Medical Policy

Blue Care Network of Michigan

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BCN Policy Effective Date: 5/1/20
(See policy history boxes for previous effective dates)

Title: Telemedicine

Description/Background

Telehealth and telemedicine are terms that are frequently used interchangeably. For this policy, telehealth is an umbrella term used to describe all the possible variations of health care services and health care education using telecommunications. Telehealth allows for health care services such as telemedicine, telemonitoring, store and forward in addition to health care education for patients and professionals, and related administrative services.

Telemedicine, a subset of telehealth, means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine, the health care professional must be able to examine the patient via a real-time, interactive audio or video, or both, telecommunications system and the patient must be able to interact with the off-site health care professional at the time the services are provided. Many have advocated the use of telemedicine to improve health care in rural areas, in the home and in other places where medical personnel are not readily available. Telemedicine may substitute for a face-to-face, hands-on encounter between a patient and the health care provider when using the appropriate technology.

The use of telecommunications to support a clinical decision can incorporate patient data collected and reviewed immediately, such as clinician interactive, or reviewed later when the patient is no longer available such as telemonitoring or store and forward.

- **Clinician Interactive** – An electronically based, real-time clinician-patient encounter where the patient and health care provider are in different locations. This virtual encounter can either be audio only or audio visual. The virtual encounter can also be hosted. A hosted visit is a virtual consult with a remote health care provider hosted by a provider who is face-to-

face with the patient. Certain clinical scenarios will dictate the use of a hosted visit, so as to minimize risk to the patient and maximize the clinical outcome. For example, when a patient presents to the emergency room with acute stroke symptoms and the neurology specialist is not on site, the emergency room physician hosts a consult with the remote neurologist in a real-time encounter.

- **Store and Forward** - The asynchronous transmission of medical information to be reviewed at a later time by a physician or practitioner at the distant site. A store and forward process eliminates the need for the patient and clinician to be present at the same time and place. Data that is sent to a remote clinician and interpreted in real-time is not store and forward. For example, a radiologist reading a study for the emergency room remotely is not considered store and forward since the clinical decision is occurring in real time.

- **Telemonitoring** - Services that enable providers to monitor test results, images and sounds that are usually obtained in a patient's home or a care facility. Post-acute care patients, patients with chronic illnesses and patients with conditions that limit their mobility often require close monitoring and follow-up. These types of programs use various strategies to monitor patients while reducing the need for face-to-face visits. An example is remote blood pressure monitoring in the home reported electronically to the provider. Telemonitoring is considered an asynchronous encounter.

- **eVisits** (or, "online visits") - Low-complexity clinician-interactive telemedicine visits. An eVisit represents a structured, real-time (synchronous) health encounter using secure online communication technology to virtually connect a physician or other healthcare provider in one location to a patient in another location for the purpose of diagnosing and providing medical or other health treatment. The patient initiates the virtual electronic medical evaluation. The medical information is exchanged via secured servers. Typically, eVisits use straightforward decision making to address urgent but non-emergent conditions that can be appropriately managed with this non face-to-face encounter. These encounters should reflect an algorithmic question and answer approach. At the point of making decisions regarding diagnosis and/or treatment, the provider does not require face-to-face contact to make an optimal decision.

Telehealth that is not delivered real-time such as store and forward and telemonitoring is out of scope for this policy.

Regulatory Status:

N/A

Medical Policy Statement

The safety and effectiveness of telemedicine have been established. It may be considered a useful diagnostic and therapeutic option when indicated.

Inclusionary and Exclusionary Guidelines (Clinically based guidelines that may support individual consideration and pre-authorization decisions)

Inclusions:

- Originating site required.
  - An originating site is the location of the member at the time the service, furnished via a telecommunications system.
  - Originating sites are as followed:
    - The offices of physicians or practitioners
    - Hospitals
    - Critical Access Hospitals (CAH)
    - Rural Health Clinics
    - Federally Qualified Health Centers
    - Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
    - Skilled Nursing Facilities (SNF)
    - Community Mental Health Centers (CMHC)
- The provider must be licensed, registered, or otherwise authorized to perform service in their health care profession in the state where the patient is located. The provider is not required to be located in the state of Michigan but must be contracted with BCN. Services must fall within their scope of practice.
- Telemedicine delivered services are available to all clinicians, however, it may not be the preferred method of delivery in certain clinical scenarios, for example chronic suicidal ideation or unstable angina. A hosted visit may be necessary due to the complexity of the clinical situation.
- Telemedicine delivered services for ongoing treatment of a condition that is chronic and/or is expected to take more than 3-5 sessions before the condition resolves or stabilizes may require a hosted visit or a face-to-face encounter during the active treatment period.
- The service must be conducted over a secured channel with provisions described in Policy Guidelines.
- Eligible providers may include:
  - MD/DO
  - Certified nurse midwife
  - Clinical nurse practitioner
  - Clinical psychologist
  - Clinical social worker
  - Physician Assistant
  - Licensed Professional Counselor

Exclusions:

- Store and Forward
- Telemonitoring
- Email only communication
- Telephone only communication
- Text only communication
- Facsimile transmission

- Request for medication refills
- Reporting of normal test results
- Provision of educational materials
- Scheduling of appointments and other health care related issues
- Registration or updating billing information
- Reminders for health care related issues
- Referrals to other providers
- Any telemedicine visit resulting in an office visit, urgent care or emergency care encounter on the same day for the same condition
- Any telemedicine visit for the same condition originating from an office visit, urgent care or emergency care encounter within the previous seven days
- Any telemedicine visit occurring during the post-operative period

Policy Guidelines:

A secured electronic channel must include and support all of the following for online encounters:

1. The electronic channel must be secure, with provisions for privacy and security, including encryption, in accordance with HIPAA guidelines.
2. A mechanism must be in place to authenticate the identity of correspondent(s) in electronic communication and to ensure that recipients of information are authorized to receive it.
3. The patient's informed consent to participate in the consultation must be obtained, including discussing appropriate expectations, disclaimers and service terms, and any fees that may be imposed. Expectations for appropriate use must be specified as part of the consent process including: use of specific written guidelines and protocols, avoiding emergency use, heightened consideration of use for highly sensitive medical topics relevant to privacy issues.
4. Expectations are established for turnaround times for responses from the provider.
5. The name and patient identification number is contained in the body of the message, when applicable.
6. A standard block of text is contained in the provider's response that contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies, when applicable.
7. A record of online communications descriptive of the eVisit should be made available to the patient if requested.
8. The channel must be free of any third party advertising on its site and must not use the patient's information for marketing.
9. If the system collects payment for patients utilizing a credit card, it should be Payment Card Industry Data Security Standard (PCI-DSS) compliant.

CPT/HCPCS Level II Codes

(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure)

Established codes – Require GT Modifier:

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845*	90846	90847
90951	90952	90954	90955	90957	90958	90960
90961	90963	90964	90965	90966	90967	90968
90969	90970	96116	96150	96151	96152	96153
96154	96160	96161	97802	97803	97804	99201
99202	99203	99204	99205	99211	99212	99213
99214	99215	99231	99232	99233	99307	99308
99309	99310	99354	99355	99356	99357	99406
99407	99495	99496	99497	99498		
G0108	G0109	G0270	G0296	G0396	G0397	G0406
G0407	G0408	G0420	G0421	G0425	G0426	G0427
G0436	G0437	G0438*	G0439*	G0442	G0443	G0444
G0445	G0446	G0447	G0459	G0506	G0508	G0509
G0513	G0514	G2086	G2087	G2088		
Q3014						

*For Medicare Only

Other codes (investigational, not medically necessary, not a benefit, etc.):

N/A

Note: Individual policy criteria determine the coverage status of the CPT/HCPCS code(s) on this policy. Codes listed in this policy may have different coverage positions (such as established or experimental/investigational) in other medical policies.

Rationale

According to the State of Michigan legislative act released in 2012 the definition of telemedicine and associated requirements were established. Telemedicine means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine, the health care professional must be able to examine the patient via a real time, interactive audio or video or both, telecommunications system and the patient must be able to interact with the off-site health care professional at the time the services are provided.

Michigan, with 34 other states and the District of Columbia, currently mandates coverage for telemedicine services. Policy makers seek to reduce healthcare delivery problems, contain

costs, improve care coordination, and alleviate provider shortages. Many are using telemedicine to achieve these goals.

Since 2012 the number of states with parity laws, laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, has doubled. Michigan adopted a parity law in 2012.

Telemedicine enables providers to extend their reach and improve their efficiency and effectiveness while still maintaining high quality care and attention to patient safety. Recognition of both the benefits and inherent limitations of care delivery via telemedicine remains the ultimate responsibility of the provider.

Telemedicine technologies should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. Telemedicine supports a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling physician-to-patient communications. For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

There is evidence that telemedicine technology can be used beneficially from a clinical and economic standpoint. While there are many promising initiatives underway, there are few mature telemedicine programs and few good scientific evaluations. There is still some need to work collaboratively to identify best practices. For example, telemedicine services for ongoing treatments or treatments of chronic conditions are feasible, but not demonstrated as best practice.

Certain health services, eg. behavioral health, neurology or endocrinology services, often rely upon more subtle and detailed observations of speech, behavior and affect. Therefore, these

services require the most advanced communications and internet technologies for the delivery of telemedical care and may not always be well-suited to a telemedicine approach. By using advanced communication technologies, health professionals are able to widen their reach to patients in a cost effective manner, ameliorating the maldistribution of specialty care.

Government Regulations

National:

There is no national coverage determination specific to Telemedicine.

CMS telehealth services: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Local:

There is no local coverage determination specific to Telemedicine.

Wisconsin Physician Service Local Coverage Determination (LCD): Psychological and Neuropsychological Testing (L34646); original effective date for services performed on or after 10/1/15; revision effective date for services performed on or after 2/1/16.

Components of the Neuropsychological Evaluation

Neurobehavioral Status Examination

- The face-to-face evaluation begins with a neurobehavioral status exam conducted by the provider (CPT code 96116; in rural areas or where there is a shortage of providers, the neurobehavioral status exam may be administered as a telehealth service using the telehealth/"GT" modifier)
- A neurobehavioral status exam is completed prior to the administration of neuropsychological testing. The status exam involves clinical assessment of the patient, collateral interviews as appropriate, and review of prior records. The interview includes clinical assessment of several domains including but not limited to; thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities. The clinical assessment would determine the types of tests and how those tests should be administered.

Medicare Change Request (CR) 10152:
As of January 1, 2018, Medicare no longer requires the GT modified on professional claims for telehealth services. Use of the telehealth Place of Service (POS) Code 02 certifies that the service meets the telehealth requirements.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

eVisits

References

1. American College of Physicians. E-Health and Its Impact on Medical Practice. Philadelphia: American College of Physicians; 2008: Position Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)
2. Clancy, Carolyn, MD, Director AHRQ, "Telemedicine Activities at the Department of Health and Human Services," Testimony before the Subcommittee on Health Committee on Veterans Affairs, May 18, 2005, https://www.govinfo.gov/content/pkg/CHRG-109hhrg22362/html/CHRG-109hhrg22362.htm (February 24, 2020)
3. CMS, 42 CFR, Supplementary Medical Insurance Benefits, 410.78 Telehealth Services, 11/1/2001, last update 11/23/2018.
4. CMS, 42 CFR, Payment for Part B Medical and Other Health Services, 414.65 Payment for Telehealth Services, 11/1/01, last update 02/28/11, https://www.govinfo.gov/app/details/CFR-2012-title42-vol3/CFR-2012-title42-vol3-sec414-65 (February 24, 2020)
5. CMS, List of Telehealth Services. CY 2020. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
6. Evidence Report/Technology Assessment, Telemedicine for the Medicare Population, Number 24, AHRQ Publication Number 01-E011, February 2001
7. American Telemedicine Association. Practice Guidelines for Videoconferencing-Based Telemental Health, October 2009.
8. Michigan Common Law. Section 500,3476.THE INSURANCE CODE OF 1956 (EXCERPT) Act 218 of 1956. Telemedicine services; provisions; definition.
9. American Telemedicine Association "State Telemedicine Gaps Analysis, Coverage and Reimbursement" - September 2014, page 4.
10. Federation of State Medical Boards. Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine. April 2014, page 3.
11. Medicare Managed Care Manual Chapter 4 Benefits and Beneficiary Protections, 30.3 Examples of Eligible Supplemental Benefits. Rev. 121 04-22-2016.
12. MLM Matters MM10152. Elimination of the GT Modifier for Telehealth Services. January 1, 2018. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10152.pdf

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 6/9/20, the date the research was completed.

BCN Medical Policy History

Date	Rationale
11/18/15	BCN policy established – Effective date 1/1/16
11/16/16	Routine maintenance
11/15/17	Routine maintenance; addition of codes; update of appendices
11/14/18	Routine maintenance; addition of codes (90785, 90839, 90840, 96160, 96161, G0296, G0506); update of appendix A; appendix B (Medicaid) deleted
9/24/19	Routine maintenance, policy retired 11/1/19. A JUMP policy has been established which is effective 11/1/19.
3/12/20	Policy unretired. JUMP policy to be effective in 2020. Routine maintenance: codes G0513, G0514, G0286,G0287, G0288 added; references updated, Appendix deleted/link added
5/1/20	The JUMP policy “Telemedicine Services”, effective 5/1/20, replaces this policy.

Next Review: NA

MEDICAL POLICY TITLE: TELEMEDICINE
BCN BENEFIT ADMINISTRATION

I. Coverage Determination

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered; criteria apply
BCNA (Medicare Advantage)	Covered; See Government Regulations section of policy.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.