NETWORK REIMBURSEMENT POLICY

POLICY TITLE	**Telehealth Services**
POLICY NUMBER	NR- 30.026

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I. DESCRIPTION/BACKGROUND TOP

This policy addresses the methodology applied to reimbursement for Telehealth Services when provided by a participating provider with Capital BlueCross.

Due to COVID-19 pandemic, Capital BlueCross is temporarily modifying this Network Reimbursement Telehealth Services Policy until further notice. Capital will continue to evaluate the ongoing impact of the COVID-19 pandemic and, if warranted, adjust the time-period that this adjusted policy is in effect. Any temporary adjustments within this policy are marked within brackets [].

II. DEFINITIONS TOP

American Medical Association (AMA) – An organization whose missions is to promote the science and art of medicine and the betterment of public health. The AMA speaks out on issues important to patients and the nation's health and exercises a strong advocacy agenda on behalf of patients and providers. The AMA is also committed to providing timely information on matters important to the health of America and includes the development and promotion of standards in medical practice, research and education.

Centers for Medicare and Medicaid Services (CMS) –The current name of the government agency that administers Medicare.

Current Procedural Terminology (CPT) – A set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of procedures and services.

Healthcare Common Procedure Coding System (HCPCS) - A national standard, alphanumeric coding system established by the Centers for Medicare and Medicaid Services. It standardizes billing and payment covered services (e.g. medical supplies, prosthetics and durable medical equipment). HCPCS Level I codes are copyrighted by the American Medical Association (CPT). Level II codes are five-position alphanumeric codes maintained jointly by the Alpha-Numeric Panel (consisting of the Centers for Medicare and Medicaid Services (CMS), the Health Insurance Association of America, and the BlueCross and BlueShield Association). The American Dental Association copyrights the D-code series in Level II HCPCS.

Modifier – A two-digit numeric, alphanumeric or alphabetic code appended to a CPT or HCPCS code, which indicates that a service or procedure has been altered by some specific circumstances but not changed in its definition or code. This information is important because it provides payors with additional information to process a claim. There are three levels of modifiers: Level I (CPT) modifiers are developed by the American Medical Association; Level II (HCPCS) modifiers are developed by the Centers for Medicare and Medicaid Services; Level III modifiers are unique to each Medicare Part B carrier and begin with an alpha prefix of S, W, X, Y or Z.

Allied Health Professional – For purposes of this policy, an individual non-physician professional health care provider duly licensed in the Commonwealth of Pennsylvania, including, without limitation, a physician assistant (PA), certified registered nurse practitioner (NP, licensed dietitian-nutritionist, Nurse- midwives, and Clinical registered nurse anesthetist (CRNA) or other applicable non-physician provider of health services approved by the Plan.

Distant Site -The location where the licensed qualified health care provider is rendering services by means of telecommunication system.

Place of Service 02 – The location where health services and health related services are provided or received, through a telecommunication system.

Telehealth - Telehealth is the practice of delivering clinical health services by means of Telecommunications, such as audio-visual and other electronic communications.

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III. POLICY

Capital BlueCross reimburses for eligible Telehealth Services when performed at a distant site where a licensed qualified health care professional is furnishing the remote service to a member via an interactive audio and or video telecommunication system.

This policy excludes geographic limitations for Metropolitan Statistical Area (MSA) and Health Professional Shortage Area (HPSA).

Physicians will be reimbursed at one hundred percent of the professional fee facility rate. The telehealth service must be submitted with the appropriate CPT and or HCPCS code on a CMS 1500 claim form. When reporting a telehealth service there are no billing requirements for the utilization of modifiers.

Allied Health Professional listed in this policy will be considered for reimbursement at their standard professional rate for the facility discounted rate when the service is performed in accordance with applicable requirements under State Law. Once the AHP meets those requirements, services should be reported identifying the AHP as the performing provider of record.

IV. Eligible Providers

Capital BlueCross recognizes the list of CMS practitioners eligible to be reimbursed for Telehealth Services. **Capital is temporarily adding the providers that are marked within the brackets[].**

- Physicians
- Physician Assistants (PAs)
- Certified Nurse Midwives (CNMs)
- Clinical Nurse Specialist (CNA)
- Certified Registered Nurse Anesthetists (CRNAs)
- Clinical Social Workers (CSWs)
- Clinical Psychologist (CPs)
- Registered dietitian or nutrition professional (RND)
- Certified Registered Nurse Practitioners (CRNPs)
- [Licensed Professional Counselors (LPCs)
- Licensed Marriage and Family Therapist (LMFTs)

- Licensed Social Worker (LSW)
- Licensed Clinical Social Worker (LCSW)]
- **[**Licensed Physical Therapist (LPT)
- Licensed Occupational Therapist (LOT)
- Licensed Speech- Language Pathologist- LSLP's
- Licensed Respiratory Therapist- (LRT**]**

***For CHIP members, only Family Practice, General Practice, and Pediatricians are eligible to provide telehealth services.**

V. Eligible medical services

The Plan will consider for reimbursement Telehealth services recognized on the most current published Centers for Medicare and Medicaid Services (CMS) list of covered services, excluding provider consultation services. From time to time CMS may update the published list of covered Telehealth services.

Place of service code 02 is for use by physicians or practitioners furnishing telehealth services from a distant site. When billing telehealth services, providers must bill with place of service code 02.

[**Capital Blue Cross is temporarily instructing that to facilitate reimbursement at the face-to-face rate, providers must identify the place of service (POS) they would bill had the visit occurred as a face-to-face visit. Providers should NOT use "02" as POS. They must also identify that it was a telehealth service by including Modifier 95 (Synchronous Telemedicine Service Rendered via a Real-Time Interactive Audio and Video Telecommunications System.]**

[Until further notice, Capital BlueCross is temporarily adding the following services to be included under this Telehealth Service Reimbursement Policy and any provider who would be eligible for reimbursement for services where the service to be performed in an onsite visit, including any variations of bill types such as an UB04:

- G2010- Remote evaluation of recorded video and/or image submitted by an established patient;
- G2012- Brief check in by MD/QHP.
- G0425- Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with patient via telehealth;

- G0426- Telehealth consultation, emergency department or initial inpatient; typically 50 minutes communicating with patient via telehealth;
- G0427- Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with patient via telehealth.
- 99421- Online digital E/M service established patient < 7 days; 5-10 minutes;
- 99422- Online digital E/M service established patient < 7 days; 11-20 minutes;
- 99423- Online digital E/M service established patient < 7 days; 21+ minutes.
- Applied Behavioral Analysis (ABA) when billed with the following CPT Codes:
    - 97151- Behavioral identification assessment, administrated by a physician or other qualified healthcare professional , each 15 minutes of the physician or other qualified healthcare professional's face-to-face time with patient and/or guardian(s) caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring /interpreting the assessment, and preparing the report/treatment plan.
    - 97153- Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
    - 97154- Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
    - 97155- Adaptive behavior treatment with protocol modification, administrated by a physician or other qualified healthcare professional, which include simultaneous direction of a technician, face-to-face with one patient, every 15 minutes;
    - 97156- Family adaptive behavioral treatment guidance, administered by a physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s) /caregiver(s, every 15 minutes.
    - 97157- Multiple –family group adaptive behavioral treatments guidance, administered by a physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardian(s) /caregiver(s), every 15 minutes.
    - 97158- Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes
    - 0362T- Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians;

for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.

- 0373T- Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)

- Physical Therapy, Occupational Therapy, Speech Therapy
  - G2061- Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes;
  - G2062- Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes;
  - G2063- Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.

- [Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)
- Pulmonary Rehab
- Applied Behavioral Analysis]

[**Capital BlueCross is temporarily adjusting our policy to allow providers (identified in the policy) to bill and receive reimbursement consistent with an in-person visit. This temporary policy change applies to our individual, CHIP, and commercial group members effective April 1, and continuing until further notice. For our Medicare Advantage membership, this change applies beginning March 6, 2020 through the end of the public health emergency].**

Please refer to the following Professional Network Reimbursement Policies for additional information:

NR-30.021 Reimbursement of Services Performed by Allied Health Professionals
NR-30.003 Reimbursement of Services Performed by Certified Nurse Midwives
NR-30.009 Reimbursement of Mental Health Services

VI. EXCLUSIONS

Rural Health Clinics (RHC) – CHIP [Until further notice. CHIP members may receive telehealth services from RHC providers whose specialties include Family Practice, General Practice, and Pediatricians.]

Federal Qualified Health Clinics (FQHC)- CHIP [Until further notice. CHIP members may receive telehealth services from FQHC providers whose specialties include Family Practice, General Practice, and Pediatricians.]

Providers rendering care to a Medicare Advantage member are not subject to the Provisions set forth within the Telehealth Services Reimbursement Policy. [**This exclusion is being suspended until further notice.]**

VII. VARIATIONS

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The existence of this reimbursement policy does not mean that this service is a covered benefit under the member's contract. Benefit determinations should be based in all cases on the applicable contract language. This reimbursement policy is intended to serve as a guide; other factors may influence reimbursement and in some cases may supersede this policy. The Provider should consult their Capital Provider Agreement for further details of their contractual obligations.

VIII. REFERENCES

Centers for Medicare & Medicaid Services website. Medicare Claims Processing Manual Chapter 12, Section 190

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html

CPT 2020, Professional Edition
American Medical Association

HCPCS Level II 2019, Professional

Centers for Medicare & Medicaid Services website. Medicare Claims Processing Manual Chapter 12, Section 190

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html

CPT 2020, Professional Edition
American Medical Association

HCPCS Level II 2019, Professional