HIGHMARK.

Reimbursement Policy

Title: Telemedicine and Telehealth Services

Policy Number: RP-046

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Claim Type:	CMS 1500 and UB04	History Versions:	Click Here → History

Disclosure: *The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan and ensure you are reimbursed based on the codes that correctly describe the health care services provided. Reimbursement Policies do not provide guidance on whether a service is a covered benefit under the members' contract. Benefit determinations are based in all cases on the applicable benefit plan contract language and applicable medical policies. Should there be any conflicts between Reimbursement Policy and the member's benefit plan, the member's benefit plan will prevail. Additionally, health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement Policy is not intended to impact care decisions or medical practice. This Reimbursement Policy is intended to serve as a guide as to how the plan pays for covered services, however, other factors may influence payment and, in some cases, may supersede this policy. The provider should consult their network provider agreement for further details of their contractual obligations. The policy is applicable to designated markets either entirely, or partially, as indicated within the policy. Policy designation of claim type is based on how the provider is contracted with the Plan.*

Description:

This policy details the Plan's reimbursement guidelines for telemedicine, telehealth, virtual care, and eVisit services. The term "telehealth" encompasses a broad spectrum of services delivered via telecommunication technologies, including videoconferencing, and is used synonymously with telemedicine, virtual care, and eVisit services as defined and covered by the Plan or its affiliates.

Highmark's reimbursement for Telehealth Services will adhere to all applicable State and Federal Mandates within Pennsylvania, West Virginia, Delaware, and New York. The Plan follows current CMS guidelines and code listings for Telemedicine and Telehealth services. All medically appropriate telehealth services rendered by network providers will be reimbursed at parity with comparable in-person services, subject to the member's benefit plan terms, conditions, and limitations.

Reimbursement Guidelines:

Reimbursement for telehealth services is contingent upon the member's individual, group, or customer benefits. Coverage for telehealth is restricted to services already designated as covered benefits within the member's specific plan. Furthermore, coverage and reimbursement for telehealth services are limited to those interactions conducted between a licensed clinician and a member/patient.

To facilitate accurate claims processing, including pricing, eligibility, and benefit application for professional telehealth services (utilizing the 1500 form), the following Place of Service (POS) codes must be employed and consistent with CMS directives:

- POS "02": For services furnished outside the patient's home.
- POS "10": For services furnished within the patient's home.

This applies universally to all synchronous audio/video, audio-only, and asynchronous delivery methods (e.g., electronic portals). For outpatient (OP) facility claims, the GT, 93, or 95 modifiers must also be appended, as appropriate and applicable to the service. Non-adherence to these policy requirements may lead to inaccurate cost-share calculations, incorrect claims pricing, or claim denial.

When an eligible benefit, evaluation and management (E/M) services provided through telehealth for both new and established patients may be reimbursed under the following stipulations:

1. Reimbursement for Professional Services: Professional services rendered via an interactive telecommunication system are eligible for reimbursement solely to the provider directly furnishing the telehealth services. Providers delivering face-to-face care should report the appropriate codes for the in-person services.

2. Patient Presence Requirement: The patient must be present at the time all billed services are rendered, unless the billed code is exclusively designed for asynchronous services or as specifically permitted by state law. If state law mandates a face-to-face examination prior to the delivery of telehealth services, these in-person services must be completed and documented in the medical record before initiating any related telehealth visits.

3. Medical Appropriateness and Necessity: All services provided must align with medical appropriateness and necessity criteria, as defined by Highmark Medical Policy Z-11: Definition of Medical Necessity.

4. Telecommunications System Requirements: The consultation/E/M service must be conducted through an interactive audio/video telecommunications system. Exceptions may apply as allowed by applicable laws, post-Public Health Emergency (PHE) CMS guidance, or for mental health services as specifically outlined within this policy. Interactive telecommunications systems are defined as multi-media

communication platforms that, at a minimum, include audio and video equipment enabling real-time (synchronous) consultation between the patient and practitioner at the Originating Site and the practitioner at the Distant Site, unless the service pertains to mental health or other services as described in this policy.

5. Technology Security Compliance: The technology platform utilized by the provider must satisfy all technology security requirements, including adherence to both HIPAA and HITECH regulations.

6. Documentation Standards: Thorough and appropriate documentation of telehealth services and all other communications relevant to the patient's ongoing medical care must 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, accurately reflecting the encounter. The provider must also document that the visit was conducted 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 unable or unwilling to utilize two-way audio/video technology. Modifier FQ or 93 must be appended to the claim line for these specific services in alignment with CMS guidelines for audio only mental health services.

Note: Providers are advised to consult published guidance from the Office for Civil Rights (OCR) of HHS concerning HIPAA and HITECH compliance for telehealth services.

For Commercial Plans only in all regions, in alignment with the American Medical Association (AMA) Providers may report E/M telehealth services using CPT codes 98000-98016 which distinguish between audio-visual and audio-only visits. Providers must report POS 02 or 10 with these Telehealth codes.

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.

Outpatient Office Visits

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
- 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 Substance Abuse (Substance Use Disorder) Visits

When billing professional services (1500/837P), virtual behavioral health/substance abuse (substance use disorder) services should be billed with existing mental health/substance abuse (substance use disorder) 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, in accordance with CMS guidelines for behavioral health telehealth.

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).

virtual behavioral health/substance abuse (substance use disorder) 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
- 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, as instructed by CMS.

Originating Site

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, following CMS recommendations for originating site facility fees. 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.

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

For Distant Site billing, see the Virtual Outpatient Office Visits section above.

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

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**,** including any specific documentation requirements outlined by CMS for telehealth services. All relevant visit documentation is subject to post-payment review.

Coding:

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

Diagnostic services involving patient-worn or activated devices, such as Holter monitoring (e.g., CPT codes 93224, 93225, 93226, 93227), should continue to be billed using their historically appropriate Place of Service codes.

Outpatient Office Visits

When billing professional services (1500/837P), Virtual Outpatient Office Visits should be billed with 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, as per CMS coding guidance.

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.

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.

References:

- American Medical Association, *Current Procedure Terminology* CPT® Manual
- Center for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual, Chapter 12
- Center for Medicare and Medicaid Services (CMS) Medicare Telemedicine Health Care Provider Fact Sheet, March 17, 2020
- American Medical Association; CPT Appendix A audio only Modifier 93 for reporting medical services
- Center for Medicare and Medicaid Services (CMS) MLN Telehealth & Remote Monitoring, MLN901705 - Telehealth & Remote Monitoring
- Center for Medicare and Medicaid Services (CMS) List of Telehealth Services CMS

Related Plan Policies:

Refer to the following Commercial Medical Policies for additional information:

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

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

- Z-11: Definition of Medical Necessity

Refer to the following Reimbursement Policies for additional information:

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

Policy Update History:

7 / 2023	Updated with post-PHE direction
1 / 2025	Removed codes 99441-99443. Added codes 98000-98016.
3 / 2025	Removed code 98016
9 / 2025	Removed policy application to New York for codes 98000-98015
9 / 2026	Changed policy application for 98000-98015 and reformatted reorganized policy direction.

Highmark Reimbursement Policy Bulletin

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HISTORY VERSION

Bulletin Number:	RP-046		
Subject:	Telemedicine and Telehealth Services		
Effective Date:	July 15, 2019	**End Date:**	
Issue Date:	September 22, 2025	**Revised Date:**	September 2025
Date Reviewed:	September 2025		
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.

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.

Services Not Separately Reimbursed

The Plan does not separately reimburse codes 98000-98015 in Pennsylvania, Delaware, West Virginia.

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.

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.
3 / 2025	Removed code 98016
9 / 2025	Removed policy application to New York for codes 98000-98015

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:	March 10, 2025	**Revised Date:**	March 2025
Date Reviewed:	February 2025		
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.

Services Not Separately Reimbursed

The Plan does not separately reimburse for codes 98000-98015.

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.

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.
3 / 2025	Removed code 98016

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
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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:	July 10, 2023	**Revised Date:**	July 2023
Date Reviewed:	May 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.

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PURPOSE:

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DEFINITIONS:

Term	Definition
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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.
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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.

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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 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