indicate the alternate delivery method.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Reimbursement for telehealth services is determined according to individual, group, or customer benefits. Coverage for telehealth is limited to the types of services already considered a covered benefit under the member's specific plan. Coverages and reimbursements for telehealth services are limited to those services performed between a licensed clinician and a member/patient.

IMPORTANT – To assist with timely processing of claims, if services are being delivered in a manner other than face-to-face, claims should always be billed using the place of service "02", including telephonic only codes. Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g. electronic portal) by a provider to deliver care, POS 02 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

Note: Diagnostic services that are patient worn or activated devices such as Holter monitoring (i.e. 93224, 93225, 93226, 93227) should continue to be billed in their historically appropriate POS.

When a covered benefit, evaluation and management and consultation services delivered through telehealth for *new and established patients may be reimbursed under the following conditions:

***Note**: In accordance with the telehealth waiver issued by CMS related to the 2019 novel coronavirus, new patients will be permitted to receive telehealth services beginning March 6, 2020, until the PHE declared by the Department of Health and Human Services (HHS) expires. Also, some of the requirements below and throughout this policy may also be waived or altered during the PHE period. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

1. Professional services rendered via an interactive telecommunication system are only eligible for reimbursement to the provider rendering the telehealth services. A provider rendering face-to-face care should report the appropriate codes for the in-person services.
2. The patient must be present at the time of all billed services unless the billed code is for exclusive use with *asynchronous* services or as specifically allowed under state law. If state law requires a face-to-face examination PRIOR to the delivery of telehealth services, the face-to-face services must be concluded and documented in the medical record prior to the initiation of any related telehealth visits.
3. All services provided must be medically appropriate and necessary in accordance with Highmark Medical Policy Z-11: Definition of Medical Necessity.
4. The consultation/evaluation and management service must take place via an interactive audio AND video telecommunications system (unless exceptions are allowed by applicable laws). Interactive telecommunications systems must be multi-media communication which, at minimum, includes audio and video equipment permitting real-time (synchronous) consultation among the patient and practitioner at the Originating Site and the practitioner at the Distant Site.
5. The technology platform used by the provider must meet technology security requirements, including being both HIPAA and HITECH compliant.
6. Thorough, appropriate documentation of telehealth services and other communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

Note: Provider should consult published guidance from the Office of Civil Rights (OCR) of HHS related to HIPAA and HITECH compliance during the PHE.

The following codes are <u>not</u> eligible for reimbursement under the telehealth policy as they do not include both audio and video communication:

98966 98967 98968 *99441 *99442 *99443 *99446 *99447 *99448 *99449

***Note**: These codes are eligible for reimbursement during the PHE period.

<u>Eligible Providers</u>

Providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face to face service.

Note: The requirement above may be waived or altered during the PHE declared by HHS pursuant to state requirements.

<u>Virtual PCP and Retail Clinic Visits</u>

When billing professional services (1500/837P), Virtual PCP Visits and Virtual Retail Clinic Visits should be billed with Evaluation & Management (E&M) CPT codes (99201-99205; 99211-99215) applicable to the services provided and with the GT or 95 modifier indicating the use of interactive audio and video telecommunications technology.

Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code (99201-99205; 99211-99215 or *G0463) with the GT or 95 modifiers and the revenue code 780.

***Note**: If mandated by your OPPS payment methodology for reporting clinic visits.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits) or treatment.
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Virtual Behavioral Health Visits

When billing professional services (1500/837P), virtual behavioral health services should be billed with existing mental health CPT codes applicable to the services provided with a GT or 95 modifiers indicating the use of an interactive (synchronous) audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code with the GT or 95 modifiers and the appropriate behavioral health revenue code (900-919).

Note: Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP Facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual behavioral health visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

Note: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Specialist Virtual Visit

The Originating Site can be either a medical site or an approved non-medical site. Only a medical Originating Site (i.e. PCP's office, outpatient facility, etc.) is eligible for reimbursement of an access fee. The Plan will accept HCPCS code Q3014 ("telehealth Originating Site facility fee") for the service. Claims for the medical Originating Site's access fee will be accepted as either professional (1500/837P) or outpatient facility (UB-04/837I using revenue code 780).

Note: No other service reported on the medical Originating Site claim will be eligible for payment by the Plan or the member.

Providers/facility at the Originating Site should bill procedure code Q3014.

Note: Code Q3014 is not covered if billed with a non-covered professional service.

The access fee is an all-inclusive fee that includes all medical Originating Site fees including, without limitation, providing a physical location for the virtual visit as well as providing all equipment to be utilized for the secure connection. No other fees may be billed to either the Plan or to the member by the medical Originating Site and all contractual member hold harmless requirements shall apply.

Note: The Plan will reimburse only one claim per encounter for the medical Originating Site access fee.

The Plan will accept only a professional claim (1500/837P) for the provider's evaluation/assessment services provided at the Distant Site.

Evaluation and management (E&M) visits (99201-99205; 99211-99215) and consultation services (99241-99245) are eligible codes for the specialist's services rendered at the Distant Site. The procedure code(s) representing the specialist's services must be billed with GT or 95 modifiers. The service appended with one of these modifiers is only billed by the specialty practitioner.

Note: Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP Facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Specialist Virtual Visit services that the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Teledermatology

The Plan will accept claims for teledermatology services from dermatologists billing on a 1500 claim form or 837P electronic format. Services should be billed using procedure code 99421, 99422 or 99423.

Outpatient facility claims (UB-04/837I) should be billed using procedure code 99421, 99422 or 99423 and revenue code 780.

Note: A telehealth modifier is not needed with the 99421, 99422 or 99423 code as the description of the code already indicates the service is "online".

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Encounter Documentation Requirements

All telehealth encounter documentation in the medical record is expected to meet the same minimum standards as required by face-to-face visit documentation**.** All relevant visit documentation is subject to Highmark post-payment review.

Delaware Telemedicine Mandate - House Bill 69

Effective January 1, 2016, Delaware law requires all individual and group policies subject to Delaware insurance law to provide coverage for health-care services provided through telemedicine and telehealth deemed covered services by the Plan. Eligible Delaware practitioners include most physicians and many other providers practicing within the scope of their license.

"Telehealth" is the use of information and communications technologies consisting of telephones, store and forward transfers, remote patient monitoring devices, or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, and health administration services.

"Telemedicine" is a form of telehealth, which is the delivery of clinical health-care services by means of real time two-way audio, visual, or other telecommunications or electronic communications. This includes the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health-care provider practicing within his or her scope of license as would be practiced in-person with a patient, and legally allowed to practice in the State.

The following are applicable to Delaware providers ONLY:

Distant Site

The distant site is the location where the provider (legally allowed to practice in the state) is rendering the service by means of telemedicine or telehealth. The Plan will not reimburse claims submitted for an access fee by the distant site.

Originating Site

The originating medical site (i.e., provider's office, outpatient facility, etc.) is a site in Delaware at which an eligible member is located at the time the service is performed by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties. The Plan will accept only one claim for the originating site access fee per visit that involves both an originating medical site and a distant site. Only the originating medical site will receive payment for an access fee.

Note: An access fee is not applicable for non-medical sites (e.g. member's home).

Professional service claims (1500/837P) should be billed using CMS Level 2 code Q3014, indicating the telehealth origination site fee, when applicable.

Outpatient facility claims (UB-04/837I) should be billed using CMS Level 2 code Q3014 and revenue code 780, when applicable.

Real-time Audio

Professional services (1500/837P) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968.

Outpatient facility claims (UB-04/837I) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968 with the appropriate revenue code.

Real-time Audio & Visual

Professional services claims (1500/837P) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT or 95 modifier indicating the use of an interactive audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT and 95 modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: Place of Service "02" (Telehealth) must be used when reporting the GT or 95 modifier on professional (1500 form) claims.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Store and Forward

Professional service claims (1500/837P) should be billed using existing E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier indicating the use of asynchronous telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: Place of Service "02" (Telehealth) must be used when reporting the GQ modifier on professional (1500 form) claims.

Telehealth Transmission

Professional service claims (1500/837P) should be billed using CMS Level 2 code T1014 indicating telehealth transmission, if appropriate.

Outpatient facility claims (UB04/837I) should be billed using CMS Level 2 code T1014 and the appropriate revenue code.

Note: The Plan will accept only one telehealth transmission code per encounter, per provider; if both a medical Originating and Distant site were involved, the Plan will accept one from each site, when applicable.

Services Not Covered

Services that the Plan **does not** reimburse include, but are not limited to, the following:

- Unsecured and unstructured services such as, but not limited to, skype and instant messaging unless such service is within the scope of practice of the provider
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements above and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: In accordance with the telehealth waiver issued by the Governor of the State of Delaware through the Second Modification to the Declaration of the State of Emergency for the State of Delaware due to a Public Health Threat ("PHT") ("Declaration"), effective March 18, 2020 at 8:00 p.m., some of the requirements throughout this policy may also be waived or altered during the PHT and until such time as the Declaration remains in effect. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by the Declaration.

West Virginia Telemedicine Mandate - House Bill 4003

Effective July 1, 2020, West Virginia law requires all individual and group policies subject to West Virginia insurance law to provide coverage for health-care services, deemed covered services by the Plan, provided through telehealth services if those same services are covered through face-to-face consultation by the policy. Telehealth services shall not be subject to annual or lifetime dollar maximum; copayment, coinsurance or deductible amounts; policy year, calendar year or other duration benefit limitation or maximum that is not equally imposed on all terms and services covered under the policy, contract or plan. Eligible West Virginia practitioners include most physicians and many other providers practicing within the scope of their license. Required coverage includes the use of telehealth technologies as it pertains to medically necessary remote patient monitoring services to the full extent that those services are available.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS or applicable state waiver. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Telehealth Services

Telehealth services means the use of synchronous or asynchronous telecommunications technology by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

Distant Site

The distant site means the telehealth site where the health care practitioner is seeing the patient at a distance or consulting with a patient's health care practitioner. The Plan will not reimburse claims submitted for an access fee by the distant site.

Health Care Practitioner

The health care practitioner means a person licensed under §30-1-1 *et seq*. of this code who provides health care services.

Originating Site

The originating site means the location where the patient is located, whether or not accompanied by a health care practitioner, at the time services are provided by a health care practitioner through telehealth, including, but not limited to, a health care practitioner's office, hospital, critical access hospital, rural health clinic, federally qualified health center, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

Note: Providers/facility at the Originating Site should bill procedure code Q3014.

Remote Patient Monitoring Services

Remote patient monitoring services means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows CMS guidelines for Telemedicine and Telehealth services.

Note: In accordance with the telehealth waiver issued by CMS, certain services are now permitted to be conducted via Telehealth. Please reference the CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19 and the MLN Connects 2020-04-03-MLNC-SE documents at the links located in the reference section of this policy.

IMPORTANT – To assist with timely processing of claims, if services are being delivered in a manner other than face-to-face, claims should always be billed using the place of service "02", including telephonic only codes. Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g. electronic portal) by a provider to deliver care, POS 02 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

More information on telehealth can be found in the Highmark Provider Manual on the Provider Resource Center. Also, the Provider Resource Center has additional guidelines on the PHE.

RELATED POLICIES:

Refer to the following Medical Policies for additional information:

- Commercial Policy Z-65: Telestroke Services
- Commercial Policy Z-11: Definition of Medical Necessity
- Medicare Advantage Policy N-4: Nutrition Therapy
- Medicare Advantage Policy Z-11: Definition of Medical Necessity

Refer to the following Reimbursement Policies for related information:

- Reimbursement Policy RP-043: Care Management

REFERENCES:

- American Medical Association, *Current Procedure Terminology* CPT® Manual
- CMS Medicare Claims Processing Manual, Chapter 12 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- Delaware Telemedicine Mandate, House Bill 69 (Codified as 18 Del. C. §§ 3770 & 3571R; 18 Del. Admin. Code 1409) http://delcode.delaware.gov/sessionlaws/ga148/chp080.pdf
- U.S. Department of Health and Human Services: Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html
- CMS Medicare Telemedicine Health Care Provider Fact Sheet. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- Second Modification of the Declaration of a State of Emergency for the State of Delaware due to a Public Health Threat https://governor.delaware.gov/wp-content/uploads/sites/24/2020/03/Second-Modification-to-the-State-of-Emergency.pdf

- CMS COVID-19 National Stakeholder Call, March 31, 2020. https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

- CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19. https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

- MLN Connects; 2020-04-03-MLNC-SE. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-03-mlnc-se

POLICY UPDATE HISTORY INFORMATION:

07 / 2019	Implementation
01 / 2020	Replaced code 99444 with 99421, 99422 and 99423
03 / 2020	Added information related to the PHE issued by HHS and the PHT Declaration issued by the Governor of the State of Delaware. Added policy to be applicable to Medicare Advantage.
04 / 2020	Added information on reporting services per National Stakeholder Call. Added note for G0463.
07 / 2020	Added direction for mandatory use of POS 02 for MA and Commercial
08 / 2020	Added note below codes that do not include both audio and video communication

Highmark Reimbursement Policy Bulletin

HISTORY VERSIONS

Bulletin Number:	RP-046		
Subject:	Telemedicine and Telehealth Services		
Effective Date:	July 15, 2019	**End Date:**	
Issue Date:	July 20, 2020	**Revised Date:**	July 8, 2020
Date Reviewed:	June 2020		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA** ☒	**WV** ☒	**DE** ☒		
Applicable Medicare Advantage Market	**PA** ☒	**WV** ☒			
Applicable Claim Type	**UB** ☒	**1500** ☒			

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy outlines the Plan's reimbursement for telemedicine, telehealth, virtual-care, or eVisit services. The term "telehealth" is often used in conjunction with telemedicine and is intended to include a broader range of services using telecommunication technologies, including videoconferencing. Unless otherwise provided herein and unless as specifically set forth in the Delaware Telemedicine Mandate – House Bill 69 Section of this Policy, "telehealth" shall include telemedicine, telehealth, virtual care, and eVisit services deemed covered services by the Plan or its affiliates.

Definitions

Distant Site:	The location of an appropriately licensed health care provider while furnishing health care services by means of telecommunication.
Originating Site:	The location of the patient at the time a telecommunication service is furnished.
Place of Service "02":	The location where health services and health related services are provided or received, through a telecommunication system.
Modifier GQ:	Via asynchronous telecommunications system.

Modifier GT: Via Interactive Audio and Video Telecommunications systems.

Modifier 95: Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System.

Note: In accordance with the telehealth waiver issued by The Centers for Medicaid and Medicare Services (CMS) related to the 2019 novel coronavirus, some of the requirements for reporting the telehealth modifiers above, for example GQ, may also be waived or altered during the Public Health Emergency (PHE) period. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: Outpatient services delivered through an alternate medium (e.g. phone, e-visit, etc.) would not need the modifier, but all codes typically delivered face-to-face will require use of the appropriate modifier to indicate the alternate delivery method.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Reimbursement for telehealth services is determined according to individual, group, or customer benefits. Coverage for telehealth is limited to the types of services already considered a covered benefit under the member's specific plan. Coverages and reimbursements for telehealth services are limited to those services performed between a licensed clinician and a member/patient.

IMPORTANT – To assist with timely processing of claims, if services are being delivered in a manner other than face-to-face, claims should always be billed using the place of service "02", including telephonic only codes. Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g. electronic portal) by a provider to deliver care, POS 02 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

Note: Diagnostic services that are patient worn or activated devices such as Holter monitoring (i.e. 93224, 93225, 93226, 93227) should continue to be billed in their historically appropriate POS.

When a covered benefit, evaluation and management and consultation services delivered through telehealth for *new and established patients may be reimbursed under the following conditions:

***Note**: In accordance with the telehealth waiver issued by CMS related to the 2019 novel coronavirus, new patients will be permitted to receive telehealth services beginning March 6, 2020, until the PHE declared by the Department of Health and Human Services (HHS) expires. Also, some of the requirements below and throughout this policy may also be waived or altered during the PHE period. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

1. Professional services rendered via an interactive telecommunication system are only eligible for reimbursement to the provider rendering the telehealth services. A provider rendering face-to-face care should report the appropriate codes for the in-person services.
2. The patient must be present at the time of all billed services unless the billed code is for exclusive use with *asynchronous* services or as specifically allowed under state law. If state law requires a face-to-face examination PRIOR to the delivery of telehealth services, the face-to-face services must be concluded and documented in the medical record prior to the initiation of any related telehealth visits.
3. All services provided must be medically appropriate and necessary in accordance with Highmark Medical Policy Z-11: Definition of Medical Necessity.
4. The consultation/evaluation and management service must take place via an interactive audio AND video telecommunications system (unless exceptions are allowed by applicable laws). Interactive telecommunications systems must be multi-media communication which, at minimum, includes audio and video equipment permitting real-time (synchronous) consultation among the patient and practitioner at the Originating Site and the practitioner at the Distant Site.
5. The technology platform used by the provider must meet technology security requirements, including being both HIPAA and HITECH compliant.
6. Thorough, appropriate documentation of telehealth services and other communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

Note: Provider should consult published guidance from the Office of Civil Rights (OCR) of HHS related to HIPAA and HITECH compliance during the PHE.

The following codes are <u>not</u> eligible for reimbursement under the telehealth policy as they do not include both audio and video communication:

98966 98967 98968 *99441 *99442 *99443 *99446 *99447 *99448 *99449

<u>Eligible Providers</u>

Providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face to face service.

Note: The requirement above may be waived or altered during the PHE declared by HHS pursuant to state requirements.

<u>Virtual PCP and Retail Clinic Visits</u>

When billing professional services (1500/837P), Virtual PCP Visits and Virtual Retail Clinic Visits should be billed with Evaluation & Management (E&M) CPT codes (99201-99205; 99211-99215) applicable to the services provided and with the GT or 95 modifier indicating the use of interactive audio and video telecommunications technology.

Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code (99201-99205; 99211-99215 or *G0463) with the GT or 95 modifiers and the revenue code 780.

***Note**: If mandated by your OPPS payment methodology for reporting clinic visits.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits) or treatment.
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Virtual Behavioral Health Visits

When billing professional services (1500/837P), virtual behavioral health services should be billed with existing mental health CPT codes applicable to the services provided with a GT or 95 modifiers indicating the use of an interactive (synchronous) audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code with the GT or 95 modifiers and the appropriate behavioral health revenue code (900-919).

Note: Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP Facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual behavioral health visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

Note: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Specialist Virtual Visit

The Originating Site can be either a medical site or an approved non-medical site. Only a medical Originating Site (i.e. PCP's office, outpatient facility, etc.) is eligible for reimbursement of an access fee. The Plan will accept HCPCS code Q3014 ("telehealth Originating Site facility fee") for the service. Claims for the medical Originating Site's access fee will be accepted as either professional (1500/837P) or outpatient facility (UB-04/837I using revenue code 780).

Note: No other service reported on the medical Originating Site claim will be eligible for payment by the Plan or the member.

Providers/facility at the Originating Site should bill procedure code Q3014.

Note: Code Q3014 is not covered if billed with a non-covered professional service.

The access fee is an all-inclusive fee that includes all medical Originating Site fees including, without limitation, providing a physical location for the virtual visit as well as providing all equipment to be utilized for the secure connection. No other fees may be billed to either the Plan or to the member by the medical Originating Site and all contractual member hold harmless requirements shall apply.

Note: The Plan will reimburse only one claim per encounter for the medical Originating Site access fee.

The Plan will accept only a professional claim (1500/837P) for the provider's evaluation/assessment services provided at the Distant Site.

Evaluation and management (E&M) visits (99201-99205; 99211-99215) and consultation services (99241-99245) are eligible codes for the specialist's services rendered at the Distant Site. The procedure code(s) representing the specialist's services must be billed with GT or 95 modifiers. The service appended with one of these modifiers is only billed by the specialty practitioner.

Note: Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP Facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Specialist Virtual Visit services that the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Teledermatology

The Plan will accept claims for teledermatology services from dermatologists billing on a 1500 claim form or 837P electronic format. Services should be billed using procedure code 99421, 99422 or 99423.

Outpatient facility claims (UB-04/837I) should be billed using procedure code 99421, 99422 or 99423 and revenue code 780.

Note: A telehealth modifier is not needed with the 99421, 99422 or 99423 code as the description of the code already indicates the service is "online".

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Encounter Documentation Requirements

All telehealth encounter documentation in the medical record is expected to meet the same minimum standards as required by face-to-face visit documentation**.** All relevant visit documentation is subject to Highmark post-payment review.

Delaware Telemedicine Mandate - House Bill 69

Effective January 1, 2016, Delaware law requires all individual and group policies subject to Delaware insurance law to provide coverage for health-care services provided through telemedicine and telehealth deemed covered services by the Plan. Eligible Delaware practitioners include most physicians and many other providers practicing within the scope of their license.

"Telehealth" is the use of information and communications technologies consisting of telephones, store and forward transfers, remote patient monitoring devices, or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, and health administration services.

"Telemedicine" is a form of telehealth, which is the delivery of clinical health-care services by means of real time two-way audio, visual, or other telecommunications or electronic communications. This includes the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health-care provider practicing within his or her scope of license as would be practiced in-person with a patient, and legally allowed to practice in the State.

The following are applicable to Delaware providers ONLY:

Distant Site

The distant site is the location where the provider (legally allowed to practice in the state) is rendering the service by means of telemedicine or telehealth. The Plan will not reimburse claims submitted for an access fee by the distant site.

Originating Site

The originating medical site (i.e., provider's office, outpatient facility, etc.) is a site in Delaware at which an eligible member is located at the time the service is performed by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties. The Plan will accept only one claim for the originating site access fee per visit that involves both an originating medical site and a distant site. Only the originating medical site will receive payment for an access fee.

Note: An access fee is not applicable for non-medical sites (e.g. member's home).

Professional service claims (1500/837P) should be billed using CMS Level 2 code Q3014, indicating the telehealth origination site fee, when applicable.

Outpatient facility claims (UB-04/837I) should be billed using CMS Level 2 code Q3014 and revenue code 780, when applicable.

Real-time Audio

Professional services (1500/837P) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968.

Outpatient facility claims (UB-04/837I) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968 with the appropriate revenue code.

Real-time Audio & Visual

Professional services claims (1500/837P) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT or 95 modifier indicating the use of an interactive audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT and 95 modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: Place of Service "02" (Telehealth) must be used when reporting the GT or 95 modifier on professional (1500 form) claims.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Store and Forward

Professional service claims (1500/837P) should be billed using existing E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier indicating the use of asynchronous telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: Place of Service "02" (Telehealth) must be used when reporting the GQ modifier on professional (1500 form) claims.

Telehealth Transmission

Professional service claims (1500/837P) should be billed using CMS Level 2 code T1014 indicating telehealth transmission, if appropriate.

Outpatient facility claims (UB04/837I) should be billed using CMS Level 2 code T1014 and the appropriate revenue code.

Note: The Plan will accept only one telehealth transmission code per encounter, per provider; if both a medical Originating and Distant site were involved, the Plan will accept one from each site, when applicable.

Services Not Covered

Services that the Plan **does not** reimburse include, but are not limited to, the following:

- Unsecured and unstructured services such as, but not limited to, skype and instant messaging unless such service is within the scope of practice of the provider
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements above and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: In accordance with the telehealth waiver issued by the Governor of the State of Delaware through the Second Modification to the Declaration of the State of Emergency for the State of Delaware due to a Public Health Threat ("PHT") ("Declaration"), effective March 18, 2020 at 8:00 p.m., some of the requirements throughout this policy may also be waived or altered during the PHT and until such time as the Declaration remains in effect. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by the Declaration.

West Virginia Telemedicine Mandate - House Bill 4003

Effective July 1, 2020, West Virginia law requires all individual and group policies subject to West Virginia insurance law to provide coverage for health-care services, deemed covered services by the Plan, provided through telehealth services if those same services are covered through face-to-face consultation by the policy. Telehealth services shall not be subject to annual or lifetime dollar maximum; copayment, coinsurance or deductible amounts; policy year, calendar year or other duration benefit limitation or maximum that is not equally imposed on all terms and services covered under the policy, contract or plan. Eligible West Virginia practitioners include most physicians and many other providers practicing within the scope of their license. Required coverage includes the use of telehealth technologies as it pertains to medically necessary remote patient monitoring services to the full extent that those services are available.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS or applicable state waiver. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Telehealth Services

Telehealth services means the use of synchronous or asynchronous telecommunications technology by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

Distant Site

The distant site means the telehealth site where the health care practitioner is seeing the patient at a distance or consulting with a patient's health care practitioner. The Plan will not reimburse claims submitted for an access fee by the distant site.

Health Care Practitioner

The health care practitioner means a person licensed under §30-1-1 *et seq*. of this code who provides health care services.

Originating Site

The originating site means the location where the patient is located, whether or not accompanied by a health care practitioner, at the time services are provided by a health care practitioner through telehealth, including, but not limited to, a health care practitioner's office, hospital, critical access hospital, rural health clinic, federally qualified health center, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

Note: Providers/facility at the Originating Site should bill procedure code Q3014.

Remote Patient Monitoring Services

Remote patient monitoring services means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows CMS guidelines for Telemedicine and Telehealth services.

Note: In accordance with the telehealth waiver issued by CMS, certain services are now permitted to be conducted via Telehealth. Please reference the CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19 and the MLN Connects 2020-04-03-MLNC-SE documents at the links located in the reference section of this policy.

IMPORTANT – To assist with timely processing of claims, if services are being delivered in a manner other than face-to-face, claims should always be billed using the place of service "02", including telephonic only codes. Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g. electronic portal) by a provider to deliver care, POS 02 should always be used to ensure correct pricing, eligibility, and benefits are applied. Failure to follow policy requirements could lead to, inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

More information on telehealth can be found in the Highmark Provider Manual on the Provider Resource Center. Also, the Provider Resource Center has additional guidelines on the PHE.

RELATED POLICIES:

Refer to the following Medical Policies for additional information:

- Commercial Policy Z-65: Telestroke Services
- Commercial Policy Z-11: Definition of Medical Necessity
- Medicare Advantage Policy N-4: Nutrition Therapy
- Medicare Advantage Policy Z-11: Definition of Medical Necessity

Refer to the following Reimbursement Policies for related information:

- Reimbursement Policy RP-043: Care Management

REFERENCES:

- American Medical Association, *Current Procedure Terminology* CPT® Manual
- CMS Medicare Claims Processing Manual, Chapter 12 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- Delaware Telemedicine Mandate, House Bill 69 (Codified as 18 Del. C. §§ 3770 & 3571R; 18 Del. Admin. Code 1409) http://delcode.delaware.gov/sessionlaws/ga148/chp080.pdf
- U.S. Department of Health and Human Services: Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html
- CMS Medicare Telemedicine Health Care Provider Fact Sheet. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- Second Modification of the Declaration of a State of Emergency for the State of Delaware due to a Public Health Threat https://governor.delaware.gov/wp-content/uploads/sites/24/2020/03/Second-Modification-to-the-State-of-Emergency.pdf

- CMS COVID-19 National Stakeholder Call, March 31, 2020. https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

- CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19. https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

- MLN Connects; 2020-04-03-MLNC-SE. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-03-mlnc-se

POLICY UPDATE HISTORY INFORMATION:

07 / 2019	Implementation
01 / 2020	Replaced code 99444 with 99421, 99422 and 99423
03 / 2020	Added information related to the PHE issued by HHS and the PHT Declaration issued by the Governor of the State of Delaware. Added policy to be applicable to Medicare Advantage.
04 / 2020	Added information on reporting services per National Stakeholder Call. Added note for G0463.
07 / 2020	Added direction for mandatory use of POS 02 for MA and Commercial

Highmark Reimbursement Policy Bulletin

HISTORY VERSIONS

Bulletin Number:	RP-046
Subject:	Telemedicine and Telehealth Services
Effective Date:	July 15, 2019
End Date:	
Issue Date:	April 20, 2020
Revised Date:	April 20, 2020
Date Reviewed:	April 2020
Source:	Reimbursement Policy

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	
Applicable Claim Type	**UB**	☒	**1500**	☒	

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy outlines the Plan's reimbursement for telemedicine, telehealth, virtual-care, or eVisit services. The term "telehealth" is often used in conjunction with telemedicine and is intended to include a broader range of services using telecommunication technologies, including videoconferencing. Unless otherwise provided herein and unless as specifically set forth in the Delaware Telemedicine Mandate – House Bill 69 Section of this Policy, "telehealth" shall include telemedicine, telehealth, virtual care, and eVisit services deemed covered services by the Plan or its affiliates.

Definitions

Distant Site:	The location of an appropriately licensed health care provider while furnishing health care services by means of telecommunication.
Originating Site:	The location of the patient at the time a telecommunication service is furnished.
Place of Service "02":	The location where health services and health related services are provided or received, through a telecommunication system.
Modifier GQ:	Via asynchronous telecommunications system.
Modifier GT:	Via Interactive Audio and Video Telecommunications systems.

Modifier 95: Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System.

Note: In accordance with the telehealth waiver issued by The Centers for Medicaid and Medicare Services (CMS) related to the 2019 novel coronavirus, some of the requirements for reporting the telehealth modifiers above, for example GQ, may also be waived or altered during the PHE period. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: Outpatient services delivered through an alternate medium (e.g. phone, e-visit, etc.) would not need the modifier, but all codes typically delivered face-to-face will require use of the appropriate modifier to indicate the alternate delivery method.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Reimbursement for telehealth services is determined according to individual, group, or customer benefits. Coverage for telehealth is limited to the types of services already considered a covered benefit under the member's specific plan. Coverages and reimbursements for telehealth services are limited to those services performed between a licensed clinician and a member/patient.

When a covered benefit, evaluation and management and consultation services delivered through telehealth for *new and established patients may be reimbursed under the following conditions:

***Note**: In accordance with the telehealth waiver issued by The Centers for Medicaid and Medicare Services (CMS) related to the 2019 novel coronavirus, new patients will be permitted to receive telehealth services beginning March 6, 2020, until the Public Health Emergency (PHE) declared by the Department of Health and Human Services (HHS) expires. Also, some of the requirements below and throughout this policy may also be waived or altered during the PHE period. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

1. Professional services rendered via an interactive telecommunication system are only eligible for reimbursement to the provider rendering the telehealth services. A provider rendering face-to-face care should report the appropriate codes for the in-person services.
2. The patient must be present at the time of all billed services unless the billed code is for exclusive use with *asynchronous* services or as specifically allowed under state law. If state law requires a face-to-face examination PRIOR to the delivery of telehealth services, the face-to-face services must be concluded and documented in the medical record prior to the initiation of any related telehealth visits.
3. All services provided must be medically appropriate and necessary.
4. The consultation/evaluation and management service must take place via an interactive audio AND video telecommunications system (unless exceptions are allowed by applicable laws). Interactive telecommunications systems must be multi-media communication which, at minimum,

includes audio and video equipment permitting real-time (synchronous) consultation among the patient and practitioner at the Originating Site and the practitioner at the Distant Site.

5. The technology platform used by the provider must meet technology security requirements, including being both HIPAA and HITECH compliant.
6. Thorough, appropriate documentation of telehealth services and other communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

Note: Provider should consult published guidance from the Office of Civil Rights (OCR) of HHS related to HIPAA and HITECH compliance during the PHE.

The following codes are <u>not</u> eligible for reimbursement under the telehealth policy as they do not include both audio and video communication:

*98966 *98967 *98968 *99441 *99442 *99443 *99446 *99447 *99448 *99449

***Note**: These codes are eligible for reimbursement during the PHE period.

<u>Eligible Providers</u>

Providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face to face service.

Note: The requirement above may be waived or altered during the PHE declared by HHS pursuant to state requirements.

<u>Virtual PCP and Retail Clinic Visits</u>

When billing professional services (1500/837P), Virtual PCP Visits and Virtual Retail Clinic Visits should be billed with Evaluation & Management (E&M) CPT codes (99201-99205; 99211-99215) applicable to the services provided and with the GT or 95 modifier indicating the use of interactive audio and video telecommunications technology.

Place of Service "02" (Telehealth) **<u>must</u>** be used when reporting professional telehealth services (1500 form). OP facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code (99201-99205; 99211-99215 or *G0463) with the GT or 95 modifiers and the revenue code 780.

***Note**: If mandated by your OPPS payment methodology for reporting clinic visits.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **<u>not</u>** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits) or treatment.
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Virtual Behavioral Health Visits

When billing professional services (1500/837P), virtual behavioral health services should be billed with existing mental health CPT codes applicable to the services provided with a GT or 95 modifiers indicating the use of an interactive (synchronous) audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code with the GT or 95 modifiers and the appropriate behavioral health revenue code (900-919).

Note: Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP Facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual behavioral health visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

Note: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Specialist Virtual Visit

The Originating Site can be either a medical site or an approved non-medical site. Only a medical Originating Site (i.e. PCP's office, outpatient facility, etc.) is eligible for reimbursement of an access fee. The Plan will accept HCPCS code Q3014 ("telehealth Originating Site facility fee") for the service. Claims for the medical Originating Site's access fee will be accepted as either professional (1500/837P) or outpatient facility (UB-04/837I using revenue code 780).

Note: No other service reported on the medical Originating Site claim will be eligible for payment by the Plan or the member.

Providers/facility at the Originating Site should bill procedure code Q3014.

Note: Code Q3014 is not covered if billed with a non-covered professional service.

The access fee is an all-inclusive fee that includes all medical Originating Site fees including, without limitation, providing a physical location for the virtual visit as well as providing all equipment to be utilized for the secure connection. No other fees may be billed to either the Plan or to the member by the medical Originating Site and all contractual member hold harmless requirements shall apply.

Note: The Plan will reimburse only one claim per encounter for the medical Originating Site access fee.

The Plan will accept only a professional claim (1500/837P) for the provider's evaluation/assessment services provided at the Distant Site.

Evaluation and management (E&M) visits (99201-99205; 99211-99215) and consultation services (99241-99245) are eligible codes for the specialist's services rendered at the Distant Site. The procedure code(s) representing the specialist's services must be billed with GT or 95 modifiers. The service appended with one of these modifiers is only billed by the specialty practitioner.

Note: Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP Facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Specialist Virtual Visit services that the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Teledermatology

The Plan will accept claims for teledermatology services from dermatologists billing on a 1500 claim form or 837P electronic format. Services should be billed using procedure code 99421, 99422 or 99423.

Outpatient facility claims (UB-04/837I) should be billed using procedure code 99421, 99422 or 99423 and revenue code 780.

Note: A telehealth modifier is not needed with the 99421, 99422 or 99423 code as the description of the code already indicates the service is "online".

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Encounter Documentation Requirements

All telehealth encounter documentation in the medical record is expected to meet the same minimum standards as required by face-to-face visit documentation**.** All relevant visit documentation is subject to Highmark post-payment review.

Delaware Telemedicine Mandate - House Bill 69

Effective January 1, 2016, Delaware law requires all individual and group policies subject to Delaware insurance law to provide coverage for health-care services provided through telemedicine and telehealth deemed covered services by the Plan. Eligible Delaware practitioners include most physicians and many other providers practicing within the scope of their license.

"Telehealth" is the use of information and communications technologies consisting of telephones, store and forward transfers, remote patient monitoring devices, or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, and health administration services.

"Telemedicine" is a form of telehealth, which is the delivery of clinical health-care services by means of real time two-way audio, visual, or other telecommunications or electronic communications. This includes the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health-care provider practicing within his or her scope of license as would be practiced in-person with a patient, and legally allowed to practice in the State.

The following are applicable to Delaware providers ONLY:

Distant Site

The distant site is the location where the provider (legally allowed to practice in the state) is rendering the service by means of telemedicine or telehealth. The Plan will not reimburse claims submitted for an access fee by the distant site.

Originating Site

The originating medical site (i.e., provider's office, outpatient facility, etc.) is a site in Delaware at which an eligible member is located at the time the service is performed by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties. The Plan will accept only one claim for the originating site access fee per visit that involves both an originating medical site and a distant site. Only the originating medical site will receive payment for an access fee.

Note: An access fee is not applicable for non-medical sites (e.g. member's home).

Professional service claims (1500/837P) should be billed using CMS Level 2 code Q3014, indicating the telehealth origination site fee, when applicable.

Outpatient facility claims (UB-04/837I) should be billed using CMS Level 2 code Q3014 and revenue code 780, when applicable.

Real-time Audio

Professional services (1500/837P) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968.

Outpatient facility claims (UB-04/837I) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968 with the appropriate revenue code.

Real-time Audio & Visual

Professional services claims (1500/837P) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT or 95 modifier indicating the use of an interactive audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT and 95 modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: Place of Service "02" (Telehealth) must be used when reporting the GT or 95 modifier on professional (1500 form) claims.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Store and Forward

Professional service claims (1500/837P) should be billed using existing E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier indicating the use of asynchronous telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: Place of Service "02" (Telehealth) must be used when reporting the GQ modifier on professional (1500 form) claims.

Telehealth Transmission

Professional service claims (1500/837P) should be billed using CMS Level 2 code T1014 indicating telehealth transmission, if appropriate.

Outpatient facility claims (UB04/837I) should be billed using CMS Level 2 code T1014 and the appropriate revenue code.

Note: The Plan will accept only one telehealth transmission code per encounter, per provider; if both a medical Originating and Distant site were involved, the Plan will accept one from each site, when applicable.

Services Not Covered

Services that the Plan **does not** reimburse include, but are not limited to, the following:

- Unsecured and unstructured services such as, but not limited to, skype and instant messaging unless such service is within the scope of practice of the provider
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements above and throughout this policy may also be waived or altered during the PHE declared by HHS. Services

will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: In accordance with the telehealth waiver issued by the Governor of the State of Delaware through the Second Modification to the Declaration of the State of Emergency for the State of Delaware due to a Public Health Threat ("PHT") ("Declaration"), effective March 18, 2020 at 8:00 p.m., some of the requirements throughout this policy may also be waived or altered during the PHT and until such time as the Declaration remains in effect. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by the Declaration.

West Virginia Telemedicine Mandate - House Bill 4003

Effective July 1, 2020, West Virginia law requires all individual and group policies subject to West Virginia insurance law to provide coverage for health-care services, deemed covered services by the Plan, provided through telehealth services if those same services are covered through face-to-face consultation by the policy. Telehealth services shall not be subject to annual or lifetime dollar maximum; copayment, coinsurance or deductible amounts; policy year, calendar year or other duration benefit limitation or maximum that is not equally imposed on all terms and services covered under the policy, contract or plan. Eligible West Virginia practitioners include most physicians and many other providers practicing within the scope of their license.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS or applicable state waiver. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Telehealth Services

Telehealth services means the use of synchronous or asynchronous telecommunications technology by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

Distant Site

The distant site means the telehealth site where the health care practitioner is seeing the patient at a distance or consulting with a patient's health care practitioner. The Plan will not reimburse claims submitted for an access fee by the distant site.

Health Care Practitioner

The health care practitioner means a person licensed under §30-1-1 *et seq*. of this code who provides health care services.

Originating Site

The originating site means the location where the patient is located, whether or not accompanied by a health care practitioner, at the time services are provided by a health care practitioner through telehealth, including, but not limited to, a health care practitioner's office, hospital, critical access hospital, rural health clinic, federally qualified health center, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

Note: Providers/facility at the Originating Site should bill procedure code Q3014.

Remote Patient Monitoring Services

Remote patient monitoring services means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows CMS guidelines for Telemedicine and Telehealth services.

Note: In accordance with the telehealth waiver issued by CMS, certain services are now permitted to be conducted via Telehealth. Please reference the CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19 and the MLN Connects 2020-04-03-MLNC-SE documents at the links located in the reference section of this policy.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

More information on telehealth can be found in the Highmark Provider Manual on the Provider Resource Center. Also, the Provider Resource Center has additional guidelines on the PHE.

RELATED POLICIES:

Refer to the following Medical Policies for additional information:

- Commercial Policy Z-65: Telestroke Services
- Medicare Advantage Policy N-4: Nutrition Therapy

Refer to the following Reimbursement Policies for related information:

- Reimbursement Policy RP-043: Care Management

REFERENCES:

- American Medical Association, *Current Procedure Terminology* CPT® Manual
- CMS Medicare Claims Processing Manual, Chapter 12 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- Delaware Telemedicine Mandate, House Bill 69 (Codified as 18 Del. C. §§ 3770 & 3571R; 18 Del. Admin. Code 1409) http://delcode.delaware.gov/sessionlaws/ga148/chp080.pdf
- U.S. Department of Health and Human Services: Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html
- CMS Medicare Telemedicine Health Care Provider Fact Sheet. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- Second Modification of the Declaration of a State of Emergency for the State of Delaware due to a Public Health Threat https://governor.delaware.gov/wp-content/uploads/sites/24/2020/03/Second-Modification-to-the-State-of-Emergency.pdf
- CMS COVID-19 National Stakeholder Call, March 31, 2020. https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts
- CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19. https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf
- MLN Connects; 2020-04-03-MLNC-SE. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-03-mlnc-se

POLICY UPDATE HISTORY INFORMATION:

07 / 2019	Implementation
01 / 2020	Replaced code 99444 with 99421, 99422 and 99423
03 / 2020	Added information related to the PHE issued by HHS and the PHT Declaration issued by the Governor of the State of Delaware. Added policy to be applicable to Medicare Advantage.
04 / 2020	Added information on reporting services per National Stakeholder Call. Added note for G0463.

Highmark Reimbursement Policy Bulletin

HISTORY VERSIONS

Bulletin Number:	RP-046		
Subject:	Telemedicine and Telehealth Services		
Effective Date:	July 15, 2019	**End Date:**	
Issue Date:	April 6, 2020	**Revised Date:**	April 6, 2020
Date Reviewed:	April 2020		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	
Applicable Claim Type	**UB**	☒	**1500**	☒	

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy outlines the Plan's reimbursement for telemedicine, telehealth, virtual-care, or eVisit services. The term "telehealth" is often used in conjunction with telemedicine and is intended to include a broader range of services using telecommunication technologies, including videoconferencing. Unless otherwise provided herein and unless as specifically set forth in the Delaware Telemedicine Mandate – House Bill 69 Section of this Policy, "telehealth" shall include telemedicine, telehealth, virtual care, and eVisit services deemed covered services by the Plan or its affiliates.

Definitions

Distant Site:	The location of an appropriately licensed health care provider while furnishing health care services by means of telecommunication.
Originating Site:	The location of the patient at the time a telecommunication service is furnished.
Place of Service "02":	The location where health services and health related services are provided or received, through a telecommunication system.
Modifier GQ:	Via asynchronous telecommunications system.
Modifier GT:	Via Interactive Audio and Video Telecommunications systems.

Modifier 95: Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System.

Note: In accordance with the telehealth waiver issued by The Centers for Medicaid and Medicare Services (CMS) related to the 2019 novel coronavirus, some of the requirements for reporting the telehealth modifiers above, for example GQ, may also be waived or altered during the PHE period. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: Outpatient services delivered through an alternate medium (e.g. phone, e-visit, etc.) would not need the modifier, but all codes typically delivered face-to-face will require use of the appropriate modifier to indicate the alternate delivery method.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Reimbursement for telehealth services is determined according to individual, group, or customer benefits. Coverage for telehealth is limited to the types of services already considered a covered benefit under the member's specific plan. Coverages and reimbursements for telehealth services are limited to those services performed between a licensed clinician and a member/patient.

When a covered benefit, evaluation and management and consultation services delivered through telehealth for *new and established patients may be reimbursed under the following conditions:

***Note**: In accordance with the telehealth waiver issued by The Centers for Medicaid and Medicare Services (CMS) related to the 2019 novel coronavirus, new patients will be permitted to receive telehealth services beginning March 6, 2020, until the Public Health Emergency (PHE) declared by the Department of Health and Human Services (HHS) expires. Also, some of the requirements below and throughout this policy may also be waived or altered during the PHE period. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

1. Professional services rendered via an interactive telecommunication system are only eligible for reimbursement to the provider rendering the telehealth services. A provider rendering face-to-face care should report the appropriate codes for the in-person services.
2. The patient must be present at the time of all billed services unless the billed code is for exclusive use with *asynchronous* services or as specifically allowed under state law. If state law requires a face-to-face examination PRIOR to the delivery of telehealth services, the face-to-face services must be concluded and documented in the medical record prior to the initiation of any related telehealth visits.
3. All services provided must be medically appropriate and necessary.
4. The consultation/evaluation and management service must take place via an interactive audio AND video telecommunications system (unless exceptions are allowed by applicable laws). Interactive telecommunications systems must be multi-media communication which, at minimum,

includes audio and video equipment permitting real-time (synchronous) consultation among the patient and practitioner at the Originating Site and the practitioner at the Distant Site.

5. The technology platform used by the provider must meet technology security requirements, including being both HIPAA and HITECH compliant.
6. Thorough, appropriate documentation of telehealth services and other communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

Note: Provider should consult published guidance from the Office of Civil Rights (OCR) of HHS related to HIPAA and HITECH compliance during the PHE.

The following codes are <u>not</u> eligible for reimbursement under the telehealth policy as they do not include both audio and video communication:

98966 98967 98968 *99441 *99442 *99443 *99446 *99447 *99448 *99449

***Note**: These codes are eligible for reimbursement during the PHE period.

<u>Eligible Providers</u>

Providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face to face service.

Note: The requirement above may be waived or altered during the PHE declared by HHS pursuant to state requirements.

<u>Virtual PCP and Retail Clinic Visits</u>

When billing professional services (1500/837P), Virtual PCP Visits and Virtual Retail Clinic Visits should be billed with Evaluation & Management (E&M) CPT codes (99201-99205; 99211-99215) applicable to the services provided and with the GT or 95 modifier indicating the use of interactive audio and video telecommunications technology.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code (99201-99205; 99211-99215 or G0463) with the GT or 95 modifiers and the revenue code 780.

Note: Place of Service "02" (Telehealth) **<u>must</u>** be used when reporting professional telehealth services (1500 form). OP Facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **<u>not</u>** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that

coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)
- Asynchronous (online) medical evaluation (e-Visits) or treatment.
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Virtual Behavioral Health Visits

When billing professional services (1500/837P), virtual behavioral health services should be billed with existing mental health CPT codes applicable to the services provided with a GT or 95 modifiers indicating the use of an interactive (synchronous) audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using the appropriate procedure code with the GT or 95 modifiers and the appropriate behavioral health revenue code (900-919).

Note: Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP Facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Virtual behavioral health visit services the Plan **does not** reimburse include, but are not limited to, the following:

- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

Note: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Specialist Virtual Visit

The Originating Site can be either a medical site or an approved non-medical site. Only a medical Originating Site (i.e. PCP's office, outpatient facility, etc.) is eligible for reimbursement of an access fee. The Plan will accept HCPCS code Q3014 ("telehealth Originating Site facility fee") for the service. Claims for the medical Originating Site's access fee will be accepted as either professional (1500/837P) or outpatient facility (UB-04/837I using revenue code 780).

Note: No other service reported on the medical Originating Site claim will be eligible for payment by the Plan or the member.

Providers/facility at the Originating Site should bill procedure code Q3014.

Note: Code Q3014 is not covered if billed with a non-covered professional service.

The access fee is an all-inclusive fee that includes all medical Originating Site fees including, without limitation, providing a physical location for the virtual visit as well as providing all equipment to be utilized for the secure connection. No other fees may be billed to either the Plan or to the member by the medical Originating Site and all contractual member hold harmless requirements shall apply.

Note: The Plan will reimburse only one claim per encounter for the medical Originating Site access fee.

The Plan will accept only a professional claim (1500/837P) for the provider's evaluation/assessment services provided at the Distant Site.

Evaluation and management (E&M) visits (99201-99205; 99211-99215) and consultation services (99241-99245) are eligible codes for the specialist's services rendered at the Distant Site. The procedure code(s) representing the specialist's services must be billed with GT or 95 modifiers. The service appended with one of these modifiers is only billed by the specialty practitioner.

Note: Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500 form). OP Facility claims must also use the GT and 95 modifiers as appropriate and applicable.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Specialist Virtual Visit services that the Plan **does not** reimburse include, but are not limited to, the following:

- Mental health counseling and therapy* (See virtual behavioral health section for eligible virtual mental health services)

- Asynchronous (online) medical evaluation (e-Visits)
- Unsecured and unstructured services such as, but not limited to, skype and instant messaging
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***Note**: Coverage for mental and behavioral health virtual visits is defined by the member's benefit plan.

Teledermatology

The Plan will accept claims for teledermatology services from dermatologists billing on a 1500 claim form or 837P electronic format. Services should be billed using procedure code 99421, 99422 or 99423.

Outpatient facility claims (UB-04/837I) should be billed using procedure code 99421, 99422 or 99423 and revenue code 780.

Note: A telehealth modifier is not needed with the 99421, 99422 or 99423 code as the description of the code already indicates the service is "online".

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Encounter Documentation Requirements

All telehealth encounter documentation in the medical record is expected to meet the same minimum standards as required by face-to-face visit documentation**.** All relevant visit documentation is subject to Highmark post-payment review.

Delaware Telemedicine Mandate - House Bill 69

Effective January 1, 2016, Delaware law requires all individual and group policies subject to Delaware insurance law to provide coverage for health-care services provided through telemedicine and telehealth deemed covered services by the Plan. Eligible Delaware practitioners include most physicians and many other providers practicing within the scope of their license.

"Telehealth" is the use of information and communications technologies consisting of telephones, store and forward transfers, remote patient monitoring devices, or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, and health administration services.

"Telemedicine" is a form of telehealth, which is the delivery of clinical health-care services by means of real time two-way audio, visual, or other telecommunications or electronic communications. This includes the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health-care provider practicing within his

or her scope of license as would be practiced in-person with a patient, and legally allowed to practice in the State.

The following are applicable to Delaware providers ONLY:

Distant Site

The distant site is the location where the provider (legally allowed to practice in the state) is rendering the service by means of telemedicine or telehealth. The Plan will not reimburse claims submitted for an access fee by the distant site.

Originating Site

The originating medical site (i.e., provider's office, outpatient facility, etc.) is a site in Delaware at which an eligible member is located at the time the service is performed by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties. The Plan will accept only one claim for the originating site access fee per visit that involves both an originating medical site and a distant site. Only the originating medical site will receive payment for an access fee.

Note: An access fee is not applicable for non-medical sites (e.g. member's home).

Professional service claims (1500/837P) should be billed using CMS Level 2 code Q3014, indicating the telehealth origination site fee, when applicable.

Outpatient facility claims (UB-04/837I) should be billed using CMS Level 2 code Q3014 and revenue code 780, when applicable.

Real-time Audio

Professional services (1500/837P) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968.

Outpatient facility claims (UB-04/837I) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968 with the appropriate revenue code.

Real-time Audio & Visual

Professional services claims (1500/837P) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT or 95 modifier indicating the use of an interactive audio and video telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed with existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GT and 95 modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: Place of Service "02" (Telehealth) must be used when reporting the GT or 95 modifier on professional (1500 form) claims.

Note: As a result of the COVID-19 emergency and expansion of telehealth eligible services, the Plan is permitting facilities to report telehealth services using the appropriate revenue code that coincides with the service being rendered and the appropriate telehealth modifier for services not typically used through a non-face-to-face method. Revenue code 780 should continue to be used when billing Q3014.

Store and Forward

Professional service claims (1500/837P) should be billed using existing E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier indicating the use of asynchronous telecommunications system.

Outpatient facility claims (UB-04/837I) should be billed using existing outpatient E&M Level 1 CPT codes or CMS Level 2 office visit codes applicable to the services provided with a GQ modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

Note: Place of Service "02" (Telehealth) must be used when reporting the GQ modifier on professional (1500 form) claims.

Telehealth Transmission

Professional service claims (1500/837P) should be billed using CMS Level 2 code T1014 indicating telehealth transmission, if appropriate.

Outpatient facility claims (UB04/837I) should be billed using CMS Level 2 code T1014 and the appropriate revenue code.

Note: The Plan will accept only one telehealth transmission code per encounter, per provider; if both a medical Originating and Distant site were involved, the Plan will accept one from each site, when applicable.

Services Not Covered

Services that the Plan **does not** reimburse include, but are not limited to, the following:

- Unsecured and unstructured services such as, but not limited to, skype and instant messaging unless such service is within the scope of practice of the provider
- Clinician-to-clinician consultations, telephone conversations, facsimile, or email communications

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements above and throughout this policy may also be waived or altered during the PHE declared by HHS. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Note: In accordance with the telehealth waiver issued by the Governor of the State of Delaware through the Second Modification to the Declaration of the State of Emergency for the State of Delaware due to a Public Health Threat ("PHT") ("Declaration"), effective March 18, 2020 at 8:00 p.m., some of the requirements throughout this policy may also be waived or altered during the PHT and until such time as the Declaration remains in effect. Services will be allowed to pay on initial processing

and any post-pay audits will **not** penalize providers for waived requirements, as defined by the Declaration.

West Virginia Telemedicine Mandate - House Bill 4003

Effective July 1, 2020, West Virginia law requires all individual and group policies subject to West Virginia insurance law to provide coverage for health-care services, deemed covered services by the Plan, provided through telehealth services if those same services are covered through face-to-face consultation by the policy. Telehealth services shall not be subject to annual or lifetime dollar maximum; copayment, coinsurance or deductible amounts; policy year, calendar year or other duration benefit limitation or maximum that is not equally imposed on all terms and services covered under the policy, contract or plan. Eligible West Virginia practitioners include most physicians and many other providers practicing within the scope of their license.

Note: In accordance with the telehealth waiver issued by CMS, some of the requirements below and throughout this policy may also be waived or altered during the PHE declared by HHS or applicable state waiver. Services will be allowed to pay on initial processing and any post-pay audits will **not** penalize providers for waived requirements, as defined by CMS.

Telehealth Services

Telehealth services means the use of synchronous or asynchronous telecommunications technology by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

Distant Site

The distant site means the telehealth site where the health care practitioner is seeing the patient at a distance or consulting with a patient's health care practitioner. The Plan will not reimburse claims submitted for an access fee by the distant site.

Health Care Practitioner

The health care practitioner means a person licensed under §30-1-1 *et seq*. of this code who provides health care services.

Originating Site

The originating site means the location where the patient is located, whether or not accompanied by a health care practitioner, at the time services are provided by a health care practitioner through telehealth, including, but not limited to, a health care practitioner's office, hospital, critical access hospital, rural health clinic, federally qualified health center, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

Note: Providers/facility at the Originating Site should bill procedure code Q3014.

Remote Patient Monitoring Services

Remote patient monitoring services means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows CMS guidelines for Telemedicine and Telehealth services.

Note: In accordance with the telehealth waiver issued by CMS, certain services are now permitted to be conducted via Telehealth. Please reference the CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19 and the MLN Connects 2020-04-03-MLNC-SE documents at the links located in the reference section of this policy.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

More information on telehealth can be found in the Highmark Provider Manual on the Provider Resource Center. Also, the Provider Resource Center has additional guidelines on the PHE.

RELATED POLICIES:

Refer to the following Medical Policies for additional information:

- Commercial Policy Z-65: Telestroke Services
- Medicare Advantage Policy N-4: Nutrition Therapy

Refer to the following Reimbursement Policies for related information:

- Reimbursement Policy RP-043: Care Management

REFERENCES:

- American Medical Association, *Current Procedure Terminology* CPT® Manual
- CMS Medicare Claims Processing Manual, Chapter 12 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- Delaware Telemedicine Mandate, House Bill 69 (Codified as 18 Del. C. §§ 3770 & 3571R; 18 Del. Admin. Code 1409) http://delcode.delaware.gov/sessionlaws/ga148/chp080.pdf

- U.S. Department of Health and Human Services: Secretary Azar Declares Public Health Emergency for United States for 2019 Novel Coronavirus https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html

- CMS Medicare Telemedicine Health Care Provider Fact Sheet. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

- Second Modification of the Declaration of a State of Emergency for the State of Delaware due to a Public Health Threat https://governor.delaware.gov/wp-content/uploads/sites/24/2020/03/Second-Modification-to-the-State-of-Emergency.pdf

- CMS COVID-19 National Stakeholder Call, March 31, 2020. https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

- CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19. https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

- MLN Connects; 2020-04-03-MLNC-SE. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-03-mlnc-se

POLICY UPDATE HISTORY INFORMATION:

07 / 2019	Implementation
01 / 2020	Replaced code 99444 with 99421, 99422 and 99423
03 / 2020	Added information related to the PHE issued by HHS and the PHT Declaration issued by the Governor of the State of Delaware. Added policy to be applicable to Medicare Advantage.
04 / 2020	Added information on reporting services per National Stakeholder Call