

	Reimbursement Policy Manual		Policy #:	RPM052
Policy Title:	Telehealth And Telemedicine			
Section:	Telemedicine	Subsection:	None	
Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:				
Companies:				
<input checked="" type="checkbox"/> All Companies: Moda Partners, Inc. and its subsidiaries & affiliates <input type="checkbox"/> Moda Health Plan <input type="checkbox"/> Moda Assurance Company <input type="checkbox"/> Summit Health Plan <input type="checkbox"/> Eastern Oregon Coordinated Care Organization (EOCCO) <input type="checkbox"/> OHSU Health IDS				
Types of Business:				
<input checked="" type="checkbox"/> All Types <input type="checkbox"/> Commercial Group <input type="checkbox"/> Commercial Individual <input type="checkbox"/> Commercial Marketplace/Exchange <input type="checkbox"/> Commercial Self-funded <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Short Term <input checked="" type="checkbox"/> Other: Oregon Self-funded plans which adopt the Oregon telehealth mandate Note: This policy does not apply to Vision-only plans.				
States:				
<input type="checkbox"/> All States <input checked="" type="checkbox"/> Alaska <input type="checkbox"/> Idaho <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Texas <input checked="" type="checkbox"/> Washington				
Claim forms:				
<input checked="" type="checkbox"/> CMS1500 <input checked="" type="checkbox"/> CMS1450/UB (or the electronic equivalent or successor forms)				
Date:				
<input checked="" type="checkbox"/> All dates <input type="checkbox"/> Specific date(s): _____ <input type="checkbox"/> Date of Service; For Facilities: <input type="checkbox"/> n/a <input type="checkbox"/> Facility admission <input type="checkbox"/> Facility discharge <input type="checkbox"/> Date of processing				
Provider Contract Status:				
<input checked="" type="checkbox"/> Contracted directly, any/all networks <input checked="" type="checkbox"/> Contracted with a secondary network <input checked="" type="checkbox"/> Out of Network				
Originally Effective:	1/1/2010	Initially Published:	8/10/2016	
Last Updated:	12/7/2022	Last Reviewed:	12/14/2022	
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No				
Last Update Effective Date for Texas:		12/14/2022		

Purpose of Policy

This policy is intended to define telehealth and telemedicine terminology for our company, plans, and claims, provide clarification of which services are and are not eligible for reimbursement, and specify the criteria and requirements which must be met.

Reimbursement Guidelines

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A. All Lines of Business, New Patient versus Established Patient Determinations

1. Telemedicine visit services are performed as the remote/technology equivalent of an in-person service.
2. Telemedicine services count the same as an in-office visit for the purposes of determining if the patient is a new patient or an established patient when they are receiving future visits and services.
3. If a provider is seeing a new patient for the first time via telemedicine using audio/video capabilities, select and report the appropriate new patient E/M code with POS 02 or 10 for the telemedicine visit (and any telemedicine modifier if needed).
4. If for some reason a new patient E/M code is not reported for that initial telemedicine visit, the patient is still considered an established patient for the next visit and any future E/M visits which occur in person.
5. New patient versus established patient visit code:
 - a. CPT guidelines:

“An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.” (AMA²⁹)
 - b. The CMS and CPT guidelines differ for determining specialty for non-physician practitioners (NPP).
 - i. CMS: “...classifies NPPs in a specialty that is not the same as a physician with whom the NPP is working...” (CMS³⁸)
 - ii. AMA/CPT: “When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician.” (AMA³⁹)
 - iii. Moda follows the AMA/CPT guidelines for NPP specialty determination.
 - c. See also:
 - i. Evaluation and Management Services Guide Booklet (CMS³⁰)
 - ii. New Patient vs Established Patient Visit (Noridian³¹)
 - iii. New vs Established Patient Decision Tree Flowchart (Noridian³²)

B. Commercial Oregon plans

Moda Health Oregon Commercial plans comply with OR SB 144 / ORS 743A.058, and ORS 743A.185.

1. Telemedicine services are eligible for reimbursement when:
 - a. The billed services must be within the provider's scope of license.
 - b. The billed services are a covered benefit under the member's plan.
 - c. The services can be safely and effectively performed as a telemedicine service.
 - d. Any applicable Medical Necessity Criteria are met.

- e. Permitted communication technologies include the following: (ORS²⁰)
- i. Landlines
 - ii. Wireless Communications
 - iii. Internet
 - iv. Telephone networks
 - v. Synchronous audio/video
 - vi. Asynchronous audio/video
 - vii. Synchronous audio-only
 - viii. Asynchronous audio-only
 - ix. Synchronous video-only
 - x. Asynchronous video-only
- f. The communication technology must use secure transmission methods and meet all federal and state requirements for privacy, security, and protected health information (HIPAA, etcetera). (ORS²⁰)
- g. Oregon licensed providers can provide telemedicine services to Oregon residents while the provider is out-of-state.
- h. The billing and coding guidelines in this policy are met.

Note: CMS originating site (patient location) restrictions and geographic restrictions do not apply to Oregon Commercial plans.

2. Telemedicine services are not eligible for reimbursement when:
- a. Email/online written communication only is used.
 - i. These are not considered “telemedicine services” and are not a covered benefit on our standard plans.
 - ii. Exception: If the member’s plan has a specific benefit addressing coverage for email or online communication.
 - b. The service is not covered under the member’s plan.
 - c. The service is provided using unsecure transmission methods such as Skype or FaceTime (*except during a state of emergency, as allowed by state and Federal law).
 - d. Other criteria in # 1 are not met.
3. Telemedicine services performed by non-contracted providers will be eligible for available benefits at the member’s out-of-network benefit level.
4. Billing and Coding Guidelines:
- a. Report the primary service(s) using the appropriate CPT or HCPCS code(s) for the professional service(s) performed.
 - i. Report with place of service (POS) 02 or 10. (MLN¹², CMS¹³)
 - ii. Append modifier GQ, modifier 93, modifier 95, or modifier GT to the procedure code to indicate the type of transmission technology used. Only one of these modifiers may be used per line item. Using more than one of these modifiers on the same line item will result in a denial for incorrect combination of modifiers.

- iii. Use modifier G0 (G Zero) for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (MLN¹⁷)
 - iv. Do not submit a telemedicine service or evaluation with CPT code 99499 (Unlisted evaluation and management service).
- b. Online evaluation and management service procedure codes include description wording of “... provided to an *established patient*...” or “...*for an established patient*...”
- i. Procedure codes 99444 (*DOS 2019 & prior*) or 99421-99423 (*DOS 1/1/2020 & following*) are used by providers in two distinct ways; to report:
 - 1) An audio/video real-time interactive telemedicine visit handled via a secure internet connection or app.
 - a) This would be a telemedicine visit eligible for coverage if all criteria is met.
 - b) Moda’s guidelines instruct to report this service with the appropriate E/M procedure code and POS 02 or 10. However, some clinics are reporting with 99444 or 99421-99423 and cite their own internal policies.
 - 2) A provider-patient exchange by written communication only online (e.g., email or private messaging), which is only a covered benefit for a few non-standard plans.
 - ii. No matter if 99444 or 99421-99423 represent an email/written exchange or a real-time audio/visual internet visit, the code definitions for CPT codes 99444 or 99421-99423 require that the patient be an established patient.
 - 1) Codes 99444 or 99421-99423 may not be used to report a telemedicine visit to a new patient. Use the appropriate new patient E/M code with POS 02 or 10.
 - 2) If 99444 or 99421-99423 are reported for a new patient member (with no previous billed services within the past 3 years), a clinical edit denial will be generated.
 - a) A corrected claim will be needed.
 - b) If the member is an established patient but previous services occurred before the member became effective on the Moda plan, submit a brief cover letter with explanation and attached medical record documentation and request a reconsideration using the provider inquiry/appeal process.
- c. Originating site fee –
- i. An originating site fee may not be billed when the patient is located at home or at a self-service kiosk.
 - ii. The originating site (office or facility where the patient was located at the time of the telemedicine professional service) may submit an originating site facility fee for telemedicine services with HCPCS code Q3014 and one unit per provider of telemedicine services.
 - 1) Per Medically Unlikely Edits (MUE) unit limits for Q3014, a maximum of one unit per date of service will be reimbursed to a professional provider or clinic, and a maximum of two units per date of service for facilities.
 - 2) The originating site fee (Q3014) may not be billed by the same provider or on the same claim as the telemedicine visit services performed by the provider at the

distant site (where the patient is not located). Even if both office locations are within a large system of multi-location clinics or facilities and even if they share the same TIN, services where the patient is located (Q3014) and services where the patient is not located (e.g., 99213-GT/POS 02 or 10 or 99213-95/POS 02 or 10) need to be submitted under separate claims with separate NPIs and separate service addresses.

- 3) A provider may do a face-to-face E/M, and then also be the originating site (space and equipment) for the patient to have a telemedicine visit with a second provider at another location, when a different specialty or more advanced care is needed. Submit the face-to-face E/M visit with modifier 25 appended to indicate this sequence of events in order for both the face-to-face E/M visit and Q3014 to be eligible for reimbursement.
- 4) Procedure code Q3014 is not eligible for reimbursement when ordinary non-secure smart phone or internet video phone call technology (e.g., Skype, FaceTime, etc.), applications, etcetera is utilized to provide the audio + visual connection for the telemedicine services. These non-secure communication services are not HIPAA-compliant for a telemedicine service/PHI.
- 5) The originating site is to keep a written record of the telemedicine session in the member's medical record, just as for any other patient service. The documentation needs to include the date, time, and duration of session; technology and equipment used; staff members present (name and licensure) at originating site; name, licensure, specialty, and location of the telemedicine provider at distant site; and reason for the telemedicine service.
- 6) The telemedicine session record must be provided for review upon request to substantiate the originating site facility fee.
- 7) Procedure code T1014 (Telehealth transmission, per minute, professional services bill separately) is not eligible for reimbursement. T1014 is a HCPCS code specific to Medicaid services.

d. Telemedicine services are not reimbursed for the following:

- i. Telemedicine that occurs the same day as an in-person visit, when performed by the same provider.
- ii. Online medical evaluations for evaluation and management services.
- iii. Patient communications incidental to E/M, counseling, or other covered medical services, including, but not limited to:
 - 1) Reporting of test results.
 - 2) Further discussion of symptoms or care.
 - 3) Provision of educational materials.

e. Some services (such as home cardiac event monitoring) are routinely performed using asynchronous telecommunications technology, and do not normally involve face-to-face

provider contact. These services do not need to be submitted with modifier GQ. See # 8 below for more information.

5. Telemedicine services include the following items which are not eligible to be separately billed or reimbursed:
 - a. Pre-service activities include, but are not limited to:
 - i. Reviewing patient data (for example, diagnostic and/or imaging studies, interim lab work).
 - ii. Communicating with other professionals.
 - iii. Communicating with the family and/or further with the patient as needed.
 - b. Intra-service activities include, but are not limited to, the key elements for each procedure code.
 - c. Post-service activities include, but are not limited to:
 - i. Completing medical records or other documentation.
 - ii. Communicating results of the service and further care plans to other health care professionals.

6. Specific types of providers who are eligible to perform telemedicine services include but are not limited to the following:
 - a. Physician (MD, DO)
 - b. Naturopathic physicians (ND)
 - c. Nurse practitioner (NP)
 - d. Physician assistant (PA)
 - e. Certified Nurse-midwife (CNM)
 - f. Nurse Practitioner Midwife (NPM)
 - g. Clinical nurse specialist (CNS), Registered Nurse Clinical Specialist (RNCS)
 - h. Certified registered nurse anesthetist (CRNA), for pain management services only.
 - i. Clinical psychologists (CP, LCP, PhD.) *(See Coding Guidelines and MLN⁵ for code restrictions.)*
 - j. Clinical social worker (LCSW, CSW) *(See Coding Guidelines and MLN⁵ for code restrictions.)*
 - k. Board Certified Behavior Analyst (BCBA)
 - l. Other contracted mental health or substance use disorder providers
 - m. Registered dietitian (RD)
 - n. Speech Therapists, Speech-Language Pathologists (SLP).
 - o. Optometrists. (ORS¹⁶)
 - p. Other provider types who meet the requirements in section A.1.

7. Providers are expected to:
 - a. Verify the member's identity and eligibility.
 - b. Ensure that all data transmission and recording is secure and HIPAA-compliant.
 - c. Comply with all state and federal laws governing privacy and security of protected health information (PHI), including laws in the state where the patient is located.

- d. Utilize and follow community standards, best practices, prevailing technology, etc. for recording consent, security, encryption, transmission, storage, and storage disclosure.
 - e. Document the service in the patient’s record in the same manner as if it were performed in-person. The written record is in addition to any stored recording of the data transmission of the service.
 - i. Include additional notations indicating the service was performed as a telemedicine service and document any relevant impacts this had on the encounter or service.
 - ii. Specify the type of transmission utilized (e.g., real-time or delayed, telephonic, audio + video, encrypted transmission of diagnostic test data, etc.).
 - iii. Identify and note participation of any additional staff present at the member’s location to assist with the telemedicine service.
 - iv. The medical record must be available and provided to the health plan upon request for review at any time (pre-payment or post-payment).
 - f. Care provided via telemedicine will be evaluated according to the clinical standard of care applicable to the relevant area of specialty for more traditional in-person medical care (e.g., pertinent physical exam findings, etc.). Additionally, telemedicine providers are expected to adhere to current standards for practice improvement and monitoring of outcomes.
 - g. For ESRD-related services, a physician, NP, PA, or CNS must furnish at least one “hands on” in-person visit (not telehealth) each month to examine the vascular access site.
8. Services are eligible to be covered as telemedicine services if they are a covered benefit when performed in-person and can be safely and effectively performed as a telemedicine service. Examples include but are not limited to:
- a. Treatment of diabetes and/or Diabetes Self-Management Training (DSMT) (individual, or group).
 - b. Most evaluation and management (E/M) services are eligible to be performed as telemedicine services.
 - c. Most behavioral health services are eligible to be performed as telemedicine services.
 - d. Medical nutrition therapy assessment, individual, or group.
 - e. Other covered condition-specific assessments or patient education (mandated benefits or verify each member’s plan benefits).
9. Services not eligible to be performed as telemedicine services (common examples, list not all-inclusive):

Service	Why not eligible for telemedicine
Anesthesia services	Requires member and provider to be in the same physical location to be performed safely and effectively.
Consultation between two physicians or providers	Does not require the presence of the patient for an in-person service.
Laboratory tests	Not performed as an in-person service.
Radiology interpretation and report services	Not performed as an in-person service.

Service	Why not eligible for telemedicine
Surgery	Requires member and provider to be in the same physical location to be performed safely and effectively.
Telephone calls with member(s).	When/if covered, a telephone call is not considered a telemedicine service, as telephone calls have always supplemented face-to-face services, and do not include video interaction.

10. Services not considered covered telemedicine services, but which may be otherwise covered as non-telemedicine services.

- a. Some professional services do not require the patient to be present in-person with the practitioner when they are furnished and are commonly furnished using some form of telecommunications technology. These services are part of the broader scope of telehealth and may be included in documentation or discussions of telemedicine by other organizations or entities. We do not consider these services to be *telemedicine* service(s); they do not need to be reported with modifier GQ to signify asynchronous technology was used, and they are not appropriate to be reported with POS 02 or 10. They are processed as usual under the member's benefits and reimbursed under the usual fee schedule.

Examples of such services include:

- i. Real-time remote intraoperative neurophysiologic monitoring.
- ii. Radiology interpretations. Bill with modifier 26 unless billing an interpretation-only procedure code.
- iii. Home cardiac event monitoring.
 - 1) May utilize real-time or asynchronous transmission technology.
 - 2) Duration of monitoring and monitor technology utilized must be documented, as proper code selection relies on a combination of both factors.
- iv. Remote transmission of data from home glucose monitor, INR testing device, etcetera.
- v. Other remote monitoring devices & data transmission.
- b. Beginning in 2017, the current CPT book Appendix P includes some procedure codes of this nature. Modifier 95 will be considered valid for these codes (based upon the CPT book information only), but modifier GT and GQ will not be considered valid for these procedure codes.

11. Services and activities not considered telemedicine services which are not eligible to be separately reported:

- a. Sending e-mail, facsimile transmission, secure messaging, etc. to another provider, office, or facility containing clinical information.
- b. Installation or maintenance of any telecommunication devices or systems to support telemedicine services.
- c. Home health or safety monitoring (e.g., Medical Guardian Alert, VueZone, QuietCare Plus, LifeFone).
- d. Advice-nurse lines, poison center, or other "health line" type services provided by nurses and other non-physician, non-nurse practitioner providers.

- e. Triage to assess the appropriate place of service and/or appropriate provider type to render needed care.
- f. Administrative services, including but not limited to: scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.

C. Commercial Alaska plans

Moda Health Alaska Commercial plans comply with Alaska Statute 21.42.422.

1. Telemedicine services are eligible for reimbursement when:
 - a. The billing provider is licensed in the state of Alaska. Billing providers outside the state of Alaska need to be registered with the Alaska telemedicine business registry.
 - b. The billed services are a covered benefit under the member's plan.
 - c. The services can be safely and effectively performed as a telemedicine service.
 - d. Any applicable Medical Necessity Criteria are met.
 - e. The billing and coding guidelines in this policy are met.
 - f. Synchronous two-way interactive audio + video (A/V) conferencing is used.
 - i. The A/V conferencing the application and technology used meet all state and federal standards for privacy and security of protected health information (HIPAA).
 - ii. The billing provider is responsible to ensure these HIPAA privacy protection standards are met.
 - g. The same benefit cost-sharing (deductible, copayment, co-insurance) applies to the telemedicine service as would apply if the service were performed in person.
 - h. Effective for dates of service March 17, 2020 and following, telehealth services may be provided to new patients; there is no requirement for the provider and the member to have had prior contact in person before the telehealth service.
 - i. Effective for dates of service March 17, 2020 and following, telephone visits and online medical evaluations for evaluation and management services are covered benefits for Alaska plans.

Note: CMS originating site (patient location) restrictions and geographic restrictions do not apply to Alaska Commercial plans.

2. Telemedicine services are not eligible for reimbursement when:
 - a. The provider is not either licensed in the state of Alaska or registered with the Alaska telemedicine business registry.
 - b. Asynchronous transmission is used (time-delay).
 - c. Audio-only conferencing or audio-web conferencing without person-to-person video abilities is used (modifier 93).
 - d. Other criteria in # 1 are not met.

3. Billing and Coding Guidelines:

- a. Report the primary service(s) using the appropriate CPT or HCPCS code(s) for the professional service(s) performed.
 - i. Report with place of service 02 or 10. (MLN¹², CMS¹³) Do not report with POS 99 (Other place of service not identified above).
 - ii. Append modifier GQ, modifier 93, modifier 95, or modifier GT to the procedure code to indicate the type of transmission technology used.
 - iii. Use modifier G0 (G Zero) for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (MLN¹⁷)
 - iv. Do not submit a telemedicine service or evaluation with CPT code 99499 (Unlisted evaluation and management service).
 - v. CPT codes 99444 and 99421-99423 all have descriptions which require that the patient be an established patient. Codes 99444 and/or 99421-99423 may not be used to report a telemedicine visit to a new patient. Use the appropriate new patient E/M code with POS 02 or 10.
- b. Originating site fee –
 - i. An originating site fee may not be billed when the patient is located at home or at a self-service kiosk.
 - ii. The originating site (office or facility where the patient was located at the time of the telemedicine professional service) may submit an originating site facility fee for telemedicine services with HCPCS code Q3014 and one unit per provider of telemedicine services.
 - 1) Per Medically Unlikely Edits (MUE) unit limits for Q3014, a maximum of one unit per date of service will be reimbursed to a professional provider or clinic, and a maximum of two units per date of service for facilities.
 - 2) The originating site fee (Q3014) may not be billed by the same provider or on the same claim as the telemedicine visit services performed by the provider at the distant site (where the patient is not located). Even if both office locations are within a large system of multi-location clinics or facilities and even if they share the same TIN, services where the patient is located (Q3014) and services where the patient is not located (e.g., 99213-95/POS 02 or 10 or 99213-GT/POS 02 or 10) need to be submitted under separate claims with separate NPIs and separate service addresses.
 - 3) A provider may do a face-to-face E/M, and then also be the originating site (space and equipment) for the patient to have a telemedicine visit with a second provider at another location, when a different specialty or more advanced care is needed. Submit the face-to-face E/M visit with modifier 25 appended to indicate this sequence of events in order for both the face-to-face E/M visit and Q3014 to be eligible for reimbursement.
 - 4) Procedure code Q3014 is not eligible for reimbursement when ordinary non-secure smart phone or internet video phone call technology (e.g., Skype, FaceTime, etc.), applications, etcetera is utilized to provide the audio + visual connection for the

telemedicine services. These non-secure communication services are not HIPAA-compliant for a telemedicine service/PHI.

- 5) The originating site is to keep a written record of the telemedicine session in the member's medical record, just as for any other patient service. The documentation needs to include the date, time, and duration of session; technology and equipment used; staff members present (name and licensure) at originating site; name, licensure, specialty, and location of the telemedicine provider at distant site; and reason for the telemedicine service.
- 6) The telemedicine session record must be provided for review upon request to substantiate the originating site facility fee.
- 7) Procedure code T1014 (Telehealth transmission, per minute, professional services bill separately) is not eligible for reimbursement. T1014 is a HCPCS code specific to Medicaid services.

c. Telemedicine services are not reimbursed for the following:

- i. Telemedicine that occurs the same day as an in-person visit, when performed by the same provider.
- ii. Patient communications incidental to E/M, counseling, or other covered medical services, including, but not limited to:
 - 1) Reporting of test results.
 - 2) Further discussion of symptoms or care.
 - 3) Provision of educational materials.

d. Some services (such as home cardiac event monitoring) are routinely performed using asynchronous telecommunications technology, and do not normally involve face-to-face provider contact. These services do not need to be submitted with modifier GQ. See # 8 below for more information.

4. Telemedicine services include the following items which are not eligible to be separately billed or reimbursed:

a. Pre-service activities include, but are not be limited to:

- i. Reviewing patient data (for example, diagnostic and/or imaging studies, interim lab work).
- ii. Communicating with other professionals.
- iii. Communicating with the family and/or further with the patient as needed.

b. Intra-service activities include, but are not limited to, the key elements for each procedure code.

c. Post-service activities include, but are not limited to:

- i. Completing medical records or other documentation.
- ii. Communicating results of the service and further care plans to other health care professionals.

5. Providers are expected to:
 - a. Verify the member's identity and eligibility.
 - b. Ensure that all data transmission and recording is secure and HIPAA-compliant.
 - c. Comply with all state and federal laws governing privacy and security of protected health information (PHI), including laws in the state where the patient is located.
 - d. Utilize and follow community standards, best practices, prevailing technology, etc. for recording consent, security, encryption, transmission, storage, and storage disclosure.
 - e. Document the service in the patient's record in the same manner as if it were performed in-person. The written record is in addition to any stored recording of the data transmission of the service.
 - i. Include additional notations indicating the service was performed as a telemedicine service and document any relevant impacts this had on the encounter or service.
 - ii. Specify the type of transmission utilized (e.g., real-time or delayed, telephonic, audio + video, encrypted transmission of diagnostic test data, etc.).
 - iii. Identify and note participation of any additional staff present at the member's location to assist with the telemedicine service.
 - iv. The medical record must be available and provided to the health plan upon request for review at any time (pre-payment or post-payment).
 - f. Care provided via telemedicine will be evaluated according to the standard of care applicable to the relevant area of specialty for more traditional in-person medical care. Additionally, telemedicine providers are expected to adhere to current standards for practice improvement and monitoring of outcomes.
6. Services and activities not considered telemedicine services which are not eligible to be separately reported:
 - a. Sending e-mail, facsimile transmission, secure messaging, etc. containing clinical information.
 - b. Installation or maintenance of any telecommunication devices or systems to support telemedicine services.
 - c. Home health or safety monitoring (e.g., Medical Guardian Alert, VueZone, QuietCare Plus, LifeFone).
 - d. Advice-nurse lines, poison center, or other "health line" type services provided by nurses and other non-physician, non-nurse practitioner providers.
 - e. Triage to assess the appropriate place of service and/or appropriate provider type to render needed care.
 - f. Administrative services, including but not limited to: scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.

D. Commercial Texas plans

1. Telemedicine services are eligible for reimbursement when:
 - a. The billed services must be within the provider's scope of license.

- b. The billed services are a covered benefit under the member’s plan.
- c. The services can be safely and effectively performed as a telemedicine service.
- d. Any applicable Medical Necessity Criteria are met.
- e. Permitted communication technologies include the following: (Texas³³, Terry³⁵)
 - i. Synchronous audio/video interaction.
 - ii. Asynchronous store and forward technology. This technology is covered under non-telemedicine benefits and is addressed below.
 - iii. Asynchronous store and forward technology in conjunction with synchronous audio interaction.
- f. The communication technology used meets all federal and state requirements for privacy, security, and protected health information (HIPAA, etcetera). (Texas³⁴)
- g. The billing and coding guidelines in this policy are met.

Note: CMS originating site (patient location) restrictions and geographic restrictions do not apply to Texas Commercial plans.

- 2. Telemedicine services are not eligible for reimbursement when:
 - a. Audio-only technology is used. (Texas³³)
 - b. Email/online written communication only is used.
 - i. These are not considered “telemedicine services” and are not a covered benefit on our standard plans.
 - ii. Exception: If the member’s plan has a specific benefit addressing coverage for email or online communication.
 - c. The service is not covered under the member’s plan.
 - d. Other criteria in # 1 are not met.
- 3. Telemedicine services performed by non-contracted providers will be eligible for available benefits at the member’s out-of-network benefit level.
- 4. Billing and Coding Guidelines:
 - a. Report the primary service(s) using the appropriate CPT or HCPCS code(s) for the professional service(s) performed.
 - i. Report with place of service (POS) 02 or 10. (MLN¹², CMS¹³)
 - ii. Append modifier GQ, modifier 93, modifier 95, or modifier GT to the procedure code to indicate the type of transmission technology used. Only one of these modifiers may be used per line item. Using more than one of these modifiers on the same line item will result in a denial for incorrect combination of modifiers.
 - iii. Use modifier G0 (G Zero) for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (MLN¹⁷)
 - iv. Do not submit a telemedicine service or evaluation with CPT code 99499 (Unlisted evaluation and management service).

- b. Online evaluation and management service procedure codes include description wording of “... provided to an *established patient*...” or “...*for an established patient*...”
- i. Procedure codes 99444 (*DOS 2019 & prior*) or 99421-99423 (*DOS 1/1/2020 & following*) are used by providers in two distinct ways; to report:
 - 1) An audio/video real-time interactive telemedicine visit handled via a secure internet connection or app.
 - a) This would be a telemedicine visit eligible for coverage if all criteria is met.
 - b) Moda’s guidelines instruct to report this service with the appropriate E/M procedure code and POS 02 or 10. However, some clinics are reporting with 99444 or 99421-99423 and cite their own internal policies.
 - 2) A provider-patient exchange by written communication only online (e.g., email or private messaging), which is only a covered benefit for a few non-standard plans.
 - ii. No matter if 99444 or 99421-99423 represent an email/written exchange or a real-time audio/visual internet visit, the code definitions for CPT codes 99444 or 99421-99423 require that the patient be an established patient.
 - 1) Codes 99444 or 99421-99423 may not be used to report a telemedicine visit to a new patient. Use the appropriate new patient E/M code with POS 02 or 10.
 - 2) If 99444 or 99421-99423 are reported for a new patient member (with no previous billed services within the past 3 years), a clinical edit denial will be generated.
 - a) A corrected claim will be needed.
 - b) If the member is an established patient but previous services occurred before the member became effective on the Moda plan, submit a brief cover letter with explanation and attached medical record documentation and request a reconsideration using the provider inquiry/appeal process.
- c. Originating site fee –
- i. An originating site fee may not be billed when the patient is located at home or at a self-service kiosk.
 - ii. The originating site (office or facility where the patient was located at the time of the telemedicine professional service) may submit an originating site facility fee for telemedicine services with HCPCS code Q3014 and one unit per provider of telemedicine services.
 - 1) Per Medically Unlikely Edits (MUE) unit limits for Q3014, a maximum of one unit per date of service will be reimbursed to a professional provider or clinic, and a maximum of two units per date of service for facilities.
 - 2) The originating site fee (Q3014) may not be billed by the same provider or on the same claim as the telemedicine visit services performed by the provider at the distant site (where the patient is not located). Even if both office locations are within a large system of multi-location clinics or facilities and even if they share the same TIN, services where the patient is located (Q3014) and services where the patient is not located (e.g., 99213-GT/POS 02 or 10 or 99213-95/POS 02 or 10) need to be submitted under separate claims with separate NPIs and separate service addresses.

- 3) A provider may do a face-to-face E/M, and then also be the originating site (space and equipment) for the patient to have a telemedicine visit with a second provider at another location, when a different specialty or more advanced care is needed. Submit the face-to-face E/M visit with modifier 25 appended to indicate this sequence of events in order for both the face-to-face E/M visit and Q3014 to be eligible for reimbursement.
 - 4) Procedure code Q3014 is not eligible for reimbursement when ordinary non-secure smart phone or internet video phone call technology (e.g., Skype, FaceTime, etc.), applications, etcetera is utilized to provide the audio + visual connection for the telemedicine services. These non-secure communication services are not HIPAA-compliant for a telemedicine service/PHI.
 - 5) The originating site is to keep a written record of the telemedicine session in the member's medical record, just as for any other patient service. The documentation needs to include the date, time, and duration of session; technology and equipment used; staff members present (name and licensure) at originating site; name, licensure, specialty, and location of the telemedicine provider at distant site; and reason for the telemedicine service.
 - 6) The telemedicine session record must be provided for review upon request to substantiate the originating site facility fee.
 - 7) Procedure code T1014 (Telehealth transmission, per minute, professional services bill separately) is not eligible for reimbursement. T1014 is a HCPCS code specific to Medicaid services.
- d. Telemedicine services are not reimbursed for the following:
- i. Telemedicine that occurs the same day as an in-person visit, when performed by the same provider.
 - ii. Online medical evaluations for evaluation and management services.
 - iii. Patient communications incidental to E/M, counseling, or other covered medical services, including, but not limited to:
 - 1) Reporting of test results.
 - 2) Further discussion of symptoms or care.
 - 3) Provision of educational materials.
 - e. Some services (such as home cardiac event monitoring) are routinely performed using asynchronous telecommunications technology, and do not normally involve face-to-face provider contact. These services do not need to be submitted with modifier GQ. See # 8 below for more information.
5. Telemedicine services include the following items which are not eligible to be separately billed or reimbursed:
- a. Pre-service activities include, but are not limited to:
 - i. Reviewing patient data (for example, diagnostic and/or imaging studies, interim lab work).
 - ii. Communicating with other professionals.

- iii. Communicating with the family and/or further with the patient as needed.
 - b. Intra-service activities include, but are not limited to, the key elements for each procedure code.
 - c. Post-service activities include, but are not limited to:
 - i. Completing medical records or other documentation.
 - ii. Communicating results of the service and further care plans to other health care professionals.
- 6. Specific types of providers who are eligible to perform telemedicine services include but are not limited to the following:
 - a. Physician (MD, DO)
 - b. Naturopathic physicians (ND)
 - c. Nurse practitioner (NP)
 - d. Physician assistant (PA)
 - e. Certified Nurse-midwife (CNM)
 - f. Nurse Practitioner Midwife (NPM)
 - g. Clinical nurse specialist (CNS), Registered Nurse Clinical Specialist (RNCS)
 - h. Certified registered nurse anesthetist (CRNA), for pain management services only.
 - i. Clinical psychologists (CP, LCP, PhD.) *(See Coding Guidelines and MLN⁵ for code restrictions.)*
 - j. Clinical social worker (LCSW, CSW) *(See Coding Guidelines and MLN⁵ for code restrictions.)*
 - k. Board Certified Behavior Analyst (BCBA)
 - l. Other contracted mental health or substance use disorder providers
 - m. Registered dietitian (RD)
 - n. Speech Therapists, Speech-Language Pathologists (SLP).
 - o. Optometrists. (ORS¹⁶)
 - p. Other provider types who meet the requirements in section A.1.
- 7. Providers are expected to:
 - a. Verify the member's identity and eligibility.
 - b. Ensure that all data transmission and recording is secure and HIPAA-compliant.
 - c. Comply with all state and federal laws governing privacy and security of protected health information (PHI), including laws in the state where the patient is located.
 - d. Utilize and follow community standards, best practices, prevailing technology, etc. for recording consent, security, encryption, transmission, storage, and storage disclosure.
 - e. Document the service in the patient's record in the same manner as if it were performed in-person. The written record is in addition to any stored recording of the data transmission of the service.

- i. Include additional notations indicating the service was performed as a telemedicine service and document any relevant impacts this had on the encounter or service.
 - ii. Specify the type of transmission utilized (e.g., real-time or delayed, telephonic, audio + video, encrypted transmission of diagnostic test data, etc.).
 - iii. Identify and note participation of any additional staff present at the member’s location to assist with the telemedicine service.
 - iv. The medical record must be available and provided to the health plan upon request for review at any time (pre-payment or post-payment).
- f. Care provided via telemedicine will be evaluated according to the clinical standard of care applicable to the relevant area of specialty for more traditional in-person medical care (e.g., pertinent physical exam findings, etc.). Additionally, telemedicine providers are expected to adhere to current standards for practice improvement and monitoring of outcomes.
- g. For ESRD-related services, a physician, NP, PA, or CNS must furnish at least one “hands on” in-person visit (not telehealth) each month to examine the vascular access site.
8. Services are eligible to be covered as telemedicine services if they are a covered benefit when performed in-person and can be safely and effectively performed as a telemedicine service. Examples include but are not limited to:
- a. Treatment of diabetes and/or Diabetes Self-Management Training (DSMT) (individual, or group).
 - b. Most evaluation and management (E/M) services are eligible to be performed as telemedicine services.
 - c. Most behavioral health services are eligible to be performed as telemedicine services.
 - d. Medical nutrition therapy assessment, individual, or group.
 - e. Other covered condition-specific assessments or patient education (mandated benefits or verify each member’s plan benefits).
9. Services not eligible to be performed as telemedicine services (common examples, list not all-inclusive):

Service	Why not eligible for telemedicine
Anesthesia services	Requires member and provider to be in the same physical location to be performed safely and effectively.
Consultation between two physicians or providers	Does not require the presence of the patient for an in-person service.
Laboratory tests	Not performed as an in-person service.
Radiology interpretation and report services	Not performed as an in-person service.
Surgery	Requires member and provider to be in the same physical location to be performed safely and effectively.

Service	Why not eligible for telemedicine
Telephone calls with member(s).	When/if covered, a telephone call is not considered a telemedicine service, as telephone calls have always supplemented face-to-face services, and do not include video interaction.

10. Services not considered covered telemedicine services, but which may be otherwise covered as non-telemedicine services.

- a. Some professional services do not require the patient to be present in-person with the practitioner when they are furnished and are commonly furnished using some form of telecommunications technology. These services are part of the broader scope of telehealth, but are not considered *telemedicine* service(s), and do not need to be reported with modifier GQ to signify asynchronous technology was used. They are processed as usual under the member's benefits and reimbursed under the usual fee schedule.

Examples of such services include:

- i. Real-time remote intraoperative neurophysiologic monitoring.
- ii. Radiology interpretations. Bill with modifier 26 unless billing an interpretation-only procedure code.
- iii. Home cardiac event monitoring.
 - 1) May utilize real-time or asynchronous transmission technology.
 - 2) Duration of monitoring and monitor technology utilized must be documented, as proper code selection relies on a combination of both factors.
- b. Beginning in 2017, the current CPT book Appendix P includes some procedure codes of this nature. Modifier 95 will be considered valid for these codes (based upon the CPT book information only), but modifier GT and GQ will not be considered valid for these procedure codes.

11. Services and activities not considered telemedicine services which are not eligible to be separately reported:

- a. Sending e-mail, facsimile transmission, secure messaging, etc. to another provider, office, or facility containing clinical information.
- b. Installation or maintenance of any telecommunication devices or systems to support telemedicine services.
- c. Home health or safety monitoring (e.g., Medical Guardian Alert, VueZone, QuietCare Plus, LifeFone).
- d. Advice-nurse lines, poison center, or other "health line" type services provided by nurses and other non-physician, non-nurse practitioner providers.
- e. Triage to assess the appropriate place of service and/or appropriate provider type to render needed care.
- f. Administrative services, including but not limited to: scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.

E. Medicare Advantage plans

1. CMS covers a limited number of Part B telemedicine services furnished by a physician or practitioner to an eligible beneficiary when specific criteria are met.
2. Medicare Advantage plans follow CMS telemedicine guidelines and requirements.
 - a. Services must be provided using real-time, interactive audio and video telecommunications system.
 - i. The physician/provider and the beneficiary/member are in different locations. They must be able to both see and hear each other and talk to each other without any time-delay or lag.
 - ii. Exception only for opioid use disorder (OUD) opioid treatment programs (OTP) (CMS³⁶):
Effective for dates of service January 1, 2022 and following:
During the COVID-19 pandemic PHE and after the PHE ends, therapy and counseling may be furnished using audio-only telephone calls rather than via two-way interactive audio-video communication technology if:
 - 1) Two-way audio/video communications technology is not available to the beneficiary,
 - 2) The beneficiary is not capable of using two-way audio/video communications technology, or
 - 3) The beneficiary does not consent to use devices that permit a two-way audio/visual interaction,Provided all other applicable requirements are met. (CMS³⁷)
 - b. Medicare Advantage plans do not participate in the Federal telemedicine demonstration programs in Alaska or Hawaii for the use of asynchronous “store and forward” technology for telemedicine services. Services billed with modifier GQ are denied to provider write-off.
 - c. Specific locations must be used.
 - i. The member must be in a geographic location designated by CMS as a qualifying rural area.
 - ii. While receiving telemedicine services, the member must be located at one of the following Medicare-approved “originating sites” (MLN⁵):
 - 1) Physician or practitioner’s office
 - 2) Hospital
 - 3) Critical Access Hospital (CAH)
 - 4) Rural Health Clinic (RHC)
 - 5) Federally Qualified Health Center (FQHC)
 - 6) Hospital-based or CAH-based Renal Dialysis Center (including satellites)
 - 7) Skilled Nursing Facility (SNF)
 - 8) Community Mental Health Center (CMHC)
 - 9) Renal Dialysis Facility
 - 10) Home of beneficiaries with End-Stage Renal Disease (ESRD) receiving home dialysis
 - 11) Mobile Stroke Units

- 12) Beginning date of service July 1, 2019: Home of beneficiaries receiving treatment of a substance use disorder or a co-occurring mental health disorder.
- d. The following types of providers are defined by CMS as eligible to perform and receive reimbursement for covered telemedicine services (subject to state law and scope of license restrictions) (MLN⁵):
- i. Physicians
 - ii. Nurse practitioners (NPs)
 - iii. Physician assistants (PAs)
 - iv. Nurse-midwives (CNMs)
 - v. Clinical nurse specialists (CNSs)
 - vi. Certified registered nurse anesthetists
 - vii. Clinical psychologists (CPs) and clinical social workers (CSWs).
Note: CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.
 - viii. Registered dietitians or nutrition professionals.
- e. Telemedicine services should not, under any circumstances, expand the scope of practice of a healthcare professional or permit practice in a jurisdiction (the location of the patient) where the provider is not licensed. (CMS³⁷)
- f. The services provided must otherwise be a benefit under the Medicare Advantage plan. Any benefit periods, limitations, or quantities exhausted will apply.
- g. The services must be on the list of Medicare-approved telemedicine procedure codes applicable for the date of service year.
- i. Medicare publishes a list of procedure codes approved for telemedicine/telehealth services which is updated annually and effective for the calendar year.
 - 1) This list of codes is available for download on the CMS website and is published in the MedLearn Matters Telehealth Services Fact Sheet annual update.
 - 2) Covered telemedicine procedure codes must be submitted with place of service 02 or 10. The use telehealth POS 02/10 certifies that the service meets the telehealth requirements. (CMS¹⁴)
 - 3) The rules for modifier GT have changed for Medicare Advantage claims.
 - a) For distant site services billed under Critical Access Hospital (CAH) method II on institutional claims, the GT modifier will still be required. (CMS¹⁴)
 - b) For non-CAH facilities with dates of service January 1, 2017 through September 30, 2018, the optional use of modifier GT will not result in denial as an inappropriate modifier.
 - c) For non-CAH facilities with dates of service October 1, 2018 and following, claims billed with modifier GT will be denied to provider liability. (CMS¹⁵) Per CMS, for dates of service October 1, 2018 and following, modifier GT is only allowed on institutional claims billed under CAH Method II billing. (CMSX)
 - d) For professional claims, POS 02 or 10 is sufficient; modifier GT is not required. There is currently no known CMS guidance to deny professional claims

submitted with modifier GT, however Moda Health requests modifier GT no longer be used on Medicare Advantage non-CAH professional claims.

- 4) The GQ modifier is still required when applicable.
 - 5) Do not use modifier 95 for Medicare Advantage telemedicine services.
 - 6) Use modifier G0 (G Zero) for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (MLN¹⁷)
- ii. Services not on the list of approved CMS telemedicine procedure codes will not be allowed as telemedicine services under Medicare Advantage plans.
 - iii. Non-covered telemedicine services (those which do not meet Medicare requirements for any reason) will be denied to provider liability. See RPM036 for pre-service requirements to seek any payment. (Moda^B)
3. PHE impacts.
- a. During the PHE, CMS was authorized to waive or modify telehealth payment requirements on an interim basis through emergency rulemaking, waivers, and flexibilities. For further information on these PHE flexibilities, see RPM073, "Telehealth and Telemedicine Expanded Services for COVID-19." (Moda^C)
 - b. During the PHE, CMS instructs providers to bill with the POS where the service would otherwise have been performed, so that service will allow at a non-facility RVU if it would otherwise have been performed at a non-facility place of service (e.g., in the office, POS 11).
 - c. At the conclusion of the PHE for COVID-19, these waivers and interim policies will expire, and payment for Medicare telehealth services will once again be limited by the previous requirements. However, to avoid abruptly eliminating the full range of expanded telehealth services available during the PHE and potentially jeopardizing member access to telemedicine services that have been clinically beneficial, CMS: (CMS¹⁸, CMS¹⁹)
 - i. Has identified a subset of procedure codes from the temporary PHE expansion list which will remain on the Medicare telehealth services list for an additional period through the end of the calendar year in which the PHE for COVID-19 ends.
 - ii. Is adding a provision to the Medicare telehealth services list for a new category of codes, "Category 3."
 - 1) Codes will be added to Category 3 on a temporary, provisional basis while additional evidence is gathered for possible permanent addition to the Medicare telehealth services list.
 - 2) Procedure codes added as part of the temporary PHE expansion list will be considered for Category 3 provisional status.
 - 3) Adding services to the Medicare telehealth services list on a Category 3 basis will give the public the opportunity to gather data and generate requests to add certain services to the Medicare telehealth services list permanently, which would then be adjudicated on a Category 1 or Category 2 basis during future PFS annual rulemaking, while maintaining access during the study and research process.
 - d. At the conclusion of the PHE for COVID-19, there will be no separate payment for audio-only E/M visit codes (99441 – 99443). These procedure codes will be assigned a status of

“bundled,” although RUC-recommended RVU values will be posted for informational purposes.

F. Oregon Medicaid plans

1. Medicaid plans cover telemedicine services to an eligible beneficiary when the specific criteria in the CMS Medicare/Medicaid Telemedicine requirements are followed.
 - a. Services must be provided using real-time, interactive audio and video telecommunications system.

The physician/provider and the beneficiary/member are in different locations. They must be able to both see and hear each other and talk to each other without any time-delay or lag.
 - b. Medicaid plans do not cover telemedicine services performed using asynchronous “store and forward” technology. Services billed with modifier GQ are denied to provider write-off.
 - c. Specific locations must be used. The member must be located at one of the following Medicare-approved “originating sites” (MLN⁵):
 - i. Physician or practitioner’s office
 - ii. Hospital
 - iii. Critical Access Hospital (CAH)
 - iv. Rural Health Clinic (RHC)
 - v. Federally Qualified Health Center (FQHC)
 - vi. Hospital-based or CAH-based Renal Dialysis Center (including satellites)
 - vii. Skilled Nursing Facility (SNF)
 - viii. Community Mental Health Center (CMHC)
 - d. The following types of providers are defined by CMS as eligible to perform and receive reimbursement for covered telemedicine services (subject to state law and scope of license restrictions) (MLN⁵):
 - i. Physicians
 - ii. Nurse practitioners (NPs)
 - iii. Physician assistants (PAs)
 - iv. Nurse-midwives (CNMs)
 - v. Clinical nurse specialists (CNSs)
 - vi. Certified registered nurse anesthetists
 - vii. Clinical psychologists (CPs) and clinical social workers (CSWs).

Note: CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.
 - viii. Registered dietitians or nutrition professionals.
 - e. The provider may be contracted with the Medicaid plan or out of network.
 - f. The provider may be located outside of the state of Oregon.

- g. The services provided must otherwise be a benefit under the Medicaid plan. Any benefit periods, limitations, or quantities exhausted will apply.
- 2. To be allowed as telehealth the services must be either:
 - a. On the list of Medicare-approved telemedicine procedure codes applicable for the date of service year.
 - i. Medicare publishes a list of procedure codes approved for telemedicine/telehealth services which is updated annually and effective for the calendar year.
 - 1) This list of codes is available for download on the CMS website and is published in the MedLearn Matters Telehealth Services Fact Sheet annual update.
 - 2) Covered telemedicine procedure codes must be submitted with place of service 02. The use telehealth POS 02 certifies that the service meets the telehealth requirements. (CMS¹⁴)
 - 3) Note: On Thursday, December 16, 2021 the Oregon Health Authority (OHA) notified us that OHP Medicaid will not be utilizing POS 10 at this time. Continue to use POS 02 for all Medicaid claims for services delivered using a telehealth modality until further notice from OHA.
 - 4) The use of modifier GT is optional and no longer required for Medicaid claims. POS 02 is sufficient.
 - 5) The GQ modifier is still required when applicable.
 - 6) Do not use modifier 95 for Medicaid telemedicine services.
 - 7) Use modifier G0 (G Zero) for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. (MLN¹⁷)
 - ii. Services not on the list of approved CMS telemedicine procedure codes will not be allowed as telemedicine services under Moda Health Medicaid plans.
 - b. On the OHA Behavioral Health fee schedule with modifier GT listed as appropriate. This applies for procedure codes in any Service Type category on the Behavioral Health fee schedule. See <https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>.
 - c. Preventive visit E/M codes 99381 – 99397 are allowed as telehealth for dates of service 4/1/2020 and following. This will continue to be effective after the PHE is declared over.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
ASO	=	Administrative Services Only
ATA	=	American Telemedicine Association
CAH	=	Critical Access Hospital

Acronym or Abbreviation		Definition
CCI	=	Correct Coding Initiative (see “NCCI”)
CMHC	=	Community Mental Health Center
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DOS	=	Date Of Service
DSMT	=	Diabetes self-management training
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
E/M E&M E & M	=	Evaluation and Management (services, visit) (Abbreviated as “E/M” in CPT book guidelines, sometimes also abbreviated as “E&M” or “E & M” in some CPT Assistant articles and by other sources.)
ESRD	=	End-stage renal disease
FQHC	=	Federally Qualified Health Center
HealthIT.gov	=	A federal government resource website maintained by ONC.
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HHS	=	U.S. Department of Health and Human Services
HIPAA	=	Health Insurance Portability and Accountability Act
HITECH	=	Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka “CCI”)
NPI	=	National Provider Identifier
NRTRC	=	Northwest Regional Telehealth Resource Center
OHA	=	Oregon Health Authority
OHP	=	Oregon Health Plan (aka Oregon Medicaid)
ONC	=	Office of the National Coordinator for Health Information Technology (ONC)
OTP	=	Opioid Treatment Program
ODU	=	Opioid Use Disorder
PHE	=	Public Health Emergency
PHI	=	Protected Health Information
POS	=	Place of Service
RHC	=	Rural Health Clinic

Acronym or Abbreviation		Definition
RPM	=	Remote patient monitoring
RPM	=	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)
SBIRT	=	Screening, Brief Intervention and Referral to Treatment
SNF	=	Skilled Nursing Facility
TIN	=	Tax ID Number
UB	=	Uniform Bill
VoIP	=	Voice over Internet Protocol

Definition of Terms

Sorting-out “Tele-“ Terminology	
Term	Definition
Telehealth	<p>Telehealth is the use of technology to deliver health care, health information or health education at a distance. Telehealth is a broad term that includes:</p> <ul style="list-style-type: none"> • Telemedicine clinical services • Other clinical services. Examples include: <ul style="list-style-type: none"> ○ Provider-to-provider consultations which are not face-to-face ○ Remote patient monitoring ○ Remote patient health education (e.g. webinars on specific health issues), prescribed or voluntary. • Non-clinical services. Examples include: <ul style="list-style-type: none"> ○ Physician teleconference about new best practices in treating angina ○ Provider training (medical students or licensed staff) ○ Administrative meetings ○ Continuing medical education • Technology – <ul style="list-style-type: none"> ○ Audio plus video ○ Audio-only (telephone) ○ Data-only (remote intraoperative monitoring) ○ Audio plus data or webinar, no person-to-person video ○ Instant messaging ○ Email contact • Timing – <ul style="list-style-type: none"> ○ Immediate, real-time, interactive exchanges. ○ Delayed data transmission and/or delayed interpretation and results. <p>“Telehealth is different from telemedicine because it refers to a <i>broader scope of remote healthcare services</i> than telemedicine.” (ONC/HealthIT.gov¹)</p>

Sorting-out “Tele-“ Terminology	
Term	Definition
Telemedicine	<p>Remote clinical services which are typically or traditionally delivered in-person with the provider and patient in the same location. Telemedicine services are delivered via technology because the patient and the provider are in two different locations (remote services).</p> <p>Note 1 (Commercial plans): Services performed via synchronous two-way interactive audio + video secure conferencing by a contracted provider are considered covered telemedicine services eligible for reimbursement, when all other requirements are met.</p> <p>Services performed by a non-contracted provider or by contracted providers via asynchronous technology are not considered covered telemedicine services and are not eligible for reimbursement under a Moda Health Commercial plan.</p> <p>Note 2 (Medicare Advantage plans): Medicare and Medicaid (CMS) considers Telemedicine to only include: Remote, face-to-face clinical services with real-time, two-way, interactive communication using both audio and video transmission. (CMS^{2,3}) This CMS definition is very strict. Any communication or data exchange which is time-delayed or does not include video (visual) transmission of information and data is not considered a telemedicine service by CMS.</p> <p>For Moda Health Commercial plans, there are covered telemedicine services and non-covered telemedicine services; but for CMS and Medicare Advantage, if the service does not meet the coverage requirements, it may not be called a “telemedicine service.”</p>
Telemonitoring	The use of telecommunications and information technology to provide patient monitoring (real-time or delayed store and transmit) to a separate monitoring and interpretation site.
Telepresenter	An individual, at the same location as the member who provides support to the patient and the telemedicine consulting provider, in completing the physical examination and/or telemedicine activity. The telepresenter is trained to use specialized telemedicine technology, such as digital stethoscope, otoscope, ophthalmoscope and examination camera, to facilitate comprehensive exams under physician guidance. (ATA ⁷ , NRTRC ⁸)

Telehealth-related Terms	
Term	Definition
Asynchronous (also called "Store and Forward")	Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image or information data that is sent (forwarded) via telecommunication to another site for consultation.

Telehealth-related Terms	
Term	Definition
Distant site (also called “Hub site”)	Site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.
E-visit	An exchange of emails between member and provider asking and addressing clinical concerns are sometimes referred to as an “e-visit.” Most groups do not provide benefits for email exchanges between member and provider or “e-visits;” a few select plans may specifically have an additional benefit for this service.
Hub site (also called “Distant site”)	Site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.
In-person	Face to face interaction when the member and provider are physically in the same location.
Originating site (or Spoke site)	Location of the patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.
Remote patient monitoring	Remote patient monitoring (RPM) is using technology to enable monitoring of patients outside of conventional clinical settings (e.g. monitoring the patient in the home instead of in the clinic or the hospital).
Remote services	Services which occur when the member and provider are not physically in the same location. The amount of distance between the member’s location and the provider’s location is not significant; the member and provider may be located in the same city but different buildings and communicating via technology. The member may be in a rural or urban location and does not need to be in a Health Professional Shortage Area (HPSA).
Secondary Provider Network AKA: “Rented Network” or “Travel Network.”	A group of providers contracted directly with another company. Moda Health then contracts with that other company to use their network of providers for specific member plans under specific circumstances. The secondary network company has control over the list of participating providers, fee schedule, and other contract terms. Moda Health pays for the additional provider access and hold-harmless protection for our members. Claims are processed as in-network when criteria is met. Different plans/groups may use different secondary networks. Examples include: Private Healthcare Services (PHCS), First Choice Health Network, Idaho Physician’s Network (IPN), and First Health Network. Sometimes also called “rented network” or “travel network.”
Spoke site (or Originating site)	Location of the patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.

Telehealth-related Terms	
Term	Definition
"Store and Forward" (also called Asynchronous)	Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation.
Virtual Care	A wide-ranging term that includes telemedicine, virtual visits, and other non-telemedicine benefits and/or services. May include a nurse-advice line, emailing a physician, etc. which are not considered telemedicine.
Virtual Visit	A telemedicine visit that uses real-time, audio-visual technology and special equipment to accomplish a visit that is virtual or "the same as being there in person." Qualifies for modifier GT or 95.

Procedure codes (CPT & HCPCS):

Online evaluation and management service procedure codes		
Code	Code Description	Applicable DOS
99444	Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network	Terminated 12/31/2019. Do not use for 2020 dates of service.
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Effective 1/1/2020
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Effective 1/1/2020
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Effective 1/1/2020

Note: These are originating site fees. They do not represent the primary service performed.	
Code	Code Description
Q3014	Telehealth originating site facility fee
T1014	Telehealth transmission, per minute, professional services bill separately

Modifier Definitions:

Modifier	Modifier Description & Definition
G0	Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke
GQ	Via asynchronous telecommunications system
GT	Via interactive audio and video telecommunication systems
93	<p>Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system: Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional.</p> <p>The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.</p>
95	<p>Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System: Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Modifier 95 may only be appended to the services listed in Appendix P. Appendix P is the list of CPT codes for services that are typically performed face-to-face but may be rendered via a real-time (synchronous) interactive audio and video telecommunications system.</p>

Place of Service code:

Note: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service. (CMS MM9726³)

Code	Short Description	Place of Service Code Long Description
02	Telehealth	The location where health services and health related services are provided or received, through telecommunication technology. (Does not apply to originating site facilities billing a facility fee.) (Effective for claims submitted 1/1/2017 – 12/31/2021, regardless of date of service.)
02	Telehealth Provided Other than in Patient's Home	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. (Description change effective January 1, 2022, and applicable for Medicare April 1, 2022.) (CMS ²⁵)
10	Telehealth Provided in Patient's Home	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. (This code is effective January 1, 2022, and available to Medicare April 1, 2022.) (CMS ²⁵)

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

“Submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, “via interactive audio and video telecommunications systems” (for example, 99201 GT). By coding and billing the GT modifier with a covered telehealth procedure code, you are certifying that the beneficiary was present at an eligible originating site when you furnished the telehealth service. By coding and billing the GT modifier with a covered ESRD-related service telehealth code, you are certifying that you furnished one “hands on” visit per month to examine the vascular access site.” (MLN⁵)

“Clinical psychologists (CPs) and clinical social workers (CSWs). CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838...” (MLN⁵)

“The originating site facility fee is a separately billable Part B payment. The contractor pays it outside of other payment methodologies. This fee is subject to post payment verification.” (CMS¹⁰)

“The list of settings where a physician’s services are paid at the facility rate include:

- Telehealth (POS code 02);
- Outpatient Hospital-Off campus (POS code 19);
- Inpatient Hospital (POS code 21);
- Outpatient Hospital-On campus (POS code 22);
- Emergency Room-Hospital (POS code 23);
- Medicare-participating ambulatory surgical center (ASC) for a HCPCS code included on the ASC approved list of procedures (POS code 24);
- Medicare-participating ASC for a procedure not on the ASC list of approved procedures with dates of service on or after January 1, 2008. (POS code 24);
- Military Treatment Facility (POS code 26);
- Skilled Nursing Facility (SNF) for a Part A resident (POS code 31);
- Hospice – for inpatient care (POS code 34);
- Ambulance – Land (POS code 41);
- Ambulance – Air or Water (POS code 42);
- Inpatient Psychiatric Facility (POS code 51);
- Psychiatric Facility -- Partial Hospitalization (POS code 52);
- Community Mental Health Center (POS code 53);
- Psychiatric Residential Treatment Center (POS code 56); and
- Comprehensive Inpatient Rehabilitation Facility (POS code 61).” (CMS²⁷)

“During the PHE, Medicare does not require use of telehealth Place of Service codes. ... However, Medicare contractors are to adjudicate claims containing this new code should it appear on a claim they (sic) same way they would adjudicate claims with POS 02.” (CMS²⁵)

Cross References

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- B. [“Modifiers GA, GX, GY, and GZ.”](#) Moda Health Reimbursement Policy Manual, RPM036.
- C. [“Telehealth and Telemedicine Expanded Services for COVID-19.”](#) Moda Health Reimbursement Policy Manual, RPM073.

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Background Information

Telehealth and telemedicine are terms which are defined in multiple ways by multiple entities and organizations. The terms "telemedicine" and "telehealth" are often used interchangeably, although "telehealth" typically refers to a broader range of services, and "telemedicine" is generally a specific subset of "telehealth" services.

In general, the terms "telehealth" and "telemedicine" refer to the use of technology to deliver health care, health information or health education at a distance. Some of these applications involve the patient directly, others are professional-to-professional consultations regarding patient care, and yet others are

professional education which is not connected to the care of a patient. Some of these telehealth applications are covered and eligible for reimbursement and others are not. Telemedicine and telehealth comprise a significant and rapidly growing component of health care in the United States. (ATA⁶) The boundaries of telehealth are limited only by the technology available - new applications are being invented and tested every day. (ONC¹)

Telehealth is a potentially useful tool that, if employed appropriately, can provide important benefits to patients and improve healthcare. A wide variety of services may be performed as telemedicine services; some may meet the requirements for coverage, and others may not. The basic service is reported with the normal procedure code(s) for the service performed. The fact that the services were performed as a telemedicine service may be identified with a modifier.

The Centers for Medicare and Medicaid Services (CMS) promotes telemedicine as beneficial and useful to improve primary and preventative care to Medicare beneficiaries who live in underserved and rural areas. CMS states that telemedicine provides remote access for face to face services when beneficiaries and providers are geographically separated and offers great promise for reducing access barriers for chronically ill Medicare beneficiaries.

In addition, there are legislative mandates for coverage of some specific telehealth and telemedicine services. Oregon state law mandates certain specific telemedicine services. OR SB 144 modified an existing telemedicine mandate, ORS 743A.058. The modified mandate of OR SB 144 applies to Oregon commercial insured medical benefit plans which are issued or renewed on and after 1/1/2016. Alaska HB 234 incorporated telehealth coverage for mental health benefits in Alaska Statute 21.42.422 for new and renewing plans on and after 10/1/2016.

This policy is intended to define telehealth and telemedicine terminology for our company, plans, and claims, provide clarification of which services are and are not eligible for reimbursement, and specify the criteria and requirements which must be met.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the [member's medical benefit plan](#). Should there be any conflicts between our Reimbursement Policy and the [member's medical benefit plan](#), the [member's medical benefit plan](#) will prevail. Fee determinations will be based on the applicable [provider](#) fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
12/14/2022	Clarification/Update: Change to new header; Idaho is included but not checked. Header: Section field changed from "Medicine" to newly created "Telemedicine." Section A.5.b - Clarification of long-standing same specialty policy for non-physician practitioners added per provider inquiry. Section B.4, C.3, & D.4: Clarification of using modifier 25 when face-to-face E/M leads to originating site Q3014 for same-day telehealth consultation for specialty/higher level of care visit. Section F.2: Preventive E/M codes added for Medicaid. Acronym Table: 3 entries added. Cross References: Hyperlinks added. References & Resources: 2 entries added for clarification in A.5.b. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
8/10/2016	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2010	Original Effective Date (with or without formal documentation). Policy based on CMS telehealth policy. (Note: Various additional state mandates and other factors were later included/addressed.)