REIMBURSEMENT POLICY STATEMENT
INDIANA MEDICAID

Original Issue Date	Next Annual Review	Effective Date
02/22/2018	07/15/2019	07/15/2018
Policy Name		**Policy Number**
Telemedicine Services		PY-0111
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.

Contents of Policy

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

- **Distant Site** – Is the location of the physician or provider rendering consultation services.
- **Interactive Television (IATV)** – Is videoconferencing equipment at the distant and originating sites that allows real-time, interactive, and face-to-face consultation.
- **Originating Site** – Is the location where the patient is physically located when services are provided.
- **Store and Forward** – Is the electronic transmission of medical information for future review by another health care provider.
- **Place of Service Codes** (POS) - These codes specifically indicate where a service or procedure was performed.
- **Telemedicine** – Is the use of videoconferencing equipment, to allow a medical provider, to render an exam or other service to a patient at a distant location.
- **Telehealth services** - Is the scheduled remote monitoring of clinical data through technologic equipment in the member's home. Data is transmitted from the member's home to the home health agency to be read and interpreted by a registered nurse (RN). The technologic equipment enables the home health agency to detect minute changes in the member's clinical status, which allows home health agencies to intercede before the member's condition advances and requires emergency intervention or inpatient hospitalization.

Note: Telemedicine is not the use of the following.
1. Telephone transmitter for trans-telephonic monitoring; or
2. Telephone or any other means of communication for consultation from one provider to another

Note: "Telemedicine" is sometimes used interchangeably with "telehealth" 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 the Indiana Medicaid guidelines found in the Indiana Medicaid provider manual and using appropriate CPT and/or HCPCS and modifier codes.

III. Telemedicine services may be rendered in an inpatient, outpatient, or office setting.

IV. In any telemedicine encounter, there will be the following:
   A. A distant site
   B. An originating site
   C. An attendant to connect the patient to the specialist at the distant site
   D. Videoconferencing equipment (computer or television monitor) to allow the patient to have:
      1. Real-time
      2. Interactive; and
      3. Face-to-face; communication with the distant specialist/consultant via IATV technology.

   Note: Store-and-forward technology is allowed by CareSource, however, separate reimbursement of the originating site payment is not provided for store-and-forward technology because of restrictions in *405 IAC 5-38-2(4)*. Only IATV is separately reimbursed by Caresource.

V. The following service or provider types cannot be directly reimbursed by CareSource for telemedicine, per *405 IAC 5-38-4(6):*
   A. Ambulatory surgical centers
   B. Home health agencies or services
   C. Outpatient surgical services
   D. Radiological services
   E. Laboratory services
   F. Long-term care facilities, including nursing facilities, intermediate care facilities, or community residential facilities for the developmentally disabled
   G. Anesthesia services or nurse anesthetist services
   H. Audiological services
   I. Chiropractic services
   J. Care coordination services
   K. Durable medical equipment (DME), medical supplies, hearing aids, or oxygen
   L. Optical or optometric services
   M. Podiatric services
   N. Services billed by school corporations
   O. Physical or speech therapy services
   P. Transportation services
   Q. Services provided under a Medicaid waiver

VI. CareSource reimburses for telemedicine services only when the following conditions are met:
   A. The member must be physically present at the originating site and able to participate in the visit.
   B. For a medical professional to receive reimbursement for professional services in addition to payment for originating services, medical necessity must be documented. If it is medically necessary for a medical professional to be with the member at the originating site, the originating site is permitted to bill an evaluation and management code in

addition to the fee for originating services. Adequate documentation must be maintained

in the patient's medical record to support the need for the provider's presence at the originating site during the visit. Documentation is subject to post payment review.

C. The audio and visual quality of the transmission must meet the needs of the physician located at the distant site. The IATV technology must meet generally accepted standards to allow the physician at the distant site to render medical decisions.

VII. Documentation must be maintained at the distant and originating locations to substantiate the services provided. Documentation must indicate that the services were rendered via telemedicine and must clearly identify the location of the distant and originating sites.

VIII. Special Considerations

A. The following special circumstances apply to telemedicine services:
   1. When ongoing services are provided, the member should be seen by a physician for a traditional clinical evaluation at least once a year. In addition, the distant physician should coordinate with the patient's primary care physician.
   2. The existing service limitations for office visits are applicable. All telemedicine consultations billed are counted against the office visit limit.
   3. Although reimbursement for ESRD-related services under HCPCS codes 90951–90970 is permitted in the telemedicine setting, the Caresource requires at least one monthly visit for ESRD-related services to be a traditional clinical encounter to examine the vascular access site.

IX. Telemedicine Services for FQHCs and RHCs

A. Subject to the following criteria, reimbursement is available to FQHCs and RHCs when they are serving as either the distant site or the originating site for telemedicine services.
B. When serving as the distant site (the location of the physician or provider rendering services), the service provided at the FQHC or RHC must meet both the requirements of a valid encounter and an approved telemedicine service. Reimbursement is based on the prospective payment system (PPS) rate specific to the FQHC or RHC facility.
C. When serving as the originating site (the location where the patient is physically located), an FQHC or RHC may be reimbursed if it is medically necessary for a medical professional to be with the member, and the service provided includes all components of a valid encounter code. Reimbursement is based on the PPS rate specific to the FQHC or RHC facility.
D. All components of the service must be provided and documented, and the documentation must demonstrate medical necessity. All documentation is subject to post payment review.
E. Separate reimbursement for merely serving as the originating site is not available to FQHCs and RHCs.

Note: An encounter is defined by the Centers for Medicare & Medicaid Services (CMS) as a face-to-face meeting between an eligible provider and a Medicaid member during which a medically necessary service is performed. Consistent with federal regulations, for an FQHC or RHC to receive reimbursement for services, including those for telemedicine, the criteria of a valid encounter must be met.

X. Telehealth Services

A. CareSource covers telehealth services provided by home health agencies.
B. In any telehealth services encounter, a licensed RN must read the transmitted health information provided from the member, in accordance with the written order of the physician.
C. To qualify for telehealth services, the member must be receiving or approved for other CareSource home health services.

D. Telehealth services are indicated for members who require scheduled remote monitoring of data related to the member's qualifying chronic diagnoses that are not controlled with medications or other medical interventions.
E. To initially qualify for telehealth services, the member must have had two or more of the following events within the previous 12 months:
   1. Emergency room visits
   2. Inpatient hospital stays
F. The two qualifying events must be for the treatment of one of the following diagnoses:
   1. Congestive heart failure
   2. Chronic obstructive pulmonary disease
   3. Diabetes

Note: An emergency room visit that results in an inpatient hospital admission does not constitute two separate events.

G. After initially qualified, to continue receiving telehealth services, the member must have a current diagnosis of one of the previous qualifying diagnoses and continue to receive other home health services.
H. Approved telehealth services are reimbursed separately from other home health services.
   1. The initial visit is limited to a one-time visit to educate the member or caregiver about how to properly operate the telehealth equipment.
   2. A remote skilled nursing visit cannot be billed on the same date of service that a member received a skilled nursing visit in the home.
   3. The telehealth reading should be included in the skilled nursing home visit when the reading and the home visit are performed on the same day.

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 Indiana Medicaid fee schedule.

- **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 source for the most current coding information.**

CPT Codes	Definition
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
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
90846	Family Psychotherapy w/o patient – 50 minutes
90847	Family psychotherapy (conjoint, w/ patient present) – 50 minutes
90849	Multiple-family group psychotherapy
90853	Group Psychotherapy (not multi-family group)
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.
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.
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
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).

99600	Unlisted home visit service or procedure
H0004	SUD Individual Counseling
H0005	SUD Group Counseling
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

Note: Modifier GT or 95 - must be used to denote telemedicine services. The payment amount for a telemedicine service is equal to the current Fee Schedule amount for the procedure code billed.

F. RELATED POLICIES/RULES

N/A

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	02/22/2018	New Policy.
Date Revised		
Date Effective	07/15/2018	
Archive Date	03/05/2021	

H. REFERENCES

1. Medical Policy Manual. (2017, January 1).
2. Telemedicine and Telehealth Services. (2016, September 20).

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