

RB.038.A Professional Telehealth Services (Individual and Family Plan)

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PRODUCT VARIATIONS

This policy only applies to Jefferson Health Plans Individual and Family Plans line of business.

Application of Claim Payment Policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Payment may vary based on individual contract.

POLICY STATEMENT

Professional Telehealth Services are covered and eligible for reimbursement when all the following requirements are met:

- The service is medically necessary and is delivered using synchronous interactive audio and video telecommunications systems.
- The member seeking medical care is present at the time of service (i.e., real-time interaction between the member and the healthcare provider).
- Service must be rendered by our Physicians (PCP or Specialist), Nurse Practitioners (NP's), Certified Registered Nurse Anesthetists (CRNA), Physician Assistants (PA's), Registered dietitians, Nurse -midwives, Clinical Nurse specialist.

Telephone based evaluations, Virtual check-ins and E-visits are not eligible for reimbursement consideration. We follow the guidelines listed below for telehealth/telemedicine services.

TYPE OF SERVICE	DESCRIPTION OF SERVICE	CODING	Patient Relationship with Provider	Required Place of Service	Required Modifier	Requires Audiovisual Synchronous Real-time Communication
Telehealth Visits*	A visit with a provider that uses synchronous interactive audio and video telecommunications system.	99202-99205 99212-99215 (office or other outpatient visits)	New or established	02 or 10	GT or 95	Yes
		99381-99385 99391-99395	New or established	02 or 10	GT or 95	Yes
		G0425, G0426, G0427 (Telehealth Consultations, emergency department or initial inpatient) G0406, G0407, G0408 (Follow-up inpatient telehealth consultations furnished to individuals in hospitals or SNFs)	New or established	02 or 10	GT or 95	Yes
		T1015 (FQHC)	New or established	02, 10 or 50	GT or 95	Yes

**For telehealth visits (synchronous interactive audio and video telecommunications system) providers must report the appropriate Evaluation & Management (E&M) procedure code that would have applied had the service been provided in the office. In addition, providers must use the appropriate telehealth modifier, 95, GT. These types of visits shall be reimbursed in accordance with the provider's contract, Health Partners Plans fee schedules and the member's benefit plan.*

Urgent Care Centers (UCC's) are NOT eligible to receive payment for their case rate code (S9083) when Professional Telehealth Services are performed. If an UCC submits a claim with their case rate code when a service is rendered via telehealth, the claim will be denied. Only services rendered in person and face to face are eligible for case rate payment (S9083). UCC's are eligible for payment of Professional Telehealth Services if the policy criteria are met, and the above Telehealth Visit procedure codes are explicitly included in the provider's contract with Health Partners Plans.

Federally Qualified Health Centers (FQHC's) are eligible to receive payment for their case rate code (T1015) when performed in person or virtually through synchronous interactive audio and video telecommunication systems.

T1015 must be reported with POS 02, 10 or 50 and modifiers GT or 95.

FQHC's are not eligible to receive payment for telehealth visit codes 99202-99205, 99212-99215, G0425-G0427 and G0406-G0408.

POLICY GUIDELINES

1. Professional Telehealth Services would typically NOT occur more than once per week for the same episode of care. Providers may be subject to an audit if increased frequency occurs.
2. Authorization is not required for Professional Telehealth Services alone.
3. Providers are expected to report the most appropriate Current Procedural Terminology (CPT[®]), or Healthcare Common Procedure Coding System (HCPCS) code and applicable modifier for Professional Telehealth Services provided.
4. Payment of Professional Telehealth Services may be impacted by CCI edits.
5. For providers paid on a capitation basis, services delivered through telehealth are considered included in capitation and are not separately payable.
6. We reserve the right to audit Professional Telehealth Services to evaluate:
 - a. Compliance with this policy or related state and federal regulations
 - b. Effectiveness and impact to our members
 - c. Quality of care

7. Nurse Practitioners (NP’s), Certified Registered Nurse Anesthetists (CRNA) Physician Assistants (PA’s), Registered dietitians, Nurse -midwives, & Clinical Nurse specialist are required to perform services within the scope of their license.
8. Professional Telehealth Services do not include text messages.
9. Providers must fully document services rendered and identify the telecommunication technology used in the patient’s medical record.
10. When providers bill for Professional Telehealth Services in hospital-based clinics, they are not eligible for payment of facility fee component.

CODING

Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.

CPT® is a registered trademark of the American Medical Association.

CPT	Description
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

<p>99204</p>	<p>Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter</p>
<p>99205</p>	<p>Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.</p>
<p>99212</p>	<p>Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter</p>
<p>99213</p>	<p>Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.</p>
<p>99214</p>	<p>Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.</p>
<p>99215</p>	<p>Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.</p>
<p>99381</p>	<p>Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)</p>

99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age 1 through 4 years)
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age 5 through 11 years)
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age 12 through 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age 18 through 39 years)
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age 1 through 4 years)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the

	ordering of laboratory/diagnostic procedures, established patient; infant (age 5 through 12 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age 12 through 17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age 18 through 39 years)

HCPCS	Description
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth.
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth.
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth.
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth.

G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth.
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth.
S9083	Global fee urgent care centers
T1015	Clinic visit/encounter, all-inclusive.

GT Modifier – GT Modifier applies when a visit was a synchronous telehealth service was administered real time through interactive audio and video telecommunication systems.

95 Modifier – 95 Modifier applies to describe a Telehealth session. A Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System. Preferred modifier to be used per Centers for Medicare & Medicaid Services (CMS).

BENEFIT APPLICATION

This Reimbursement Policy does not constitute a description of benefits. Rather, this assists in the administration of the member’s benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage.

DESCRIPTION OF SERVICES

- **E-Visits:** An established patient-initiated non-face-to-face communication through an online patient portal.
- **Interactive telecommunications system:** Multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient and distant site physician or practitioner.

Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.

- **Professional Telehealth Services:** Services performed by professional providers using technology to evaluate and communicate with members are limited to telehealth visits, virtual check-ins, telephone based-evaluations, and e-visits.
- **Synchronous interaction:** A real-time interaction between a patient and a health care provider located at a distant site.
- **Telehealth Visits:** A visit with a provider that uses synchronous interactive audio and video telecommunications system.
- **Telephone-based evaluations:** Telephone services are non-face-to-face encounters originating from the established patient for evaluation or management of a problem provided by a qualified clinician.
- **Virtual check-ins:** A brief (5-10-minute) check-in with a provider via telephone or other telecommunications device to determine whether an office visit or other service is needed for an established patient. A remote evaluation of recorded video and/or images submitted by an established patient.

DEFINITIONS

N/A

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making. Policy Bulletins are developed to assist in administering plan benefits and constitute neither offers of coverage nor medical advice. For Health Partners Plans Medicaid and Health Partners Plans Chip products: Any requests for services that do not meet criteria set in PARP will be evaluated on a case-by-case basis.

This Policy Bulletin may be updated and therefore is subject to change.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Date
New policy.	A	01/01/2024

REFERENCES

N/A