Telemedicine Services - Payment Policy

Policy Overview

This policy documents Neighborhood Health Plan of Rhode Island's (Neighborhood) coverage and reimbursement requirements for services rendered by participating providers via telemedicine.

Definition: Telemedicine means the delivery of clinical health-care services by means of real time, two-way electronic audiovisual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health-care delivery, which facilitate the assessment, diagnosis, treatment, and care management of a patient's health care while such patient is at an originating site and the health-care provider is at a distant site. The communication of information exchanged between the physician or other qualified healthcare professional and the patient during the course of the telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via face-to-face interaction.

Scope

This policy applies to **Medicaid** for limited services and **INTEGRITY** for services provided within the scope of licensure as defined by RI EOHHS- CMS contract 2.4.1.10.1.[i]
Commercial lines of business, for services provided within the scope of licensure as defined by R.I.G.L. §27-81.[ii]

Prerequisites

All services must be medically necessary to qualify for reimbursement.

Telemedicine may be used when the provider is at a distant site, and member is present at any of the following originating sites:

- Community Mental Health Center;
- Critical Access Hospital (CAH);
- Federally Qualified Health Center;
- Hospital based/CAH based Dialysis Center;
- Hospitals;
- Member's home;
- Office of physician/practitioner;
- Rural Health Clinic; and
- Skilled Nursing Facility.

Note: Independent Renal Dialysis Facilities are not eligible originating sites.

All services must be medically necessary to qualify for reimbursement.

Coverage is provided for services performed within the scope of state licensure, as defined by the Rhode Island Department of Health.

Service-specific criteria benefit limitations and prior authorizations requirements may apply. For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page: Neighborhood's Prior Authorization Reference Guide
- Neighborhood's Clinical Medical Policies. In the absence of a clinical medical policy, Neighborhood utilizes industry standard evidenced-based clinical review criteria.

Please contact Utilization Management at (401) 459-6060 for additional details.

The benefit limitations outlined in Neighborhood's service-specific Coverage and Reimbursement policies, Clinical Medical Policies, and certificates of coverage apply to all services rendered by telemedicine as if they were provided face-to-face.

Prior authorization requirements vary by line of business and services provided.

The following services require Prior Authorization:

- Neurobehavioral status exam.

Reimbursement Guidelines

INTEGRITY

The originating sites authorized for telemedicine is limited to:

- Outpatient Office Visits
- Hospitals including Critical Access Hospitals (CAHs)
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospital based Renal Dialysis Centers
- Skilled Nursing Facilities
- Community Mental Health Centers

An originating site is the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:

- A county outside of a Metropolitan Statistical Area (MSA) or
- A rural Health Professional Shortage Area (HPSA) located in a rural census tract

Coverage for services provided by telemedicine is limited to the following provider types:

- Clinical nurse specialist (CNS);
- Clinical social worker (CSW);
- Nurse Midwife;
- Nurse practitioner (NP);
- Physician assistant (PA);

- Physician;
- Clinical Psychologist; and
- Registered dietician.

Coverage for services provided by telemedicine:

- Subsequent hospital services are limited to 1 telehealth visit every 3 days.
- Subsequent nursing facility care services are limited to 1 tele heath visit every 30 days.

Coverage requirements for telemedicine services includes the use of an interactive audio and video telecommunications system that permits real-time communication between you, at the distant site, and the beneficiary, at the originating site.

Asynchronous "store and forward" technology, the transmission of medical information the physician or practitioner at the distant site reviews at a later time, is permitted only in Federal telemedicine demonstration programs in Alaska or Hawaii.

Commercial Lines of Business

Neighborhood provides coverage for limited services when delivered through telemedicine, as defined by the Telemedicine Coverage Act (the Act), effective 1/1/2018.

In accordance with the Act, services provided through telemedicine must utilize HIPAA compliant real time, two-way, secure audiovisual video conferencing or store-and-forward technology.

To be considered compliant, at a minimum, the technology must:

- Use an encryption software for data transmission;
- Have a secure access portal with multi-level authentication, individual user credentials, and defined user access.

Providers are required to obtain informed member consent and provide a description of the potential benefits, risks, and consequences of receiving services through telemedicine. Treatment must meet the same standard of care as, and be an appropriate substitute for, a face-to-face encounter.

Coverage for services provided by telemedicine is limited to the following provider types:

- Clinical nurse specialist (CNS);
- Clinical social worker (CSW);
- Licensed Marriage and Family Therapist (LMFT);
- Licensed Mental Health Counselor (MHC);
- Nurse Midwife;
- Nurse practitioner (NP);
- Physician assistant (PA);
- Physician;
- Psychiatrist;
- Psychologist; and
- Registered dietician.

Claim Submission

Billable services are subject to contractual agreements and must meet timely filing requirements to be considered for reimbursement.

Telemedicine is not considered a distinct benefit and is covered as a place of service. Place of Service (POS) 02 must be on the claim to indicate that the service was delivered via telemedicine.

Claims must include modifier "95", defined as: Synchronous telemedicine service rendered via real-time interactive audio and video telecommunication system.

Professional claims for telehealth services no longer require the GT modifier to be billed as of 1/1/18.

Professional telehealth services coded with the GQ modifier (asynchronous telecommunications system), shall approve services only if the physician or practitioner is affiliated with a Federal telemedicine demonstration conducted in Alaska or Hawaii.

Institutional claims for telehealth services, billed under Critical Access Hospital (CAH), require the GT modifier.

Adjustments, corrections, and reconsiderations must include the required forms. All submissions must be in compliance with national claims standards.[iii]

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.[iv]

Member Responsibility

Commercial plans include cost sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost sharing obligations or contact Member Services prior to finalizing member charges.

Disclaimer

This guideline is informational only, and not a guarantee of reimbursement.

Claim payments are subject to Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. All services billed to Neighborhood for reimbursement are subject to audit.

Effective dates noted reflect the date the long standing policy was documented or updated to assist with provider education, unless otherwise noted. Neighborhood reserves the right to update this policy at any time.

Document History

Date	Action
12/31/2018	Policy effective.

References

[i] RI EOHHS CMS contract §2.4.1.10.1
[ii] R.I.G.L. §27-81
[iii] National Uniform Claims Committee
[iv] AMA CPT Editorial Panel; CMS ICD-10-CM; AAPC HCPCS Level II