Telehealth – Medicare

State(s):	LOB(s):
☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☒ *Other:*	☐ *Commercial* ☒ *Medicare* ☐ *Medicaid*

Medicare Policy

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies PacificSource Community Health Plans. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determination are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

This policy describes PacificSource Community Health Plans billing, reimbursement and coverage guidelines for Telehealth services which occur when an eligible provider and member are not at the same site. This policy is meant to outline medical and behavioral health telehealth services. The guidelines and information provided are applicable to the state in which the member's plan originated, not where the member is residing at the time of service.

General Guidelines and Information

PacificSource recognizes federal and state mandates in regards to Telehealth and Telemedicine. Any terms not otherwise defined in this policy are directed by the federal and state mandates.

- This is a general reference regarding PacificSource's reimbursement policy for the services described and is not intended to address every reimbursement situation.
- Other factors affecting reimbursement may supplement, modify, or supersede this policy which include, but are not limited to the following:
  - Legislative mandates
  - Provider contracts
  - Benefit and coverage documentation
  - Other medical, behavioral health, or drug policies
- Services are subject to medical necessity, evidence-based protocols, and member's eligibility and benefit at time of service.

Criteria

Medicare

Prior authorization to use a telehealth service is not required unless the service requires prior authorization when performed in-person.

PacificSource considers telehealth services medically necessary when **ALL** of the following conditions to qualify for coverage under the health plans are met:

- Synchronized video; except where otherwise mandated by state and/or federal law.
- Services must be medically necessary and member must be eligible for coverage.
- Providers and originating site must be eligible for reimbursement.
- Provider compliance with medical records requirements and provisions of HIPAA and HITECH is required for telehealth services

Definitions

Distant Site – The physical location of the eligible health care provider.

Eligible Providers - Provider types recognized by PacificSource who are eligible for services in the healthcare setting, are qualified health professionals, who are licensed, and are eligible for reimbursement of appropriate services via telehealth.

- PacificSource follows the Center for Medicare and Medicaid Services (CMS) for coverage of telehealth and telemedicine services. Please refer to CMS.gov for coverage criteria.
- In addition to what is covered under CMS, PacificSource Medicare allows for Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapists (LMFT), Licensed Clinical Professional Counselors (LCPC), Licensed Mental Health Counselors (LMHC, Washington only), Federally Qualified Health centers (FQHC), and Rural Health Clinics (RHC) to be eligible providers for tele-video and telephonic services as appropriate with state law.

Originating Site - The physical location of the patient receiving telemedical health services. Eligible originating sites are limited to:

- Office of a qualified health care professional
- A hospital (inpatient or outpatient)
- Critical Access Hospital (CAH)
- Rural Health Clinic (RHC)
- Federal Qualified Health Center (FQHC)
- A hospital based or critical access hospital based renal dialysis center. Independent renal dialysis facilities are not eligible originating sites.
- Skilled Nursing Facility (SNF)
- Mobile Stroke Unit

- Patient Home

Telehealth or Telemedicine - Consultations with a qualified healthcare professional provided in real-time over an electronic mechanism. These services are rendered to patients using electronic communications such as secure email, patient portals, and online audio and/or video conferencing

Coding Information

Reimbursement Information

- Telehealth visits will be subject to retrospective review as appropriate.
- For services that a provider also bills for when done in the office (e.g., office visit E&M codes, psychotherapy visit codes), they will be processed under comparable benefits (such as office and home visits or mental health office visits), regardless of whether they were done in the office or over the phone/video. For services that a provider would only bill as telehealth (i.e., specific telephone-visit-only codes), those would fall under the telehealth/telemedicine benefit and apply the lower copay (shown as telemedicine visits on benefit summary), if applicable for the plan.

Claim Information

- Place of Service (POS) code 02 or 10 on CMS HCFA 1500 form will calculate using the facility RVU for the applicable CPT code. Telehealth performed in the urgent care setting should be billed with POS location 02, not 20.
- Place of Service code 11 for telehealth claims is allowed but must be billed with either the -GT or -95 modifier.
- Modifier -GT, -GQ, -93, or -95 and additional modifiers may be appended when appropriate to the CPT or HCPCS for telemedicine consultations.
- Documentation for telehealth services should be the same as if services were rendered face-to-face:
    - Document if the service was provided via technology with synchronous audio/video or audio alone.
    - Document where the patient and provider are located.
    - Document provider is speaking to the correct person (properly identified the person on the call).
    - Consent must also be documented for the visit to be performed via telehealth (can be done annually).
    - Document if the call started out with audio/video but was completed as audio only due to technical issues.
- For COVID-specific reimbursement information, please see the COVID-19 Benefit and Reimbursement FAQ at https://medicare.pacificsource.com/Providers/Notice/Index/563

Related Policies

Telehealth and Telemedicine – Oregon Medicaid

Telehealth – Idaho, Montana and Oregon Commercial Commercial

Appendix

Policy Number:

Effective: 5/1/2022 **Next review:** 5/1/2023

Policy type: Medicare

Author(s):

Depts.: Health Services, Provider Network; Claims;

Applicable regulation(s): 45 CFR Part 92 and The Americans with Disabilities Act (ADA).

Government Ops: 8/2022