REIMBURSEMENT POLICY STATEMENT
OHIO MEDICARE ADVANTAGE

Original Issue Date	Next Annual Review		Effective Date
10/04/2013	07/01/2019		07/01/2018
Policy Name			**Policy Number**
Telemedicine Services			PY-0108
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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A. SUBJECT

Telemedicine Services

B. BACKGROUND

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment.

Telemedicine is used to support health care when the provider and patient are physically separated. Typically, the patient communicates with the provider via interactive means that is sufficient to establish the necessary link to the provider who is working at a different location from the patient. CareSource will reimburse participating providers, for telemedicine services, who are credentialed to deliver telemedicine services rendered to CareSource members, as set forth in this policy.

C. DEFINITIONS

- **Asynchronous store and forward technologies** - is the transmission of a patient's medical information from an originating site to the physician or practitioner at the distant site.
- **Distant Site** - is the location of the physician or provider rendering health care services, via a telecommunications system.
- **Interactive telecommunications system** - is multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.
- **Originating Site** - is the location of a CareSource member at the time the service, via a telecommunications system, occurs. **Place of Service Codes** (POS) - are codes that specifically indicate where a service or procedure was performed.
- **Telemedicine** - is the direct delivery of services to a patient via synchronous, interactive, real-time electronic communication that comprises both audio and video elements.
- **Telemedicine vendor** - is the participating provider with CareSource that renders the telemedicine services.

  Note: "Telehealth" is sometimes used interchangeably with "telemedicine" in Current Procedural Terminology (CPT®)/and Healthcare Common Procedure Coding System (HCPCS) code descriptions of services.

D. POLICY

I. CareSource does not require prior authorization for Telemedicine services.

II. Telemedicine services may be reimbursed according to Medicare guidelines set forth by Centers for Medicare & Medicaid Services (CMS) and using appropriate CPT and/or HCPCS and modifier codes.

III. As a condition of payment, providers must use an interactive audio and video telecommunications system that permits real-time communication between you, at the distant site, and the CareSource member, at the originating site.
   A. The service must be furnished via an interactive telecommunications system.
   B. The service must be furnished by a physician or authorized practitioner.
   C. The service must be furnished to an eligible telehealth individual.
   D. The individual receiving the service must be located in a telehealth originating site.

   Note: Asynchronous "store and forward" technology is permitted only in Federal telemedicine demonstration programs in Alaska or Hawaii.

IV. For ESRD-related services, a physician, NP, PA, or CNS must furnish at least one "hands on" visit (not telehealth) each month to examine the vascular access site, for End-Stage Renal Disease (ESRD).

V. Originating sites are paid an originating site facility fee for telehealth services as described by HCPCS code Q3014.
   A. Independent Renal Dialysis Facilities are not considered originating sites
   B. When a Community Mental Health Centers (CMHCs) serves as an originating site, the originating site facility fee does not count toward the number of services used to determine payment for partial hospitalization services.

   Note: Although telemedicine/telehealth services do not require a prior authorization CareSource may request documentation to support medical necessity. Appropriate and complete documentation must be presented at the time of review to validate medical necessity.

E. CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting CMS approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the Medicare fee schedule https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates. Please refer to the above referenced sources for the most current coding information.

Codes	Description
G0108 and G0109	Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training
G0270	Individual and group medical nutrition therapy
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 and G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services
G0425–G0427	Telehealth consultations, emergency department or initial inpatient
G0406–G0408	Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs
G0420 and G0421	Individual and group kidney disease education services
G0436 and G0437	Smoking cessation services
G0438	Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit

G0439	Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) 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
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management
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
G0459	Telehealth Pharmacologic Management
90785	Interactive Complexity Psychiatry Services and Procedures
90791	Psychiatric Diagnostic Evaluation w/o Medical
90792	Psychiatric Diagnostic Evaluation w/ Medical
90832	Individual Psychotherapy - 30 minutes
90833	Individual Psychotherapy w/ E/M Service
90834	Individual Psychotherapy – 45 minutes
90836	Individual Psychotherapy w/ E/M Service
90837	Individual Psychotherapy – 60+ minutes
90838	Individual Psychotherapy w/ E/M Service
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis; each additional 30 minutes
90845	Psychoanalysis
90846	Family Psychotherapy w/o patient – 50 minutes
90847	Family psychotherapy (conjoint, w/ patient present) – 50 minutes
96116	Neurobehavioral Status Exam
90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961	End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment
90963	End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents (effective for services furnished on and after January 1, 2016)
90964	End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents (effective for services furnished on and after January 1, 2016)
90965	End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 12-19 years of age to include monitoring

	for the adequacy of nutrition, assessment of growth and development, and counseling of parents.
90966	End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older.
90967	End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age
90968	End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 2-11 years of age
90969	End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 12-19 years of age
90970	End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 20 years of age and older
96116	Neurobehavioral status examination
96150–96154	Individual and group health and behavior assessment and intervention
96160	Health Risk Assessment (eg, health hazard appraisal)
96161	Health Risk Assessment (eg, depression inventory)
97802-97804	Individual and group medical nutrition therapy
99201–99215	Office or other outpatient visits
99231–99233	Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days
99307–99310	Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days
99354	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour
99355	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes
99356	Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service).
99357	Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service).
99406 and 99407	Smoking cessation services
99495	Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)
99496	Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)
99497	Advance Care Planning, 30 minutes
99498	Advance Care Planning, additional 30 minutes
Q3014	Telehealth originating site facility fee
Modifier	**Description**
GT	Via interactive audio and video telecommunication systems
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System

For further information please reference:

1. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf
2. https://www.medicare.gov/coverage/telehealth.html#1368

F. RELATED POLICIES/RULES

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	10/04/2013	
Date Reviewed	11/29/2016	
	02/22/2018	Added 1 modifier and 16 behavioral health codes.
Date Effective	07/01/2018	
Archive Date	03/05/2021	

H. REFERENCES

1. Telehealth - Centers for Medicare & Medicaid Services. (2017, December 1). Retrieved December 1, 2017 from https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html
2. Telehealth Services. (2016, November). Retrieved December1, 2017 from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf
3. Telehealth Services (2017, December 1). Retrieved December 1, 2017 from https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-78.pdf
4. Telehealth | *Medicare.gov*. (2017, December 1). Retrieved December 1, 2017 from https://www.medicare.gov/coverage/telehealth.html

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.