Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

***Current Policy Effective Date: 11/1/21**
(See policy history boxes for previous effective dates)

Title: Telemedicine Services

Description/Background

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

Historically, telemedicine, a subset of telehealth, has been defined as the use of telecommunications technology for real-time, medical diagnostic and therapeutic purposes when distance separates the patient and healthcare provider. This definition is consistent with the State of Michigan 2012 mandate. In June of 2020, influenced by the COVID-19 pandemic, the State of Michigan expanded the definition of telemedicine to include store and forward (asynchronous) as well as real-time (synchronous) interactions. With this expanded definition, telemedicine now includes the synchronous and asynchronous delivery of care between a patient and provider, or between provider and provider. Telemedicine may substitute for a face-to-face, hands-on encounter between a patient and the healthcare provider when using the appropriate, HIPAA-compliant, secure technology. 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.

- **Clinician Interactive Visit** – An electronically based, real-time (synchronous) clinician-patient encounter where the patient and healthcare provider are in different locations. Patient data is collected and reviewed immediately. This virtual encounter can either be audio only or audio visual. The virtual encounter can also be hosted. A hosted visit is a virtual consultation with a remote health care provider which is 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 consultation with the remote neurologist in a real-time encounter.

- **Online Visit** – A type of low complexity, real-time (synchronous) clinician interactive visit that requires an audio visual online communication. The patient initiates the evaluation. The visit is typically straight-forward decision making that addresses urgent but not emergent clinical conditions. 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. It is not anticipated that a follow-up encounter is required.

  Examples of online visits include, but are not limited to: upper respiratory infections, such as sore throat, runny nose, sinus congestion, ear ache; mild gastrointestinal distress, such as GERD, diarrhea, nausea, constipation; skin disorders such as itching, rash, limited cuts; joint irritations such as aches, stiffness; headaches that are simple and uncomplicated; seasonal allergies, hay fever; urinary tract infections; acute situational anxiety.

- **Store and Forward** – Also called "asynchronous telemedicine", store and forward is a method by which healthcare providers and patients are able to share medical information; however, not in real time. The data can include patient records, MRI scans, test results, X-ray photos, lab reports, imaging studies and still or video images. The data is transmitted via a secure encrypted Internet connection.
  - Clinician-to-specialist consultation: Store and forward can be used by a qualified health care practitioner who requests a consultation, which eliminates the need for the patient and consulting specialist to be present at the same time. The consultant receiving the data reviews it outside of the time of the patient encounter, and the clinical documentation is consistent with the level of complexity involved with the clinical scenario. Store and forward telemedicine applications are typically used by specialty practices in fields such as radiology, ophthalmology and dermatology – where documented information and images are integral to diagnosis and treatment.
  - Patient-to-clinician interaction: A patient may electronically submit still or video images to a physician who reviews and interprets the information outside of a real time interaction.

- **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 not the subject of this policy.

Regulatory Status

NA

Medical Policy Statement

Medical
The safety and effectiveness of telemedicine (synchronous and asynchronous care) for medical care has been established. It may be considered a useful diagnostic and therapeutic option when indicated.

Behavioral Health
The safety and effectiveness of telemedicine synchronous care for behavioral health care has been established, with the exception of specific autism services.*

Telemedicine asynchronous care is not appropriate for behavioral health services.

**Refer to the policy "Autism Spectrum Disorder Services."*

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

INCLUSIONS:

SYNCHRONOUS / REAL-TIME ENCOUNTER
- 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. Services must fall within their scope of practice.
- Telemedicine delivered services are available to all clinicians; however, this may not be the preferred method of delivery in certain clinical scenarios, for example chronic suicidal ideation or unstable angina. A hosted visit* or a face-to-face visit may be necessary due to the complexity of the clinical situation. The telemedicine provider may provide the face-to-face encounter.
- Telemedicine delivered services for ongoing treatment of a condition that is chronic and/or is expected to take more than 5 sessions before the condition resolves or stabilizes may require a hosted visit* or a face-to-face visit. The telemedicine provider may provide the face-to-face encounter.
- The service must be conducted over a secured channel*.
- The delivery of the service can be either audio only (telephone) or audio/video (a secured computer-based system).

*see Policy Guidelines

Online Visit
- An audio visual online communication
- The patient initiates the medical or behavioral health encounter
- 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.
- A low complexity, straight forward decision making encounter that addresses urgent but not emergent clinical conditions

- A single encounter where a follow-up encounter is not anticipated
- Services must fall within the provider's scope of practice.

ASYNCHRONOUS / STORE AND FORWARD ENCOUNTER
- 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. Services must fall within their scope of practice.
- The patient data (pre-recorded videos, digital images such as x-rays or photos, test results or any other information necessary for the evaluation) must be transmitted over a secured channel*.

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

BEHAVIORAL HEALTH CARE

Behavioral health care services may be delivered via synchronous telemedicine, including intensive outpatient program (IOP) and partial hospital program (PHP) services.

BH-SPECIFIC SYNCHRONOUS CARE EXCLUSIONS

Autism services are allowed via telemedicine synchronous care, but with limitations and exceptions. Refer to the policy "Autism Spectrum Disorder Services."

BH-SPECIFIC ASYNCHRONOUS CARE EXCLUSIONS

Behavioral health services are not appropriate via telemedicine asynchronous care.

POLICY GUIDELINES

An eligible provider is any practitioner who is able to bill independently and receive direct reimbursement for services, such as, but not limited to:
- MD/DO
- Certified nurse midwife
- Clinical nurse practitioner
- Clinical psychologist
- Clinical social worker
- Physician assistant
- Licensed professional counselor

Any eligible provider is able to provide telemedicine services.

Hosted Visit
A hosted visit is a virtual consultation with a remote (telehealth) health care provider, which is "hosted" by a provider who is face-to-face with the patient. The clinician providing telemedicine services is the consultant, and cannot be considered the host. The complexity of a hosted visit excludes it from being an online visit.

Secured Communication
A secured electronic channel must include and support all of the following for audio and audio/ visual 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. The name and patient identification number is contained in the body of the message, when applicable.
5. 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.
6. The medical record of the telemedicine visit should include, if applicable, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record.[9]

The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records.[9]
Finally, the documentation should adequately support the billing code used for the visit.

BILLING GUIDANCE

Modifiers / Place of Service
When the nomenclature of the code does not specify how the service is being delivered, then a modifier is required to clarify this. Use the modifier that is appropriate for the code.

Synchronous Encounters
GT – Via interactive audio and video telecommunications systems **OR**
95 – Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system

POS 02 – Telehealth – The location where health services and health related services are provided or received, through telecommunication technology.

Billing an originating site is **not** required, but may be used if clinically necessary.

Asynchronous Encounters
GQ – Via asynchronous telecommunications system

POS 02 – Telehealth – The location where health services and health related services are provided or received, through telecommunication technology.

Synchronous Care Billing Requirements		
	Modifier	**Place of Service 02**
Online Codes 98970-98972, 99421-99423	None	Yes
Telephone Codes 99441 – 99443 98966 – 98968	None	Yes
CPT/HCPCS Codes Any code that is appropriate for the encounter and provider scope	Yes GT or 95	Yes
Asynchronous Care Billing Requirements		
	Modifier	Place of Service 02
CPT/HCPCS Codes Any code that is appropriate for the encounter and provider scope Behavioral Health services are not appropriate via asynchronous care.	Yes GQ	Yes
99446, 99447, 99448, 99449, 99451, 99452 G2010	None	Yes

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.)*

SYNCHRONOUS CARE

Established codes:

- Any code that is appropriate for both the encounter and provider scope and is delivered synchronously (in real time)
- Online codes: 98970-98972, 99421-99423
- Telephone codes: 99441-99443, 98966-98968
- Behavioral health codes (multiple)

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

- Refer to the medical policy "Autism Spectrum Disorder Services"

ASYNCHRONOUS CARE

Established codes:

- Any code that is appropriate for both the encounter and provider scope and is delivered asynchronously
- Clinician to clinician interaction: 99446, 99447, 99448, 99449, 99451, 99452

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

Behavioral health services: there are multiple billing codes for behavioral health services; behavioral health services are not appropriate for asynchronous care.

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

The State of Michigan Insurance Code of 1956, Act 218 (2012)[1] was enacted to prohibit an insurance policy or certificate from requiring "face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine". It also provided a definition of the term "telemedicine" and delineated requirements.

> "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."

Public Act 359 of 2016 amended Michigan's Public Health Code to establish initial standards for the use of telehealth in medical practice. It defined telehealth as "the use of electronic information and telecommunication technologies to support or promote long-distance clinical health care, patient and professional health-related education, public health, or health administration."[2]

Public Act 97 of 2020 (House Bill No. 5412) amended section 3476 of the State of Michigan Insurance Code of 1956, and states:

> An insurer that delivers, issues for delivery or renews in this state a health insurance policy shall not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the insurer. Telemedicine service must be provided by a health care professional who is licensed, registered or otherwise authorized to engage in his or her health care profession in the state where the patient is located.

> "Telemedicine" means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine under this section, the health care professional must be able to examine the patient via a health insurance portability and accountability act of 1996, Public Law 104-191 compliant, secure interactive audio or video, or both, telecommunications system, or through the use of store and forward online messaging.[3]

The State of Michigan Public Act 99 of 2020 (House Bill No. 5414) amended 1974 PA 258, which is an act to codify, revise, consolidate and classify the laws relating to mental health. The definition of telemedicine was added, and a "recipient" is defined as "an individual who receives mental health services, either in person or through telemedicine from the department, a community mental health services program, or a facility or from a provider that is under contract with the department or a community mental health services program."[4]

The Center for Connected Health Policy reports that all 50 states and the District of Columbia provide reimbursement for some form of live video in Medicaid fee-for-service. Forty-three states and the District of Columbia have laws that governs private payer telehealth reimbursement policy. No two states are alike in the scope and administration of telehealth.[5]

Grigsby et al (1995) reported that data concerning the costs, effects and effectiveness of telemedicine are limited. The authors identify the need for studies of efficacy and effectiveness, the evaluation of cost-effectiveness, and the identification of specific processes of telemedicine that are associated with optimal health outcomes.[6] Although there is more information than was available when this article was published, research is still lacking, most specifically in the area of randomized clinical trials.

Kruse et al (2017) reported on patient satisfaction of telehealth services in regard to effectiveness and efficiency. The researchers filtered 2193 articles for suitability, and performed a systematic review of 44. Findings reported: "Providers and patients should embrace telehealth modalities because of its ease of use, its tendency to improve outcomes and communications, and its low cost. It can decrease travel time and increased communications with providers. Telehealth can provide a high-quality services, increase access to care, increase self-awareness and it empowers patients to manage their chronic conditions. Healthcare organisations should embrace telehealth because it decreases missed appointments, is a good modality for education, decreases wait times, decreases readmissions and improves medication adherence. But most importantly, policymakers need to help legislation catch up with the technology by enabling additional means of reimbursement for telehealth because the modality improves outcomes, which improves public health." Limitations of the literature review included utilizing only two databases and the relatively young age of the telehealth modality of care.[7]

Langarizadeh et at (2017) performed a systematic review on the applications, technologies, advantages and challenges associated with telemental health care published since the year 2000. From four databases, 156 articles were identified. Of these, 25 met all inclusion criteria and were used in the review. Materials derived from 55 credible articles were used as further support and complementary facts. The findings revealed that telemental health care is an extended domain supportive of conventional mental health services. Currently, telemental health care has multiple capabilities and technologies for providing effective interventions to

patients with various mental illnesses. It provides clinicians with a wide variety of innovative choices and strategies for mental interventions, in addition to significant future potential. The reviewers concluded that telemental health care can provide effective and adaptable solutions to the care of mental illnesses universally. While being comparable to in-person services, telemental health care is particularly advantageous and inexpensive through the use of current technologies and adaptable designs, especially in isolated communities.[8]

Lee et al (2019) reported on a study of the impact of a telemedicine-based home management program (THMP) on patient adherence, hospital readmissions and quality of life after liver transplantation. One hundred six consecutive liver transplantation recipients were randomized (1:1) to 1 of 2 posttransplant care strategies: standard of care or THMP. The THMP included an electronic tablet and bluetooth devices to support daily text messages, education videos, and video FaceTime capability; data was cyber-delivered into our electronic medical record daily. Endpoints were THMP participation, 90-day hospital readmission rate, and quality of life. One hundred patients completed the study with 50 enrolled in each arm. Participation and adherence with telemedicine was 86% for basic health sessions (vital sign recording), but only 45% for using messaging or FaceTime. The THMP group had a lower 90-day readmission rate compared to SOC (28% vs 58%; P = 0.004). The THMP cohort also showed improved quality of life in regard to physical function (P = 0.02) and general health (P = 0.05) at 90 days. The authors concluded that the magnitude of effect on liver transplant outcomes, hospital readmissions, and quality of life suggests that the adoption of telemedicine has great potential for other major surgeries.[9]

Supplemental Information

The American Telemedicine Association, which is focused on advancing telehealth, has developed numerous clinical and administrative Practice Guidelines. The ATA offers accreditation to organizations that provide telehealth services.

The Federation of State Medical Boards (2014) developed “Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine”.[10] The policy provides guidance to state medical boards for regulating the use of telemedicine and also educates licensees as to the appropriate standards of care in delivery of services to patients via telemedicine technologies. The guidelines discuss ten areas of responsibility, including the following topics:

Licensure: a physician must be licensed in the state where the patient is located.
Establishment of a Physician-Patient Relationship: a physician must take appropriate steps to establish a physician-patient relationship, where the physician recognizes the obligations, responsibilities and patient rights associated with the establishment of the relationship.
Evaluation and Treatment of the Patient: there is to be a documented medical evaluation and collection of relevant clinical history. Treatment recommendations will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings.
Privacy and Security of Patient Records: compliance with HIPPA and state privacy, confidentiality, security and medical record retention rules.

The Agency for Healthcare Research and Quality (AHRQ) (2016) issued a technical brief, "Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews" in which it evaluated 58 systematic reviews.

> "The largest volume of research reported that telehealth interventions have produced positive results when used in the clinical areas of chronic conditions and behavioral health and when telehealth is used for providing communication/ counseling and monitoring/management … In areas where we did not find sufficient synthesized research, such as telehealth for consultation, in ICU and surgery, and in maternal and child health new systematic reviews may be able to organize primary research (some of which is new and some of which has been included in reviews in the past) into better reviews designed to address practice and policy considerations related to these issues."[11]

AHRQ (2019) published a systematic review "Telehealth for Acute and Chronic Care Consultations." The investigators reviewed 233 articles and concluded that in general, the evidence indicated that telehealth consultations are effective in improving outcomes or providing services, with no difference in outcomes. The evidence was stronger for some applications. Remote intensive care unit (ICU) consultations likely reduce ICU and total hospital mortality with no significant difference in ICU or hospital length of stay; specialty telehealth consultations likely reduce the time patients spend in the emergency department; telehealth for emergency medical services likely reduces mortality for patients with heart attacks; and remote consultations for outpatient care likely improve access and a range of clinical outcomes (moderate strength of evidence in favor of telehealth).[12]

The American Academy of Family Physicians in its policy "Telehealth and Telemedicine" (1994, 2021) states:

> "The AAFP supports expanded use of telehealth and telemedicine as an appropriate and efficient means of improving health, when conducted within the context of appropriate standards of care. The appropriateness of a telemedicine service should be dictated by the standard of care and not by arbitrary policies. Available technology capabilities as well as an existing physician-patient relationship impact whether the standard of care can be achieved for a specific patient encounter type."[13]

Government Regulations
National:

Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

190.1 Background (Rev.1635, Issued: 11-14-08, Effective: 01-01-09)
190.2 Eligibility Criteria (Rev.2848, Issued 12-30-13; Effective 01-01-14)
190.3 List of Medicare Telehealth Services (Rev.3476, Issued: 03-11-16, Effective: 04-11-16)
190.4 Conditions of Payment (Rev.1, 10-01-03)
190.5 Originating Site Facility Fee Payment Methodology (Rev.3476, Issued: 03-11-16, Effective: 04-11-16)

190.6 Payment Methodology for Physician/Practitioner at the Distant Site (Rev.3586, Issued: 08-12-16, Effective: 01-01-17)
190.7 AB MAC (B) Editing of Telehealth Claims (Rev.3817, Issued: 07-28-18, Effective: 01-01-18)

CMS 42 CFR Part 410 Supplementary Medical Insurance (SMI) Benefits
Subpart B – Medical and Other Health Services
§ 410.78 - Telehealth services
Origination Date 1/1/01, Last Update 12/28/2020

CMS mln Booklet Telehealth Services, March 2020

Local:
NA

(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

Autism Spectrum Disorder Services
Remote Patient Monitoring

References

1. State of Michigan, The Insurance Code of 1956 (Excerpt), Act 218 of 1956, 500.3476 Telemedicine Services; provisions; definitions. Effective 6/28/12, updated effective date 12/20/17.
2. State of Michigan, 98th Legislature Regular Session of 2016, Act No. 359, Public Acts of 2016, https://www.legislature.mi.gov/documents/2015-2016/publicact/pdf/2016-PA-0359.pdf Accessed 5/18/21.
3. State of Michigan, 100th Legislature Regular Session of 2020, Enrolled House Bill 5412. https://legiscan.com/MI/text/HB5412/2019 Accessed 5/18/21.
4. State of Michigan, 100th Legislature Regular Session of 2020, Enrolled House Bill 5414. http://www.legislature.mi.gov/documents/2019-2020/publicact/pdf/2020-PA-0099.pdf Accessed 5/18/21.
5. The Center for Connected Health Policy, State Telehealth Laws & Reimbursement Policies Report, https://www.cchpca.org/telehealth-policy/state-telehealth-laws-and-reimbursement-policies-report Accessed 5/18/21.
6. Grigsby J et al. Effects and Effectiveness of Telemedicine. Health Care Finance Rev. 1995 Fall; 17(1):115-131.
7. Kruse CS, et al. Telehealth and patient satisfaction: a systematic review and narrative analysis. BMJ Open 2017;7:e016242. June 23, 2017.

8. Langarizadeh M, et al. Telemental health care, an effective alternative to conventional mental care: a systematic review. ACTA INFORM MED. 2017 Dec; 25(4): 240-246.
9. Lee TC, et al. Telemedicine based remote home monitoring after liver transplantation: results of a randomized prospective trial. Ann Surg 2019, Jul 25. PMID: 31356267.
10. Federation of State Medical Boards, Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine, Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup, https://www.fsmb.org/siteassets/advocacy/policies/fsmb_telemedicine_policy.pdf Accessed 5/18/21.
11. Agency for Healthcare Research and Quality (AHRQ), Issue #525, Telehealth: mapping the evidence for patient outcomes from systematic reviews, Technical Brief Number 26, July 16, 2016,
12. AHRQ Comparative Effectiveness Review Number 216, Telehealth for Acute and Chronic Care Consultations, April 2019. https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/cer-216-telehealth-final-report.pdf Accessed 5/18/21.
13. American Academy of Family Physicians, Telehealth and Telemedicine https://www.aafp.org/about/policies/all/telemedicine.html Accessed June 25, 2020.
14. CMS, 42 CFR, Part 410 Supplementary Medical Insurance (SMI) Benefits, Subpart B Medical and Other Health Services, § 410.78 Telehealth Services, 1/1/2001, last update 12/28/20.
15. CMS mln Booklet, Telehealth Services, March 2020, https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/telehealthsrvcsfctsht.pdf Accessed 5/18/21.

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 5/18/21, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
6/12/02	6/12/02	7/19/02	Joint policy established
3/21/06	3/21/06	4/14/06	Routine maintenance, policy retired
9/1/09	6/1/09	6/16/09	Unretired, routine maintenance
11/1/10	8/28/10	8/17/10	Routine maintenance
5/1/11	2/15/11	3/3/11	Routine maintenance
5/1/12	2/21/12	2/21/12	Routine maintenance
11/1/13	8/20/13	9/3/13	Routine maintenance
N/A	N/A	N/A	Blue Cross and BCN policies established, see Pre-Consolidation Medical Policy History below
5/1/20	2/7/20	N/A	Joint policy re-established Combined the following: Blue Cross and BCN Telemedicine policies; and BCN eVisits policy. Direct ABA therapy for autism spectrum disorder is excluded from telemedicine. 6/11/20: CPT codes for psychotherapy crisis (90839, 90840) deleted from table and inclusions. These CPT codes do not specify a specific telemedicine mode and are considered as general CPT codes.
11/1/20	9/24/20		Routine maintenance Added: store and forward; Ref 11. Added: 99446, 99447, 99448, 99449, 99451, 99452, G2010; BH: 96130, 96156. Removed S5108 from non-covered list.
11/1/21	8/17/21		Routine maintenance Clarification of BH services and autism services allowed via telemedicine.

Next Review Date: 3rd Qtr, 2022

Pre-Consolidation Medical Policy History

Original Policy Date	Comments
BCN: 1/1/16	Revised: 11/16/16, 11/15/19, 11/14/18
BCBSM: 1/1/16	Revised: 1/19/17, 1/25/18, 5/14/18, 3/19/19

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: TELEMEDICINE SERVICES

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered
BCNA (Medicare Advantage)	See Government Regulations section.
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 individual 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.