Telehealth

Policy ID:	HWC-PA-RP-010
Approved By:	Highmark Wholecare – Market Leadership
Provider Notice Date:	09/01/2024, 07/27/2026
Original Effective Date:	10/01/2024
Annual Approval Date:	10/2024, 10/01/2026
Last Revision Date:	09/2025, 06/2026
Products:	Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1 of 3

Disclaimer

Highmark Wholecare reimbursement policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

This policy provides information regarding the coverage of, as determined by applicable federal and/or state legislation.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Pennsylvania Department of Health (DHS) and all applicable state and federal regulations.

DEFINITIONS

Highmark Wholecare – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Wholecare members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Wholecare currently services Pennsylvania Medicaid: PA HealthChoices.

Telehealth – The use of information and communication technologies consisting of telephones, Remote Patient Monitoring devices or other electronic means to provide or support health care delivery. It occurs when the patient is at an originating site and the health care provider is at a distant site.

PROCEDURES

Prior Authorization may be required. Please validate codes on the Prior Authorization Lookup Tool https://providers.highmark.com/wholecare/provider-resources/prior-authorization-code-lookup

Telehealth visits must provide the same level of care and achieve the same outcomes as an in-person visit. These visits must be consistent with the requirements in Medical Assistance Bulletin 99-23-08.

Telephone calls are acceptable in situations where the individual/family does not possess or have access to video technology. Text messages may be used to provide supplemental communication but are not considered a telehealth visit. The PH-MCO or contracted CBCM entity must obtain and document consent for the use of telehealth technology for the initial telehealth visit.

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

- Professional services rendered via an interactive telecommunication system are only eligible for reimbursement to the provider rendering the telemedicine services. A provider rendering face-to-face care should report the appropriate codes for the in-person services.
- The patient must be present at the time of all billed services. If state law requires a face-to-face examination PRIOR to the delivery of telemedicine services, the face-to-face services must be concluded and documented in the medical record prior to the initiation of any related telehealth visits.
- The referring, consulting, or distant provider should obtain written valid consent from the member agreeing to participate in services delivered via the means of telemedicine. The member has the right to refuse these services at any time and must be made aware of any alternatives, including any delays in service, need to travel, or risks associated with not having services provided via telemedicine.
- All services provided must be medically appropriate and necessary.
- Prior authorization for telehealth-delivery is not required, but the Distant Site provider must obtain prior approval for any other covered services which would normally require prior authorization. This applies for participating and non-participating providers.
- The consultation/evaluation and management service must take place via an interactive audio and/or video telecommunications system (unless exceptions are allowed by applicable laws). Interactive telecommunications systems must be multi-media communication which, at minimum, includes audio and video equipment permitting real-time (synchronous) consultation among the patient and practitioner at the Originating Site and the practitioner at the Distant Site.
- Thorough, appropriate documentation of telemedicine services and other communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.
- Services billed which indicate telemedicine as the mode of service delivery but are not substantiated by either the claim form or written medical records are subject to disallowances in the course of an audit.
- Please note that valid consent is required to assure that the member agrees to receive service via Telehealth delivered service and to assure that the member retains a voice in their treatment. The member must be informed and given an opportunity to request an in-person assessment before receiving a Telehealth service. The member’s verbal consent must be documented in the member’s record. The Contractor shall not require written consent for the provision of Telehealth services.
- Telehealth platform being used must be private, secure, HIPPA-compliant and high-quality virtual medical consultations via videoconference.

BILLING

Claims must be submitted using the appropriate CPT or HCPS code for the professional service according to CMS guidelines.

The claim should reflect the designated Place of Service (POS) code 02 when telehealth is delivered in a setting other than the individual’s home and code 10 when telehealth is delivered in the individual’s home in accordance with MA Bulletin 99-23-08.

Eligible Providers

Providers performing and billing telemedicine services must be eligible to independently perform and bill the equivalent face-to-face service. Providers must be located in the United States to provide these services.

For services delivered through telehealth, healthcare practitioners must:

- Act within their scope of practice.
- Be licensed for the service for which they are providing to members.
- Be a participating provider with Highmark wholecare or engaged in the process to become a participating provider.
- Be located within the continental United States.
- Provider at originating site and the provider at distant site must be licensed in Pennsylvania or in the state in which the provider is located, if allowed under Pennsylvania law to provide Telehealth services without a Pennsylvania license through the Interstate Medical Licensure Compact or otherwise must be enrolled with Highmark Wholecare

Post-payment Audit Statement

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Wholecare at any time pursuant to the terms of your provider agreement.

Place of Service: Inpatient/Outpatient

REIMBURSEMENT

Participating facilities will be reimbursed per their Highmark Wholecare contract.

References

CMS
MedicaidManual.pdf