Blue Cross Blue Shield of Massachusetts (Blue Cross*) reimburses contracted health care providers for covered, medically necessary telehealth (telemedicine) services.

In line with Chapter 224 of the Acts of 2012, Blue Cross defines telemedicine as the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. Telehealth (telemedicine) does not include the use of audio-only telephone, fax machine, or email.

Blue Cross providers must deliver telehealth (telemedicine) services via a secure and private data connection. All transactions and data communication must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA). For more information on HIPAA and electronic protected health information compliance, please see: hhs.gov/ocr/privacy/hipaa/understanding/srsummary.html.

**Asynchronous telecommunication**
Medical information is stored and forwarded to be reviewed at a later time by a physician or health care practitioner at a distant site. The medical information is reviewed without the patient being present. Asynchronous telecommunication is also referred to as store-and-forward telehealth or non-interactive telecommunication.

**Interactive audio and video telecommunication**
Medical information is communicated in real-time with the use of interactive audio and video communications equipment. The real-time communication is between the patient and a distant physician or health care specialist who is performing the service reported. The patient must be present and participating throughout the communication.

**Telehealth**
Telehealth is a broader term which includes telemedicine.

**General benefit information**
Covered services and payment are based on the member’s benefit plan and provider Agreement. Providers and their office staff may use our online tools to verify effective dates and member copayments before providing services. Visit our eTools page for information on member eligibility and benefits. Member liability may include, but is not limited to: copayments, deductibles, and co-insurance. Members’ costs depend on member benefits.

Certain services require prior authorization or referral.

**Payment information**
Blue Cross reimburses health care providers based on your contracted rates and member benefits.

Claims are subject to payment edits, which Blue Cross updates regularly.

**Blue Cross reimburses:**
- Certain evaluation and management codes when submitted with modifier GT or modifier 95 as listed in the billing information section below. Effective January 1, 2019, modifier G0 may be submitted.
  - Office or other outpatient visit for the evaluation and management of a new patient. Typically, ten minutes are spent face-to-face with the patient or family
  - Office or other outpatient visit for the evaluation and management of an established patient. Typically, five minutes are spent performing or supervising these services
  - Office or other outpatient visit for the evaluation and management of an established patient. Typically, ten minutes are spent face-to-face with patient or family
- Certain behavioral health codes as defined in the Telehealth (Telemedicine) – Behavioral Health Payment Policy.

**Blue Cross does not reimburse:**
Telehealth (Telemedicine) – Medical Payment Policy

- Asynchronous telecommunication
- Costs associated with enabling or maintaining contracted providers’ telehealth (telemedicine) technologies
- Interprofessional telephone or internet consultations
- Online medical evaluation
- Telephone services
- Any services not defined with modifier GT, 95, or G0

General reimbursement information:
- Modifier GT, 95, and G0
  - Practitioners must use modifier GT or 95 (via interactive audio and video telecommunications systems) or modifier G0 to differentiate a telehealth (telemedicine) encounter from an in-person encounter with the patient.
  - When reporting modifier GT, 95, or G0, the practitioner is attesting that services were rendered to a patient via an interactive audio and visual telecommunications system.
- Reimbursement
  - Reimbursement for telehealth (telemedicine) services is calculated using a reduced Practice Expense Relative Value Unit (RVU). See the CPT and HCPCS Modifiers Payment Policy for additional information.
- Telehealth (telemedicine) services are reimbursed when the following criteria are met:
  - The provider is contracted with Blue Cross Blue Shield of Massachusetts or is providing services through a telehealth or telemedicine vendor contracted with another Blue Cross Blue Shield Plan, and meets all terms and conditions of the applicable contracts, including credentialing and licensure.
  - The provider renders care from the location listed in his or her contract with Blue Cross Blue Shield of Massachusetts or other appropriate location(s) within Massachusetts, in a professional, non-public space.

Billing information

Specific billing guidelines
The list of codes below is included for informational purposes only. This may not be a complete list of all the codes related to this service. Whether or not a code is listed here does not guarantee coverage or reimbursement.

- The following codes are reimbursable when submitted with either modifier GT or 95. Effective January 1, 2019, modifier G0 may be submitted. Any other codes submitted with modifier G0, GT, or 95 will be denied.
- Services rendered must fall within the scope of the provider’s license.

<table>
<thead>
<tr>
<th>Code</th>
<th>Service description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Modifiers</strong></td>
<td></td>
</tr>
<tr>
<td>GT</td>
<td>Via interactive audio and video telecommunication systems</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Synchronous teledicine service rendered via a real-time interactive audio and video telecommunication system</td>
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</tr>
<tr>
<td>G0</td>
<td>Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CPT and HCPCS codes</strong></td>
<td></td>
</tr>
<tr>
<td>98966</td>
<td>Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>98967</td>
<td>Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>Code</td>
<td>Service description</td>
<td>Comments</td>
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<tr>
<td>98968</td>
<td>Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>98969</td>
<td>Online assessment and management service provided by a qualified non-physician health care professional to an established patient or guardian, not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>99201</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient. Typically, 10 minutes are spent face-to-face with the patient and/or family.</td>
<td>Reimbursable with modifiers GT, 95 or G0</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient. Typically, 5 minutes are spent performing or supervising these services.</td>
<td>Reimbursable with modifiers GT, 95 or G0</td>
</tr>
<tr>
<td>99212</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient. Typically, 10 minutes are spent face to face with patient and/or family</td>
<td>Reimbursable with modifiers GT, 95 or G0</td>
</tr>
<tr>
<td>99441</td>
<td>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</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>99442</td>
<td>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</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>99443</td>
<td>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</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>99444</td>
<td>Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the internet or similar electronic communications network</td>
<td>Not reimbursed</td>
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<tr>
<td>99451</td>
<td>Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>99452</td>
<td>Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>Code</td>
<td>Service description</td>
<td>Comments</td>
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<tr>
<td>G2010</td>
<td>Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, 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</td>
<td>Not reimbursed</td>
</tr>
</tbody>
</table>

When submitting claims, report all services with:
- Up-to-date, industry-standard procedure and diagnosis codes, and
- Modifiers that affect payment in the first modifier field, followed by informational modifiers

**Related policies**

- CPT and HCPCS Modifiers
- Behavioral Health and Substance Use
- Evaluation and Management
- General Coding and Billing
- Non-Reimbursable Services
- Telehealth (Telemedicine) - Behavioral Health

**Policy update history**

- **10/01/2015** Documentation of policy
- **01/01/2016** Effective date for reimbursement of the following codes when submitted with modifier GT: 90791, 90832, 99201, 99211, and 99212
- **07/01/2016** Addition of the following codes eligible for reimbursement when submitted with modifier GT: effective 07/01/2016: 90833, 90834, 90836, 90837, and 90838
- **01/01/2017** Annual review; template update; addition of information on modifier 95 effective 01/01/2017
- **01/01/2018** Annual review; inclusion of information on provider reimbursement criteria
- **03/31/2018** Policy renamed Telemedicine – Medical. Please refer to the Telemedicine – Behavioral Health Payment Policy for additional telemedicine reimbursement information
- **06/01/2018** Policy renamed Telehealth (Telemedicine) – Medical
- **12/31/2018** Annual coding update; inclusion of 99451-99452, G2010 and modifier G0
- **03/31/2019** Annual review; addition of modifiers GT, 95, and G0 to the coding grid; addition of related policies
- **06/30/2019** Edits for clarity on reimbursement criteria for telemedicine services

This document is for informational purposes only and is not an authorization, an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.

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Payment policies are intended to help providers obtain Blue Cross Blue Shield of Massachusetts’ payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy development takes into consideration a variety of factors, including: the terms of the participating provider’s contract(s); scope of benefits included in a given member’s benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

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