



# INDIANA HEALTH COVERAGE PROGRAMS

## PROVIDER REFERENCE MODULE

# Telemedicine and Telehealth Services

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## Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: September 20, 2016	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of October 1, 2017 Published: January 11, 2018	Scheduled update: <ul style="list-style-type: none"> <li>• Edited and reorganized text as needed for clarity</li> <li>• Added a note box to the <a href="#">Telemedicine Services</a> section explaining that standard restrictions and limitations apply to services when delivered as telemedicine</li> <li>• Updated the <a href="#">Excluded Provider Types and Services</a> section</li> <li>• Updated the <a href="#">Hub Site Services and Billing Requirements</a> section:               <ul style="list-style-type: none"> <li>– Removed “individual” from the psychotherapy bullet</li> <li>– Specified Professional for the Fee Schedule reference</li> <li>– Added information about modifier 95</li> </ul> </li> <li>• Added modifier 95 information to the <a href="#">Spoke Site Services and Billing Requirements</a> section</li> <li>• Updated the <a href="#">Telemedicine Services for FOHCs and RHCs</a> section:               <ul style="list-style-type: none"> <li>– Updated the M&amp;S website link</li> <li>– Removed extraneous information, including PPS rate information, (and changed billable/nonbillable to reimbursable/nonreimbursable)</li> </ul> </li> </ul>	FSSA and DXC



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# Telemedicine and Telehealth Services

*Note: For policy information regarding coverage of telemedicine and telehealth services, see the [Medical Policy Manual](#) at [indianamedicaid.com](#).*

## Introduction

*Telemedicine services* are defined as the use of videoconferencing equipment to allow a medical provider to render an exam or other service to a patient at distant location. Telemedicine services may be rendered in an inpatient, outpatient, or office setting. The Indiana Health Coverage Programs (IHCP) covers telemedicine services, including medical exams and certain other services normally covered by Medicaid, within the parameters specified in *Indiana Administrative Code 405 IAC 5-38*.

*Note: Telemedicine is **not** the use of the following:*

- *Telephone transmitter for transtelephonic monitoring*
- *Telephone or any other means of communication for consultation from one provider to another*

*Telehealth services* are defined as 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: For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, providers must contact the appropriate managed care entity (MCE) for specific policies and procedures. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at [indianamedicaid.com](#).*

## Telemedicine Services

In any telemedicine encounter, the following must be available:

- A hub site – Location of the physician or provider rendering consultation services
- A spoke site – Location where the patient is physically located when services are provided
- An attendant to connect the patient to the specialist at the hub site
- Videoconferencing equipment, such as a computer or television monitor, at the hub and spoke sites to allow the patient to have real-time, interactive, and face-to-face communication with the hub specialist or consultant via interactive television (IATV) technology

The IHCP allows *store-and-forward technology* – the electronic transmission of medical information for subsequent review by another healthcare provider – to facilitate other reimbursable services; however, separate reimbursement of the spoke-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 the IHCP.

*Note: All services that are available for reimbursement when delivered as telemedicine are subject to the same limitations and restrictions as they would be if not delivered by telemedicine. See the appropriate provider reference module and the [Medical Policy Manual](#) for service-specific limitations and restrictions, including prior authorization (PA) requirements.*

## ***Excluded Provider Types and Services***

The IHCP does not reimburse the following provider types or services for telemedicine, per 405 IAC 5-38-4(6):

- Ambulatory surgical centers
- Long-term care facilities, including nursing facilities, intermediate care facilities, and community residential facilities for the developmentally disabled
- Services billed by school corporations
- Home health agencies or services (**Telehealth** services provided by home health agencies are reimbursed; see the [Telehealth Services](#) section.)
- Outpatient surgical services
- Radiological services
- Laboratory services
- Anesthesia services or nurse anesthetist services
- Audiological services
- Chiropractic services
- Care coordination services
- Durable medical equipment (DME), medical supplies, hearing aids, or oxygen
- Optical or optometric services
- Podiatric services
- Physical or speech therapy services
- Transportation services
- Services provided under a Medicaid waiver

## ***Conditions of Payment***

The IHCP reimburses for telemedicine services only when the following conditions are met:

- The hub and spoke sites are greater than 20 miles apart, except for the following providers, which have no distance requirements:
  - Federally qualified health centers (FQHCs)
  - Rural health clinics (RHCs)
  - Community mental health centers (CMHCs)
  - Critical access hospitals (CAHs)

- The member must be physically present at the spoke site and able to participate in the visit.
- For a medical professional to receive reimbursement for professional services in addition to payment for spoke services, medical necessity must be documented. If it is medically necessary for a medical professional to be with the member at the spoke site, the spoke site is permitted to bill an evaluation and management code in addition to the fee for spoke services. Adequate documentation must be maintained in the patient's medical record to support the need for the provider's presence at the spoke site during the visit. Documentation is subject to postpayment review.
- The audio and visual quality of the transmission must meet the needs of the physician located at the hub site. The IATV technology must meet generally accepted standards to allow the physician at the hub site to render medical decisions.

## **Hub Site Services and Billing Requirements**

The following Current Procedural Terminology (CPT<sup>®1</sup>) codes are reimbursable for providers that render services via telemedicine at the hub site:

- Office or other outpatient visits – 99201–99205 and 99211–99215
- Psychotherapy – 90832–90834, 90836–90840, 90846, 90847, and 90853
- Psychiatric diagnostic interviews – 90791 and 90792
- End-stage renal disease (ESRD) services – 90951–90970

Modifier GT – *Via interactive audio and video telecommunications system* must be used to denote telemedicine services. The payment amount for a telemedicine service is equal to the current [Professional Fee Schedule](#) amount for the procedure code billed.

Modifier 95 – *Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system* is used for informational purposes.

## **Spoke Site Services and Billing Requirements**

The following Healthcare Common Procedure Coding System (HCPCS) code and revenue code are reimbursable for providers that render services via telemedicine at the spoke site.

- Spoke services are reimbursed using HCPCS code Q3014 – *Telehealth originating site facility fee*. The GT modifier must be used to denote telemedicine services. (Modifier 95 is used for informational purposes.) The payment amount is equal to the current Fee Schedule amount for HCPCS code Q3014 – *Telehealth originating site facility fee*.
- Revenue code 780 represents telemedicine services. If a different, separately reimbursable treatment room revenue code is provided on the same day as the telemedicine consultation, the appropriate treatment room revenue code should also be included on the claim. Documentation must be maintained in the patient's record to indicate that services were provided separate from the telemedicine visit.

If spoke site services are provided in a physician's office and other services are provided on the same date as the spoke service, the medical professional should bill Q3014 as a separate line item from other professional services.

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## Documentation Standards

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

All other IHCP documentation guidelines apply for services rendered via telemedicine, such as chart notes and start and stop times. Documentation must be available for postpayment review.

Providers must have written protocols for circumstances when the member requires a hands-on visit with the consulting provider. The member should always be given the choice between a traditional clinical encounter versus a telemedicine visit. Appropriate consent from the member must be obtained by the spoke site and maintained at the hub and spoke sites.

## Special Considerations

The following special circumstances apply to telemedicine services:

- When ongoing services are provided, the member should be seen by a physician for a traditional clinical evaluation at least once a year, unless otherwise stated in policy. In addition, the hub physician should coordinate with the patient's primary care physician.
- The existing service limitations for office visits are applicable. All telemedicine consultations billed using the codes listed in the [Hub Site Services and Billing Requirements](#) section of this document are counted against the office visit limit.
- Although reimbursement for ESRD-related services under CPT codes 90951–90970 is permitted in the telemedicine setting, the IHCP requires at least one monthly visit for ESRD-related services to be a traditional clinical encounter to examine the vascular access site.

## Telemedicine Services for FQHCs and RHCs

Subject to the following criteria, reimbursement is available to FQHCs and RHCs when they are serving as either the hub site or the spoke site for telemedicine services.

- When serving as the *hub 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 as defined in the IHCP's telemedicine policy. Reimbursement is based on the prospective payment system (PPS) rate specific to the FQHC or RHC facility.
- When serving as the *spoke 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.

All components of the service must be provided and documented, and the documentation must demonstrate medical necessity. All documentation is subject to postpayment review.

Separate reimbursement for merely serving as the spoke site is not available to FQHCs and RHCs. Neither the originating site facility fee, as billed by HCPCS code Q3014, nor the facility-specific PPS rate is available, because the requirement of a valid encounter is not met. Pursuant to the *Code of Federal Regulations 42 CFR 405.2463*, 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. For a list of valid encounter codes, see the [Myers and Stauffer](#) website at mslc.com.

FQHCs and RHCs may submit telemedicine claims to a member's MCE and receive reconciliation review through Myers & Stauffer, which, in coordination with the Family and Social Services Administration (FSSA), determines reimbursable and nonreimbursable services.

For more information about FQHCs and RHCs, see the [Federally Qualified Health Centers and Rural Health Clinics](#) module.

## Telehealth Services

The IHCP covers telehealth services provided by home health agencies. Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages. The IHCP reimburses for telehealth services when the service is provided in compliance with all IHCP guidelines, including obtaining prior authorization (PA) as described in this document.

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. See *405 IAC 1-4.2-6*.

To qualify for telehealth services, the member must be receiving or approved for other IHCP home health services. For more information on home health services, see the [Home Health Services](#) module.

### ***Prior Authorization Requirements for Telehealth Services***

PA is required for all for telehealth services, per *Indiana Administrative Code 405 IAC 1-4.2-3* and *405 IAC 5-16-3*. 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.

Per *405 IAC 5-16-3.1*, to initially qualify for telehealth services, the member must have had two or more of the following events within the previous 12 months:

- Emergency room visits
- Inpatient hospital stays

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

The two qualifying events must be for the treatment of one of the following diagnoses:

- Congestive heart failure
- Chronic obstructive pulmonary disease
- Diabetes

The PA request for telehealth services must be submitted separately from other home health service PA requests. 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. Services may be authorized for members for up to 60 days per PA request.

The telehealth PA request form must include a physician's written order that is signed and dated by the physician. The PA request must also include an attestation from the home health agency that the telehealth equipment to be placed in the member's home is capable of monitoring any data parameters included in the plan of care (POC), and that the transmission process meets *Health Insurance Portability and Accountability Act* (HIPAA) compliance standards.

A POC must be signed and dated by the physician and submitted with the PA request. Monitoring criteria and interventions for the treatment of the member's qualifying conditions must be developed collaboratively between the member's physician and the home health agency and included in the member's POC. The POC must clearly outline the patient's health data and information to be monitored and measured, and the circumstances under which the ordering physician should be contacted to address any potential health concerns. The monitoring criteria and interventions should be directly related to the member's qualifying diagnoses. Other monitoring criteria and interventions may be developed for other conditions the member may have, but the primary criteria and interventions must be for treatment of the qualifying diagnoses. The POC must also indicate how often an RN must perform a reading of transmitted health information.

## ***Billing and Reimbursement for Telehealth Services***

Approved telehealth services are reimbursed separately from other home health services. The initial visit is limited to a one-time visit to educate the member or caregiver about how to properly operate the telehealth equipment. A remote skilled nursing visit cannot be billed on the same date that a member received a skilled nursing visit in the home. 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.

All equipment and software costs associated with the telehealth services must be separately identified on the home health provider's annual cost report so that the equipment and software costs may be removed from the calculation of overhead costs.

Rates for telehealth services are not adjusted annually.

Home health agencies bill telehealth services using revenue code 780 and CPT code 99600 along with the appropriate modifiers, as follows:

- 99600 U1 – *Unlisted home visit service or procedure; one time initial face-to face visit necessary to train the member or caregiver to appropriately operate the telehealth equipment*
- 99600 U2 TD – *Unlisted home visit service or procedure; remote skilled nursing visit to monitor and interpret telehealth reading; RN*