Temporary Payment Policy: Supplemental Telehealth Guidelines

Commercial/Medicare Advantage

POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
R20200020	03/13/2020	RPC (Reimbursement Policy Committee)

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY:

ConnectiCare has policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. ConnectiCare will inform you of new policies or changes in policies through updates to the Provider Manual and/or provider news. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in ConnectiCare's policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by ConnectiCare due to programming or other constraints; however, ConnectiCare strives to minimize these variations.

ConnectiCare follows coding edits that are based on industry sources, including, but not limited to; CPT guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. ConnectiCare uses industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how ConnectiCare handles specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, ConnectiCare may deny the claim and/or recoup claim payment.

ConnectiCare, Inc. will temporarily allow telemedicine and limited telehealth services provided via telephone as outlined in the policy below.

This policy applies to ConnectiCare, Inc. participating providers only.

This change in policy is effective until May 31, 2020, but we may extend that date if necessary and will communicate through all appropriate channels.
ConnectiCare, Inc. reserves the right to implement and revoke this policy without the contractual sixty-day (60) notification for a change in policy that is normally required under ConnectiCare, Inc. contracts with its providers. This would apply both for the effective date, due to the urgent and emergent nature of a pandemic, as well as for the withdrawal of the policy.

Overview

Effective March 13, 2020, ConnectiCare is expanding our policies around telehealth services for our Medicare Advantage and commercial memberships, making it even easier for patients to connect with their health care provider. Consistent with the Centers for Medicare & Medicaid Services (CMS), ConnectiCare will waive the CMS originating site restriction for Medicare

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Advantage and commercial members, so that health care providers can bill for telehealth services performed while a patient is at home. **Additionally, Medicare Advantage and some D-SNP plans, ConnectiCare already reimburses appropriate claims for several technology-based communication services, including virtual check-ins, which may be done by telephone, for established patients. Exceptions may exist for self-funded plans that opt out.**

Definitions:

Telehealth/Telemedicine: Telehealth services are live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technology. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

What is the difference between telehealth services and telephone calls?
Telehealth services are live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technology. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology. Telephone calls, which are considered audio transmissions, per the CPT definition, are non-face-to-face evaluation and management (E/M) services provided to a patient using the telephone by a Physician or Other Qualified Health Care Professional, who may report evaluation and management services.

Policy Statement:

Commercial and Medicare – Telephone and Telemedicine Services

Telehealth or telephone services are covered when all of the following criteria are met:

1. The patient is present/participates at the time of service.
2. Services should be similar to in-person services with a patient.
3. Services must be medically necessary and otherwise covered under the member's benefit booklet or subscriber agreement.
4. Services must be within the provider's scope of license.
5. A permanent record of the telephonic communication(s) must be documented/maintained as part of the patient's medical record. It must be sufficiently documented to support the code used.
6. Consistent with CMS, the providers' use of certain non-HIPAA compliant technology such as FaceTime and Skype at their discretion and patient consent will not affect reimbursement.
7. Only the provider rendering the services may submit for reimbursement for telehealth services.

Non-Behavioral Health Providers

For non-behavioral health providers, services *provided via telephone only* during a state of emergency or implementation of this policy by ConnectiCare are limited to the following provider types/primary care physician and midlevel primary care providers.
The following provider types may render services

- Physician
- Nurse practitioner
- Physician assistant
- Nurse-midwife
- Clinical nurse specialist

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- Registered dietitian or nutrition professional

Behavioral Health Providers
For behavioral health providers, services *provided via telephone only* during a state of emergency or implementation of this policy by ConnectiCare are limited to the following providers.

- Clinical nurse specialist
- Psychiatrist
- Psychologist
- Clinical social worker
- Licensed Marriage and Family Therapist (not allowed for Medicare)
- Licensed Mental Health Counselor (not allowed for Medicare)

Exclusions:
The following services are excluded from reimbursement:

1. Services rendered through email, text or by fax.
2. Telemedicine that occurs the same day as a face-to-face visit, when performed by the same provider and for the same condition. Services rendered within the past 7 days or 24 hours after telehealth/telemedicine visits will be considered bundled.
3. Patient communications incidental to E/M services, including, but not limited to reporting of test results or provision of educational materials.
4. 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.

Coding

Procedure Code(s) for Telephone Services:
(Covered for both Medicare Advantage and Commercial plans)

CPT Code	Description
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
G2012 (Medicare only)	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

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Procedure Code(s) for Telemedicine Services:

(Covered for both Medicare Advantage and Commercial plans by all provider types)

ConnectiCare requires Place of Service (POS) code 02 for reporting telemedicine services rendered by a physician or practitioner. Place of Service 02 with Modifier GT is required to identify telemedicine services.

CPT Code	Description
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
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. Typically, 5 minutes are spent performing or supervising these services
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused 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 presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and 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 presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed 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 presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive 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. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

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Modifier(s) for Telehealth Services: *Must be used for telemedicine services*

Modifier	Description
CR	Catastrophe/Disaster Related (Reporting only)
GT	Via interactive audio and video telecommunication systems. (must be real-time)

ICD-10-CM Official Coding Guidelines - Supplement Coding Encounters Related to COVID-19 Coronavirus Outbreak

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf
https://www.cdc.gov/nchs/data/icd/Announcement-New-ICD-code-for-coronavirus-3-18-2020.pdf

To ensure proper adjudication please make sure the following are reported if applicable:

ICD-10	Description
Z03.818 *Possible exposure/ruled out*	Encounter for observation for suspected exposure to other biological agents ruled out
Z20.828 *Exposure confirmed*	Contact with and (suspected) exposure to other viral communicable diseases.

Revision history

DATE	REVISION
3/2020	• New Policy