BlueCross BlueShield of Texas

CLINICAL PAYMENT AND CODING POLICY

If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Telemedicine and Telehealth Services

Policy Number: CPCP033

Version 9.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: November 9, 2020

Plan Effective Date: February 12, 2021 (Blue Cross and Blue Shield of Texas Only)

Telemedicine and Telehealth Coverage Expansion in Response to COVID-19

For temporary modifications to payment and coding policies relating to telehealth or telemedicine in response to COVID-19, see:

https://www.bcbstx.com/provider/pdf/tx_using_telemed_telehealth_covid19.pdf

Description

The Plan recognizes federal and state mandates regarding Telehealth and Telemedicine.

The purpose of the Telemedicine Services and Telehealth Services policy is to provide guidance on payment and coding for services that are provided by an eligible healthcare provider to a member when neither is present at the same physical location. These services can be performed through various delivery methods.

Term Descriptions:

Health professional - A physician or an individual who is licensed or certified in the Plan's state to perform a health care service; and is authorized to assist a physician in providing a telemedicine medical service that is delegated and supervised by the physician or a licensed or certified health professional acting within the scope of the license or certification who does not perform the telemedicine medical service.

Physician - A person who is licensed to practice medicine in the Plan's state.

Telehealth service - The use of electronic information and telecommunications technologies to support long distance clinical health care, patient and professional health-related education, public health, and health administration. Typically, telehealth describes provider to provider interaction, or indirect provider to patient interaction.

Telemedicine service - The use of a telecommunication system to provide services for the purpose of evaluation and treatment when the patient is at one location and the rendering provider is at another location.

Delivery Methods:

Interactive electronic telecommunications equipment includes, audio and video equipment permitting two-way, or live video interactive communication between the member and physician or practitioner. Qualified physicians or healthcare professionals should utilize the appropriate communication service described below depending on the type of service needed.

- **Synchronous:** 2-way, live interactive audio and video communications and digital video consultations
- **Asynchronous telecommunication** - Via image and video not provided in real-time (a service is recorded as video or captured as an image; the provider evaluates it later) in connection with a synchronous audio interaction between the practitioner and the patient in another location.
    - **Store and forward** - Technology that stores and transmits or grants access to a member's clinical information for review by a health professional at a different physical location than the person, in connection with a synchronous audio interaction between the practitioner and the patient in another location.
- Other methods allowed by state and federal laws, which can allow members to connect with physicians while reducing the risk of contagion.

Providers can find the latest guidance on acceptable Health Insurance Portability and Accountability (HIPAA) compliant remote technologies issues by the U.S. Department of Health and Human Services' Office for Civil Rights in Action.

Reimbursement Information:

The following requirements must be met for eligible reimbursement unless otherwise agreed upon:

- The provider must maintain complete and accurate medical records including but not limited to start and end times of the telemedicine service or telehealth service; Method of communication must be documented.
- Ensure HIPAA compliant, Federal and State privacy laws are implemented for member communications, recordings and member's records.
- Qualified providers providing telemedicine services must possess the necessary license to treat members of the Plan's state.

Billing/Coding:

Modifiers **G0**, **GT**, **GQ** and **95** are used to describe the technology used during the telemedicine service and telehealth service. The appropriate modifiers must be appended to the HCPCS or CPT code when the telehealth or telemedicine claims are submitted. Additionally, telehealth or telemedicine professional claims submitted on a CMS 1500 form must be submitted with Place of Service (POS) Code '**02**'. POS 02 does **not** apply to originating site facilities when billing a facility fee.

Note: If a claim is submitted using a telemedicine procedure code, the modifier is not necessary. Only codes that are not traditional telemedicine procedure codes require the modifier.

Place of Service (POS) Code 02- **(Telehealth)** Location where health services and health related services are provided or received through a telecommunication system.
Modifier G0: Telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke.
Modifier GT: Via interactive audio and video telecommunications system.
Modifier GQ: Via asynchronous telecommunications system.
Modifier 95: Synchronous telemedicine services rendered via real-time interactive audio and video telecommunications system. Modifier 95 is applicable to certain codes that can be found in AMA, CPT documents. Check current CPT documents for the appendix on **CPT Codes That May Be Used for Synchronous Telemedicine Services**. These procedures codes are billed when electronic communication using interactive telecommunications equipment include, at a minimum, audio and video. In addition, codes that are appropriate for use with modifier 95 are indicated with a star (★) throughout the AMA, CPT codebook.

Facility originating site fees (e.g., Q3014) will not be reimbursed **unless required by state or federal mandate.**

Effective January 1, 2021, the Plan will cover telehealth codes consistent with the Centers for Medicare and Medicaid Services (CMS) and American Medical Association (AMA). Any information regarding the codes covered effective January 1, 2021 supersedes prior schedules, manuals, or other information provided by the plan regarding reimbursement of telehealth or telemedicine codes. Codes referenced in this policy do not guarantee reimbursement for claims. Providers must follow all Plan rules regarding reimbursement.

The CMS and AMA codes may be updated from time to time. Information regarding the codes can be found at:

www.cms.gov

www.ama-assn.org

The plan reserves the right to request supporting documentation. Claim(s) that do not adhere to coding and billing guidelines may be denied. Claims may be reviewed on a case by case basis.

For additional information on telemedicine services or telehealth services or procedures, please check the Plan's website or contact your Network Management Office.

References:

Centers for Medicare and Medicaid Services (CMS) permanent telemedicine codes and/or the American Medical Association (AMA) telemedicine codes may be eligible for coverage.

www.cms.gov

Texas Insurance Code, Title 8, Subtitle F, Chapter 1455 Telemedicine and Telehealth

Texas Occupations Code, Title 3, Subtitle A, Chapter 111 Telemedicine and Telehealth

Senate Bill 1107

Texas Administrative Code, Title 22, Part 9, Chapter 172, Subchapter C

Texas Administrative Code, Title 22, Part 9, Chapter 174, Subchapter A

Policy Update History:

11/9/2020	New policy