Blue Cross Blue Shield of Michigan

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Blue Cross Blue Shield of Michigan
Medical Policy

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Enterprise:	Blue Cross Blue Shield of Michigan
Department	Medical Affairs
Effective Date:	January 1, 2016
Next Review Date	1st Quarter of 2019

Telemedicine

Background:

Telehealth and telemedicine are terms that are frequently used interchangeably. For this policy, Telehealth is an umbrella term used to describe all the possible variations of healthcare services and health care education using telecommunications. Telehealth allows for health care services such as telemedicine, telemonitoring, store and forward in addition to healthcare education for patients and professionals, and related administrative services.

Telemedicine, a subset of telehealth, is the use of telecommunications technology for real time, medical diagnostic and therapeutic purposes when distance separates the patient and healthcare provider. Many have advocated the use of telemedicine to improve health care in rural areas, in the home and in other places where medical personnel are not readily available. Telemedicine may substitute for a face-to-face, hands-on encounter between a patient and the healthcare provider when using the appropriate technology.

The use of telecommunications to support a clinical decision can incorporate patient data collected and reviewed immediately, such as clinician interactive, or reviewed later when the patient is no longer available such as telemonitoring or store and forward.

- **Clinician Interactive** – An electronically based, real time clinician-patient encounter where the patient and healthcare provider are in different locations. This virtual encounter can either be audio only or audio visual. The virtual encounter can also be hosted. A hosted visit is a virtual consult with a remote health care provider hosted by a provider who is face to face with the patient. Certain clinical scenarios will dictate the use of a hosted visit, so as to minimize risk to the patient and maximize the clinical outcome. For example, when a patient presents to the emergency room with acute stroke symptoms and the neurology specialist is not on site, the emergency room physician hosts a consult with the remote neurologist in a real time encounter.

An online visit is a type of low complexity clinician interactive visit that requires an audio visual online communication. The patient initiates the medical **or behavioral health** evaluation. The visit is typically straight forward decision making that addresses urgent but not emergent clinical conditions. At the point of making decisions regarding diagnosis and/or treatment, the provider does not require face to face contact to make an optimal decision. **It is not anticipated that a follow-up encounter is required.**

Examples of an online visit would include, but are not limited to:
Upper respiratory infections such as colds, sore throat runny nose, sinus congestion; ear aches; gastrointestinal mild distress such as GERD, diarrhea, nausea, constipation; skin disorders such as itching, rash, limited cuts; joint irritations such as aches, stiffness; headaches that are simple and uncomplicated; seasonal allergies, hay fever; urinary tract infections; acute situational anxiety.

- **Store and Forward** - The asynchronous transmission of medical information to be reviewed at a later time by a physician or practitioner at the distant site. A store and forward process eliminates the need for the patient and clinician to be present at the same time and place. Data that is sent to a remote clinician and interpreted in real time is not store and forward. For example, a radiologist reading a study for the emergency room remotely is not considered store and forward since the clinical decision is occurring in real time.

- **Telemonitoring** - Services that enable providers to monitor test results, images and sounds that are usually obtained in a patient's home or a care facility. Post-acute care patients, patients with chronic illnesses and patients with conditions that limit their mobility often require close monitoring and follow-up. These types of programs use various strategies to monitor patients while reducing the need for face-to-face visits. An example is remote blood pressure monitoring in the home reported electronically to the provider. Telemonitoring is considered an asynchronous encounter.

Medical Policy Statement:

The safety and effectiveness of telemedicine has been established. It may be considered a useful diagnostic and therapeutic option when indicated. The restriction limiting the originating site to a rural health professional shortage area or in a county outside of a metropolitan statistical area is no longer required.

Inclusion Criteria: Telemedicine Services

- The provider must be licensed, registered, or otherwise authorized to perform service in their health care profession in the state where the patient is located. The provider is not required to be located in the state of Michigan. Services must fall within their scope of practice.
- Telemedicine delivered services are available to all clinicians, however, it may not be the preferred method of delivery in certain clinical scenarios, for example chronic suicidal ideation or unstable angina. A hosted visit may be necessary due to the complexity of the clinical situation.

- Telemedicine delivered services for ongoing treatment of a condition that is chronic and/or is expected to take more than 5 sessions before the condition resolves or stabilizes may require a hosted visit or a face-to-face encounter during the active treatment period and should not be considered for an “on line visit”. The clinician providing telemedicine services cannot be considered the host. The clinician providing the telemedicine services can provide the face to face encounter.

- The service must be conducted over a secured channel with provisions described in Policy Guidelines.

- The delivery of the service can be either audio only such as telephone or audio/video such as a secured computer based system. Applicable modifiers should be attached to reflect how the service is delivered. See below for details of modifiers.

Online Visit Services – A Specific Type of Telemedicine

  - An audio visual online communication
  - The patient initiates the medical or behavioral health encounter
  - A low complexity, straight forward decision making encounter that addresses urgent but not emergent clinical conditions
  - It is not anticipated that a follow-up encounter is required
  - The provider must be licensed, registered, or otherwise authorized to perform service in their health care profession in the state where the patient is located. The provider is not required to be located in the state of Michigan. Services must fall within their scope of practice.

- **Eligible providers may include:**
  - MD/DO
  - Certified nurse midwife
  - Clinical nurse practitioner
  - Clinical psychologist
  - Clinical social worker
  - Physician Assistant

Exclusions:

- Telemonitoring
- Email only communication
- Facsimile transmission
- Text only communication
- Request for medication refills
- Reporting of normal test results
- Provision of educational materials
- Scheduling of appointments and other healthcare related issues
- Registration or updating billing information
- Reminders for healthcare related issues
- Referrals to other providers
- Any Online or telemedicine visit resulting in an office visit, urgent care or emergency care encounter on the same day for the same condition
- Any Online visit for the same condition originating from an Online visit within the previous seven days
- Any Online or telemedicine visit occurring during the post-operative period

Modifiers/Place of Service

When the nomenclature of the CPT code does not specify how the service is being delivered, than a modifier is required to clarify this. Whenever a service is delivered via telehealth, the place of service 02 must be submitted.

95 - Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System

GQ - Via asynchronous telecommunications system

POS 02 – Telehealth – The location where health services and health related services are provided or received, through telecommunication technology.

Billing Changes		
	Modifier GT 95	Place of Service 02 -Telehealth 3 - Office
Online Codes 99444 and 98969	NO	02-Telehealth
Telephone codes 99441-99443 and 98966 – 98968	NO	02-Telehealth
CPT Codes Audio and Visual	Yes	02-Telehealth
Crisis Codes 90839 and 90840 on the telephone	NO	02-Telehealth

When care is delivered virtually meaning by telemedicine, you must identify this using a modifier and/or place of service.

1. When care is delivered using a secure audio and video transmission, append modifier GT or 95, and place of service 02.
2. When care is delivered using a secure telephone transmission do not append either modifier GT or 95, only submit place of service 02.
3. When an “online visit” is delivered and the CPT code 99444 or 98969 is submittyed, a place of service 02 should be submitted. A modifier is not necessary since the description or the code identifies how the service is delivered.

Established Codes

All codes specific to scope of practice.

Rationale:

According to the State of Michigan legislative act released in 2012 the definition of telemedicine and associated requirements were established. So, telemedicine means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine, the health care professional must be able to examine the patient via a real time, interactive audio or video or both, telecommunications system and the patient must be able to interact with the off-site health care professional at the time the services are provided.

Michigan, along with almost half of the other states in the country, currently mandates coverage for telemedicine services. Policy makers seek to reduce healthcare delivery problems, contain costs, improve care coordination, and alleviate provider shortages. Many are using telemedicine to achieve these goals.

Since 2012 the number of states with parity laws; those are laws that require private insurers to cover telemedicine in provided services comparable to that of in person, has doubled. Michigan adopted a parity law in 2012. Also, BCBSM has decided to remove the originating site requirement from our telemedicine policy. As a result, providers are eligible to deliver telemedicine services that are consistent with their scope of practice.

Telemedicine enables providers to extend their reach and improve their efficiency and effectiveness while still maintaining high quality care and attention to patient safety. Recognition of both the benefits and inherent limitations of care delivery via telemedicine remains the ultimate responsibility of the provider.

Telemedicine technologies should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. Telemedicine supports a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling physician-to- patient communications. For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider’s identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be

unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

There is evidence that telemedicine technology can work, and can be used beneficially from a clinical and economic standpoint. While there are many promising initiatives underway, there are few mature telemedicine programs and few good scientific evaluations. There is still some need to work collaboratively to identify best practices. For example, even though psychotherapy can be delivered via telecommunications and fit within the definition of an online visit, ongoing psychotherapy may not be a best practice.

Telemedicine services for mental health are one of the most active applications of telemedicine rendered in the United States. Mental health services often rely upon more subtle and detailed observations of speech, behavior and affect and often require, therefore, the most advanced communications and internet technologies for the delivery of care. By using advanced communication technologies, mental health professionals are able to widen their reach to patients in a cost effective manner, ameliorating the maldistribution of specialty care.

Historically, the originating site might include the following:

- Hospital outpatient departments
- Inpatient hospitals
- Physician or practitioner office
- Rural health clinic
- Critical access hospitals
- Federally qualified health centers

When the originating site was required, a medical professional could be present to present the patient to the clinician at the distant site when medically necessary. The determination of medical necessity was made by the clinician at the distant site. With the removal of the originating site requirement, it is possible that there are still clinical scenarios when the clinician may think it is medically necessary to present the patient to the physician at the distant site. The decision to do this will not be required but it is understood it may occur. For example, certain services, such as psychotherapy or acute life threatening medical conditions, may be restricted to originating clinical sites where the patient can be monitored or assisted by an onsite provider. Mental health services in settings other than an originating site should be limited to stable patients with limited straight forward needs. Patients with acute psychiatric needs may not be candidates for telemedicine. Similarly, patients requiring ongoing psychotherapy beyond crisis resolution are not typically good candidates for telemedicine, at least not without an originating site. Any ongoing psychotherapy (that expected to require more than 5 visits) should be delivered face-to-face whenever possible.

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underway, there are few mature telemedicine programs and few good scientific evaluations. There is still some need to work collaboratively to identify best practices.

Policy Guidelines when applicable:

A secured electronic channel must include and support all of the following for audio and audio/ visual encounters:

1. The electronic channel must be secure, with provisions for privacy and security, including encryption, in accordance with HIPAA guidelines.
2. A mechanism must be in place to authenticate the identity of correspondent(s) in electronic communication and to ensure that recipients of information are authorized to receive it.
3. The patient's informed consent to participate in the consultation must be obtained, including discussing appropriate expectations, disclaimers and service terms, and any fees that may be imposed. Expectations for appropriate use must be specified as part of the consent process including use of specific written guidelines and protocols, avoiding emergency use, heightened consideration of use for highly sensitive medical topics relevant to privacy issues.
4. The name and patient identification number is contained in the body of the message, when applicable.
5. A standard block of text is contained in the provider's response that contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies, when applicable.
6. A record of online communications descriptive of the online visit should be made available to the patient if requested.

Related Policy:

N/A

Government Regulations:

National: CMS, 42CFR, Payment for Part B Medical and Other Health Services, 414.65 Payment for Telehealth Services, 11/1/01, last update 11/25/09.

CMS Manual System, List of Medicare Telehealth Services, Pub. 100-04, Medicare Claims Processing, Transmittal 517, April 1, 2005, change request 3747.
CMS telehealth guidelines indicated as in Appendix A

Local:

There is no local coverage determination for Telemedicine.

Michigan Department of Community Health:

Michigan Department of Community Health; Telemedicine Database, January 2015

Note: Contract and group coverage may vary. Please check individual contract, certificate and rider for specific coverage information.

Scope:

This policy applies to all Underwritten contracts and Self-funded or ASC contracts will apply, pending customer approval.

BCBSM Policy History

Policy Effective Date	BCBSM Signature Date	Comments
01/01/2016	10/27/2015	BCBSM medical policy established • Telemedicine and online visit policies combined. • JUMP medical policy retired.
01/01/2016	1/19/2017	Annual review – Added Modifier 95; Removed the MDCH and CMS telehealth information and listed as a reference.
01/01/2016		Annual review – Policy changes were added.

References:

1. American College of Physicians “e- Health and its Impact on Medical Practice - A Position Paper” 2008
2. Clancy, Carolyn, MD, Director AHRQ, “Telemedicine Activities at the Department of Health and Human Services,” Before the Subcommittee on Health Committee on Veterans Affairs, May 18, 2005, < http://www.ahrq.gov/news/test51805.htm > (December 7, 2009).
3. CMS, 42CFR, Supplementary Medical Insurance Benefits, 410.78 Telehealth Services, 11/1/2001, last update 11/25/09.

4. CMS, 42CFR, Payment for Part B Medical and Other Health Services, 414.65Payment for Telehealth Services, 11/1/01, last update 11/25/09.
5. CMS Manual System, List of Medicare Telehealth Services, Pub. 100-04, Medicare Claims Processing, Transmittal 517, April 1, 2005, change request 3747.
6. Evidence Report/ Technology Assessment, Telemedicine for the Medicare Population, Number 24, AHRQ Publication Number 01-E011, February 2001. http://www.ahrq.gov/clinic/epcsums/telemedsum.htm > (December 7, 2009)
7. HAYES Medical Technology Directory, “Telephone intervention for depression,” Lansdale, PA: HAYES, Inc., September 3, 2008.
8. HAYES Medical Technology Brief, “Electronic intensive care unit (ICU) use and patient outcomes," Lansdale, PA: HAYES, Inc., August 21, 2008.
9. HAYES Search and Summary, "Telephone intervention for depression," Lansdale, PA: HAYES, Inc., August 17, 2009.
10. HAYES Search and Summary, "Electronic intensive care unit (ICU) use and patient outcomes," Lansdale, PA: HAYES, Inc., September 15, 2009.
11. American Telemedicine Association “Practice Guidelines for Videoconferencing-Based Telemental Health” October 2009
12. Michigan Common Law-500-3476 - THE INSURANCE CODE OF 1956 (EXCERPT)
13. American Telemedicine Association “State Telemedicine Gaps Analysis, Coverage and Reimbursement” - September 2014, page 4
14. Federation of State Medical Boards “Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine” – April 2014, page 3
15. Medicare Managed Care Manual Chapter 4 - Benefits and Beneficiary Protections 30.3 – Examples of Eligible Supplemental Benefits
16. CY Medicare Telehealth Services; Appendix A
17. Michigan Department of Community Health; Telemedicine Database, January 2015, Appendix B