Telehealth (Telemedicine) – Medical
Payment Policy

MASSACHUSETTS

Policy

Blue Cross Blue Shield of Massachusetts (Blue Cross*) reimburses contracted 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 (EPHI) compliance, please see: http://www.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

Services and subsequent payment are based on the member's benefit plan and provider Agreement. Providers and their office staff may use our electronic technologies to verify effective dates and members' copayments before initiating services. Please visit our eTools page to access links that provide information on member eligibility and benefits. Member liability may include, but is not limited to copayments, deductibles, and co-insurance and will be applied depending upon the member's benefit plan.

Certain services may require prior authorization or referral(s). Please refer to the member's subscriber certificate for more information and Authorization Requirements by Product.

Payment Information

Blue Cross reimburses health care providers based on:
- Network provider reimbursement or contracted rates
- 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 1/1/19 modifier G0 may be submitted.
  - 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
  - Office or other outpatient visit for the evaluation and management of an established patient. Typically, 5 minutes are spent performing or supervising these services
  - 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
- Certain behavioral health codes as defined in the Telehealth (Telemedicine) – Behavioral Health Payment Policy.

Blue Cross does not reimburse:

- 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 GT modifier or 95 modifier

General reimbursement information:

- Modifier GT and modifier 95 (Effective 1/1/19 modifier G0 may be submitted.)
    - Practitioners must use modifier GT or modifier 95 (via interactive audio and video telecommunications systems) to differentiate a telehealth (telemedicine) encounter from an in-person encounter with the patient.
    - When reporting modifier GT, 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 (PE) 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 and 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/her contract with Blue Cross and Blue Shield of Massachusetts and, where contractually specified, in accordance with the requirements regarding a professional, non-public space.

Billing Information

Specific billing guidelines

- The following codes are reimbursable when submitted with modifier GT or modifier 95. Effective 1/1/19 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. The absence or presence of a procedure code or service does not imply or guarantee coverage or reimbursement.

Code	Service description	Comments
98966	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	Not reimbursed
98967	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	Not reimbursed
98968	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	Not reimbursed

Code	Service description	Comments
98969	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	Not reimbursed
99201	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.	Reimbursable with modifier GT or modifier 95. Effective 1/1/19 reimbursable with modifier G0.
99211	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 5 minutes are spent performing or supervising these services.	Reimbursable with modifier GT or modifier 95. Effective 1/1/19 reimbursable with modifier G0.
99212	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	Reimbursable with modifier GT or modifier 95. Effective 1/1/19 reimbursable with modifier G0.
99441	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	Not reimbursed
99442	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	Not reimbursed
99443	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	Not reimbursed
99444	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	Not reimbursed
99451	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	Not reimbursed
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes	Not reimbursed
G2010	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	Not reimbursed

When submitting claims for reimbursement, report all services with:

- Up-to-date industry-standard procedure and diagnosis codes
- Modifiers that affect payment in the first modifier field, followed by informational modifiers

Related Policies

Telehealth (Telemedicine) - Behavioral Health
Behavioral Health and Substance Abuse
Evaluation and Management
General Coding and Billing
CPT and HCPCS Modifiers

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 to Telemedicine – Medical. Please refer to the Telemedicine – Behavioral Health Payment Policy for additional telemedicine reimbursement information.
06/01/2018	Policy renamed to Telehealth (Telemedicine) – Medical.
12/31/2018	Annual coding update; inclusion of 99451-99452, G2010 and modifier G0.

Payment policies are intended to assist providers in obtaining 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 formulation 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.