TELEHEALTH

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Description

Telehealth is a potentially useful tool that, if employed appropriately, can provide important benefits to patients, including: increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and the reduced cost of patient care.

Centers for Medicare and Medicaid Services (CMS) promote 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 such as consultations, office visits, preventative care, and mental health services. Telemedicine, the use of telecommunications technology to deliver medical diagnostic, monitoring, and therapeutic services when health care users and providers are geographically separated, offers great promise for reducing access barriers for chronically ill Medicare beneficiaries.

Definition of services:

Telehealth is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. Telehealth includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications.

The terms "**telemedicine**" and "**telehealth**" are often used interchangeably, although "telehealth" is intended to include a broader range of services such as videoconferencing, remote monitoring, online digital evaluation and management services, and transmission of still images. The main proposed advantage of telehealth is the capability of delivering medical services to distant areas with low access to medical specialists. For the purposes of this policy, **"telemedicine**" refers specifically to the subset of telehealth represented by the delivery of clinical services via synchronous, interactive audio and video telecommunications systems.

There has been interest on behalf of patients and providers to use electronic means to manage common medical conditions in lieu of a formal office visit. Online digital evaluation and management services using Internet resources is a subset of telehealth that gives health providers the ability to interact with patients through a secured electronic channel. For the purposes of this policy, online digital evaluation and management services may include communication by any secured electronic channel. Online digital evaluation and management services are non-face-to-face evaluation and management (E/M) services by a physician or other non-physician qualified health care professional, typically in response to a patient's online inquiry, and are used to address non-urgent ongoing or new symptoms.

Professional Oversight and Regulation:

North Carolina has enacted Senate Bill 780 which requires that non-resident physicians who treat patients through the use of electronic or other media shall be licensed in this state and shall be subject to reasonable regulations by the North Carolina Medical Board. This bill went into effect September 17, 1997.

According to the November 2014 North Carolina Medical Board (NCMB) position statement for telemedicine, licensees practicing via telemedicine will be held to the same standard of care as licensees employing more traditional in-person medical care. A failure to conform to the appropriate standard of care, whether that care is rendered in-person or via telemedicine, may subject the licensee to potential discipline by NCMB. There is not a separate standard of care applicable to telemedicine. Telemedicine providers will be evaluated according to the standard of care applicable to their area of specialty. Additionally, telemedicine providers are expected to adhere to current standards for practice improvement and monitoring of outcomes.

The American Medical Association (AMA) has issued policy H-160.937, titled, "The Promotion of Quality Telemedicine." This policy includes three principles, summarized below, for responsible use of electronic communication in providing healthcare.

1. The physician is responsible for supervising the safety and quality of services provided to patients by non-physician providers through telemedicine.

2. Supervising physicians are required to visit sites where patients receive care from non-physician providers. They must also have knowledge of the non-physicians' qualifications and should be able to contact those providers as necessary. Both supervising providers and non-physician providers must conform to the applicable medical practice act in the state where the patient receives services.

3. Providers who utilize telemedicine systems, must maintain recording, * reporting and supervision of patient care and conform to confidentiality and privacy principles.

The North Carolina Board of Pharmacy (NCBOP) has published rules regarding the appropriate handling of prescriptions. Telemedicine providers are expected to adhere to the NCBOP rules as outlined regarding prescriptions. These rules are available at: http://www.ncbop.org/LawsRules/Rules.pdf

* Blue Cross Blue Shield North Carolina (Blue Cross NC) interprets this statement to refer to medical record documentation.

Same group practice is defined as a physician and/or other qualified health care professional of the same specialty with the same Federal Tax ID number.

Policy

Blue Cross NC will provide reimbursement for Telehealth services according to the criteria outlined in this policy.

Reimbursement Guidelines

Services using telemedicine technologies between a provider in one location and a patient in another location, may be reimbursed when **all** of the following conditions are met:

- The patient is present at the time of service;
- All services provided are covered benefits under the member certificate of coverage/benefit booklet, and are eligible for separate payment when performed face to face;
- All services provided are medically appropriate and necessary;

- A service by a provider licensed to practice independently in the state of North Carolina;
- The encounter satisfies the elements of the patient-provider relationship, as determined by the relevant healthcare regulatory board of the state where the patient is physically located;
- The service takes place via an interactive audio and/or video telecommunications system, unless otherwise stated in this policy. Interactive telecommunications systems permitting real-time consultation among the patient, consulting practitioner, and referring practitioner (as appropriate);
- The service is conducted over a secured channel with provisions described in Policy Guidelines;
- A permanent record of online communications relevant to the ongoing medical care and follow-up of the patient is maintained as part of the patient's medical record.
- Evaluation and management services (E/M) provided via Telemedicine must adhere to the criteria outlined in the current version of the Current Procedural Terminology (CPT®) manual. Please see current CPT® manual for guidance and criteria for coding and documenting the appropriate Evaluation & Management levels.

Audio-Only Telehealth

Blue Cross NC recognizes audio-only telehealth as an important means of access to care for members lacking technological access or literacy. Audio-only telehealth is generally not considered an equal substitute to audio/video telehealth or face-to-face service, with inherent limitations and lower delivery cost. Audio-only telehealth will therefore receive 75% of the audio/video telehealth or face-to-face allowed reimbursement.

Originating Site (Q3014):

HCPCS Q3014 (Origination site fee) is considered an incidental service.

Reimbursement Exclusions

Telemedicine services **are not reimbursed** for the following:

- Telemedicine that occurs the same day as a face-to-face visit, when performed by the same provider and for the same condition. A single code should typically be reported for all E/M services a member is provided each day. Physicians and/or other qualified health care providers in the same group practice should select the appropriate code level representative of the cumulative related services.
- Services performed via asynchronous communications systems or submitted with a GQ modifier, except for online digital evaluation and management services. *Some member benefits may offer additional asynchronous telehealth access through specialized vendor services.*
- Triage to assess the appropriate place of service and/or appropriate provider type.
- Telehealth services not required to be performed by a qualified health professional (QHP).
- Non evaluative services and patient communications incidental to E/M, counseling, or medical services covered by this policy, including, but not limited to:

  - Reporting of test results;
  - Provision of educational materials.

- Administrative matters, 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.
- The transmission of digitalized data is considered integral to the procedure being performed and is not reimbursed separately.
- Facilities

Online Digital Evaluation and Management Services

Online digital evaluation and management services are patient initiated, and include multiple and mixed telecommunications modalities, such as live audio visual (synchronous), asynchronous, telephonic, and other digital or online communication via electronic medical record portal or secure email. They may also include cumulative service time reported by more than one provider in a group practice responding to the same patient within seven-day time frame. These services do not include nonevaluative communications and administrative matters, such as scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.

Please note that CPT® 99421-99423 for online digital evaluation and management service and 98970-98972 for nonphysician professional online assessment should be reported for **established** patients only.

Online digital evaluation and management services and telemedicine services billed within the pre- and post-operative period of a previously completed major or minor surgical procedure or global maternity will be considered part of the global payment for the procedure and not paid separately.

Online digital evaluations are not separately reimbursable when an E&M service is performed within 7 days of the digital evaluation for the same member by the same physician and/or other qualified health care provider in the same group practice within the same specialty. In this instance, work devoted to the digital evaluation should be incorporated into the E&M service.

Remote Monitoring Services

Remote therapeutic monitoring (RTM) treatment management services are provided when a physician or other qualified healthcare professional uses the results of RTM to manage an individual's chronic condition under a specific treatment plan. The service must be ordered by a physician or other qualified healthcare professional.

Remote physiologic monitoring (RPM) involves monitoring of physiological data only. RPM services involve data from monitoring devices which have the capability to transmit clinical data for physician review and for the intended use of managing the individual's condition using these results under a specific treatment plan. Remote monitoring of physiologic parameter(s) and remote physiologic monitoring treatment management services (99453, 99454, 99457, 99458) as well as remote physiologic monitoring (98975, 98976, 98977, 98980, 98981) are considered incidental to evaluation and management services performed by the same provider or same group practice on the same day, regardless of modifier usage. Separate reimbursement is not allowed for incidental services.

Rationale

Telehealth is an effective means of providing healthcare to patients with accessibility problems, including living in isolated communities, physical disabilities or chronic illnesses. Telehealth has become increasingly important in the healthcare community and general population.

The telehealth service list in the Billing and Coding section is a cumulative representation of what Blue Cross NC considers quality care deliverable via Telehealth.

Security and Confidentiality

Providers who utilize telemedicine systems must consider security, patient confidentiality, and privacy. A secured electronic channel is required to be utilized by a telemedicine provider. The electronic channel must be secure, encrypted, and include and support all of the following:

- A mechanism to authenticate the identity of correspondent(s) in electronic communication and to ensure that recipients of information are authorized to receive it.
- The patient's informed consent to participate in the consultation, including 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 privacy issues.
- An established turnaround time for responses from the provider. The system should alert the physician or practice that there is an outstanding request for an e-visit.
- Structured symptom assessment and risk reduction features. (i.e., patients are directed to contact the practice and/or emergency room if certain symptoms are reported).
- An electronic communication system that generates an automatic reply to acknowledge receipt of messages or indicates that the provider is unable to respond.
- The name and patient identification number.
- A standard block of text contained in the provider's response that displays the physician's full name, contact information and reminders about security and the importance of alternative forms of communication for emergencies.
- No inclusion of third party advertising and the patient's information is not to be used for marketing.
- Payment Card Industry Data Security Standard (PCI-DSS) compliant.

Licensing

The practice of medicine is deemed to occur in the state in which the patient is located. Therefore, any provider using telemedicine to provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina. North Carolina licensees intending to practice medicine via telemedicine technology to treat or diagnose patients outside of North Carolina should check with other state licensing boards. Most states require physicians to be licensed, and some have enacted limitations to telemedicine

practice or require or offer a special registration. A directory of all U.S. medical boards may be accessed at the Federation of State Medical Boards website.

The provider using telemedicine should verify the identity and location of the patient and should be prepared to inform the patient of the provider's name, location, and professional credentials.

Prescribing of Controlled Substances

It is the position of the North Carolina Medical Board that prescribing controlled substances for the treatment of pain by means of telemedicine is not consistent with the standard of care. Providers prescribing controlled substances for other conditions by means of telemedicine within North Carolina should follow all relevant federal and state laws, and are expected to participate in the Controlled Substances Reporting System.

The U.S. Drug Enforcement Administration (DEA) has issued guidance supporting practice patterns that enable safe access to appropriate medications and controlled substances during the COVID-19 pandemic. For information regarding the practice of telemedicine please visit the DEA COVID-19 Information Page and their press release.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross NC web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable Service Codes and Modifiers For Telehealth Services	
CPT® / HCPCS Code / Modifier	**Description**
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service)
90845	Psychoanalysis
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes

90853	Group psychotherapy (other than of a multiple-family group)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92521	Evaluation of speech fluency (eg, stuttering, cluttering)
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family
96110	Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (list separately in addition to code for primary procedure)
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (list separately in addition to code for primary procedure)
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when

	performed; each additional hour (list separately in addition to code for primary procedure)
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96133	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (list separately in addition to code for primary procedure)
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (list separately in addition to code for primary procedure)
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (list separately in addition to code for primary procedure)
96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (list separately in addition to code for primary service)
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (list separately in addition to code for primary service)
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (list separately in addition to code for primary service)
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face 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
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
99221*	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99222*	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
99223*	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or

	examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
99231*	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
99232*	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99233*	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
99238*	Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter
99239*	Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other

	qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, audit, dast), and brief intervention (sbi) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, audit, dast), and brief intervention (sbi) services; greater than 30 minutes
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
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
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
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure)
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes
G0270	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
G0296	Counseling visit to discuss need for lung cancer screening using low dose ct scan (ldct) (service is for eligibility determination and shared decision making)
G0396	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes
G0397	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth

G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit
G0442	Annual alcohol misuse screening, 15 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
G0444	Annual depression screening, 15 minutes
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes
G0447	Face-to-face behavioral counseling for obesity, 15 minutes
G0508	Telehealth consultation, critical care, initial , physicians typically spend 60 minutes communicating with the patient and providers via telehealth
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth
G2012	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion
G2252	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
G9887	Distance learning attendance behavioral counseling for diabetes prevention, distance learning, 60 minutes.
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
S0265	Genetic counseling, under physician supervision, each 15 minutes
S0285	Colonoscopy consultation performed prior to a screening colonoscopy procedure

S9140	Diabetic management program, follow-up visit to non-md provider
S9141	Diabetic management program, follow-up visit to md provider
S9152	Speech therapy, re-evaluation
S9452	Nutrition classes, non-physician provider, per session
S9455	Diabetic management program, group session
S9460	Diabetic management program, nurse visit
S9465	Diabetic management program, dietitian visit
S9480	Intensive outpatient psychiatric services, per diem
Modifier G0	Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke
Modifier FR	The supervising practitioner was present through two-way, audio/video communication technology
Modifier FQ	The service was furnished using audio-only communication technology
Modifier GT	Via interactive audio and video telecommunication systems
Modifier GQ	Via asynchronous telecommunications system
Modifier 93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system
Modifier 95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system

Services with an asterisk (*) are limited to providers performing Behavioral Health Services.

Telehealth services must be submitted on a professional claim form with an appropriate modifier to distinguish between different forms of telehealth (synchronous vs asynchronous, audio vs audio/video, etc.).

Note: Intensive Outpatient Program (IOP) facilities may submit telehealth services on a Facility claim form according to their contractual agreement.

Audio-only telehealth services, as indicated by modifier FQ or 93, will receive 75% of the allowed reimbursement.

Telemedicine services performed via asynchronous communications systems or submitted with a GQ modifier are not reimbursable, except for online digital evaluation and management services. *Some member benefits may offer additional asynchronous telehealth access through specialized vendor services.*

Telehealth services must be reported with place of service code 02 or 10.

Place of Service	Description
02	Telehealth Provided Other than in Patient's Home
10	Telehealth Provided in Patient's Home

Eligible providers: Providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face to face service. Facilities are not eligible for telehealth reimbursement.

Remote Monitoring Services

Remote Monitoring Services do not have a face-to-face equivalent and therefore are **not** to be submitted with Telehealth POS or Modifiers.

CPT® / HCPCS Code / Modifier	Description
99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)
98975	Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment
98976	Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days
98977	Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes
98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)

Related policy

Bundling Guidelines

Evaluation & Management Services

Guidelines for Global Maternity Reimbursement

Modifier Guidelines

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History

11/97	Original Policy developed.
8/98	Policy reviewed. Wording corrected in Policy section.
9/99	Reformatted. Medical Term Definitions added.
12/99	Medical Policy Advisory Group
3/01	Medical Policy Advisory Group review. No changes to criteria. Approve. System changes.
2/02	Coding format change.
10/02	Specialty Matched Consultant Advisory Panel review. No change in policy.
12/02	Code Q3014 added to the policy. System coding changes.
11/03	Medical Policy Advisory Group review. Formatting change. No change to policy statement.
3/04	Policy Number changed from ADM9110 to MED1395.
10/8/05	Medical Policy Advisory Group review on 9/8/05. No changes made to policy coverage criteria. MED1395 added as key term. In sections "When Covered" and "When Not Covered," the term Telemedicine replaced "it." These sections also revised to further clarify when Telemedicine is covered and when Telemedicine is not covered. Telemedicine is not a covered service when billed with an Evaluation and Management code. In addition, Telemedicine is not covered when provided by an MD who is not licensed in the state of North Carolina.
7/16/07	Definition of Telemedicine revised and definition of Telehealth added to Description section. Policy statement revised to read: BCBSNC will provide coverage for Telemedicine or Teleheath services when it is determined to be medically necessary because the medical criteria and guidelines shown below are met. Interpretation of lab or radiology services by providers who are not licensed in the state of North Carolina is not covered. Note added to Benefits Application section: reimbursement for telephone consultations is excluded by most benefit plans. Criteria for coverage of Telemedicine evaluation and management and consultation services added to When Telemedicine is Covered section. Following statement added to When Telemedicine is Not Covered section: BCBSNC does not reimburse for evaluation and management and consultations services provided via telephone, Internet, or other communication network or devices that do not involve direct, in-person patient contact. NC General Statute 90-18 updated to reflect current version. CPT codes updated and the following statement added to Billing/Coding section: The transmission of digitalized data is considered integral to the procedure being performed and is not reimbursed separately. References updated. (adn)
10/22/07	Specialty Matched Consultant Advisory Panel review meeting 9/20/07. No changes to policy statement or coverage criteria. (adn)
12/31/07	CPT codes 98966, 98967, 98968, 98969, 99441, 99442, 99443, 99444, added to Billing/Coding section. Removed codes 0074T and T1014. (adn)

2/11/08	Added information regarding Modifiers GQ and GT to the Billing/Coding section. (adn)
6/30/08	Added CPT codes 0188T and 0189T to Billing/Coding section. New codes effective 7/1/08.
01/05/09	Coding update. Added codes G0406, G0407, G0408.
6/1/09	Information regarding "E-visits" added to Description section. The following statement was added to the Not Covered section: Telemedicine services are not covered when the criteria listed above are not met. And the following statement was deleted from the Not Covered section: BCBSNC does not reimburse for evaluation and management and consultation services provided via telephone, Internet, or other communication network or devices that do not involve direct, in-person patient contact.
10/26/09	Specialty Matched Consultant Advisory Panel review 9/28/09. No change to policy statement or coverage criteria. (adn)
1/5/10	HCPCS Codes G0425, G0426, G0427 added to Billing/Coding section.
6/22/10	Policy Number(s) removed (amw)
4/12/11	Specialty Matched Consultant Advisory Panel Review meeting 3/31/2011. Added HCPCS codes G0420, G0421, G0108, G0109 to Billing/Coding Section. Under “Policy Guidelines”: substituted live link: www.ncga.state.nc.us/enactedlegislation/statutes/pdf/bysection/chapter_90/gs_90-18.pdflpr for the legal insert for practicing without a license. Under “When Covered” section: added bullet: “A permanent record of online communications relevant to the ongoing medical care of the patient should be maintained as part of the patient’s medical record.” References added. (lpr).
3/20/12	Specialty Matched Consultant Advisory Panel review meeting 2/29/2012. No change to policy statement. (lpr)
5/15/12	Added CPT codes 90801, 90862 to Billing/Coding section. (UHS Telepsychiatry). (lpr)
12/28/12	Deleted CPT code 90862 from Billing/Coding section for effective date 1/1/13. (lpr)
4/16/13	Deleted CPT code 90801 from Billing/Coding section for 2013 coding update. (lpr)
3/11/14	Specialty Matched Consultant Advisory Panel review meeting 2/25/2014. No change to policy statement. (lpr)
7/28/15	Corporate medical policy converted to Reimbursement policy titled “Telehealth.” Merged Telemedicine and E-visits corporate medical policies into Telehealth policy. Extensive revisions to entire policy. References added. Specialty Matched Consultant Advisory Panel review meeting 2/2015. Medical Director review 7/2015. (mot)(lpr)
12/30/16	Codes G0508, G0509 added to Billing/Coding section. Added Modifier 95--*Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System* and Place of Service 02--*The location where health services and health related services are provided or received, through a telecommunication system* which are effective January 1, 2017. The following statement regarding place of service was deleted: *Telemedicine and online medical evaluation services without an intervening provider should be submitted with the place of service that would be appropriate if the service had occurred face to face. Telemedicine services with an intervening provider should be submitted with a place of service code to indicate the facility or physical location of the member and intervening provider.* The Telehealth Provider Coding Grid was deleted. (an)
8/25/17	Typos corrected. (an)
12/29/17	Updates to Billing/Coding section. Telehealth services should be reported with place of service code 02. Use of modifiers GT and 95 are optional. (an)
12/31/18	Routine review. Codes 0188T, 0189T deleted. No change to policy. (an)
2/12/19	Additional to Reimbursement Guidelines: “New and established outpatient E/M and outpatient consultation E/M services performed without an intervening provider present with the patient, except: when reimbursed as online medical evaluations or for behavioral health

	evaluation and management services." Revision to Billing/Coding section: "Modifier GQ—(Via asynchronous telecommunications systems). Service codes noted above will not be allowed when modifier –GQ is appended. (See the member's benefit booklet regarding availability of member benefits for asynchronous telehealth services. Some member benefits may offer additional telehealth access through specialized vendor services.)" Medical Director review 1/2019. (an)
12/31/19	Codes 96150, 96151 deleted and replaced with 96156 for health behavior assessment or re-assessment. Deleted codes 98969 and 99444. Added codes 99421, 99422, 99423 for online digital evaluation and management service of an established patient. The following statement added to the Billing/Coding section: Online digital evaluation and management services or assessment by nonphysician health care professionals (98970, 98971, 98972 or G2061, G2062, G2063) are not covered. (an)
1/14/20	Correction to the Billing/Coding section: codes 98970, 98971, 98972, G2061, G2062, G2063 added to the list of covered telehealth services. Also adding G2012. Medical Director review 12/2019. (an)
3/5/20	Expanded reimbursement of telehealth services in support of the coronavirus outbreak. The expansion is limited to the timeframe outlined in the policy and subject to defined extensions as needed. Medical Director review 3/2020. (kd)
3/13/20	Temporary waiver of video requirement for telehealth visit in support of coronavirus outbreak. The waiver is limited to the timeframe outlined in the policy and subject to defined extensions as needed. Medical Director review 3/2020. (kd)
3/20/20	"Temporary Expansion of Reimbursement for Telehealth Services" added. "* BCBS interprets this statement to refer to medical record documentation." Added to Description section. Note added to Policy Guidelines Security and Confidentiality section. "Encryption is not required for telephonic modalities during the temporary COVID-19 expansion of coverage." Updated Online evaluation and management services in Coding section. Reimbursement and Policy Guidelines updated with "Note in response to the COVID-19 outbreak." References updated. Medical Director review 3/2020. (eel)
3/27/20	Prescriptions for controlled substances and provider licensure requirements updated in policy guidelines related to treatment for COVID-19. (eel)
4/3/20	COVID-19 changes were extended for an additional 30-day period starting on April 6, 2020, and will continue to be re-evaluated every 30 days for further extension. (eel)
5/1/20	COVID-19 changes were extended until June 5, 2020, and then will be re-evaluated for extension every 30 days thereafter. (eel)
5/22/20	COVID-19 changes were extended through July 31, 2020. We will reevaluate if an additional extension is needed as we approach July 31. (eel)
6/12/20	CMS interim rule 85 FR 19230 added to Coding section allowing providers to file E/M telehealth visits based on MDM or time. (eel)
6/19/20	COVID-19 changes were extended through December 31, 2020. We will reevaluate if an additional extension is needed as we approach December 31. (eel)
6/26/20	Coding section updated with preventative and wellness services. (eel)
11/20/20	COVID-19 changes were extended through June 30, 2021. We will reevaluate if an additional extension is needed as we approach June 30. (eel)
12/31/20	Routine policy review. Medical Director approved 12/2020. References updated. No changes to policy statement. (eel)
4/15/21	COVID-19 changes were extended through December 31, 2021. We will reevaluate if an additional extension is needed as we approach December 31. (eel)
11/4/21	COVID-19 changes were extended through March 31, 2022. We will reevaluate if an additional extension is needed as we approach March 31. (eel)
12/30/21	Routine policy review. Newly created place of service 10 added throughout policy. Medical Director approved. (eel)

3/10/22	COVID-19 changes were extended through September 30, 2022. We will reevaluate if an additional extension is needed as we approach September 30. (eel)
8/2/22	COVID-19 changes were extended through December 31, 2022. (ckb)
9/21/22	Extensive revision throughout policy. Reimbursement Guidelines section updated with new topics: Audio-only Telehealth, Origination Site, Online Digital Evaluation and Management Services. Billing and Coding section updated code list of telehealth services. Billing instructions updated requiring telehealth modifier and place of service codes. Medical Director approved. **Notification on 9/21/2022 for effective date 1/1/2023.** (eel)
02/07/2023	Added Remote Therapeutic Monitoring Section to the Reimbursement Guidelines and Billing and Coding Sections. Medical Director Approved. **Notification on 2/7/2023 for Effective date 4/18/2023**. (cjw)
4/18/2023	Clarification to remove legislative information from the rationale section. (cjw)
7/18/2023	Added clarifying language under Billing and Coding referencing IOP's billing according to their contractual agreement. No change to policy intent. Effective 7/18/2023. (tlc)
10/01/2023	Added procedure code 97168. (tlc)
1/1/2024	Added procedure code G9887. (tlc)
4/10/2024	Added procedure codes 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239 to billing and coding grid for providers performing Behavioral Health Services. (tlc)
8/21/2024	Added procedure codes 97153 and 97155 (ss)
11/1/2024	Added procedure codes 97110 and 97164. Clarification to the definition of same group practice. (ss)

Application

These reimbursement requirements apply to all commercial, Administrative Services Only (ASO), and Blue Card Inter-Plan Program Host members (other Plans members who seek care from the NC service area providers). This policy does not apply to Blue Cross North Carolina members who seek care in other states.

This reimbursement policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Some member benefits may offer additional telehealth access through specialized vendor services. Telehealth benefits are available for professional services only.

Member's benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this reimbursement policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.