P R O V I D E R B U L L E T I N

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To: All Providers

Subject: Telemedicine

Overview

Effective April 1, 2007, telemedicine services are covered by the Indiana Health Coverage Programs (IHCP). This bulletin discusses applicable coverage parameters and billing guidelines. Telemedicine services are covered by Medicaid within the parameters specified in rule *405 IAC 5-38* (Appendix A).

Definitions

- Hub Site – Location of the physician or provider rendering consultation services.
- Spoke Site – Location where the patient is physically located when services are provided.
- Interactive Television (IATV) – Videoconferencing equipment at the hub and spoke sites that allows real-time, interactive, and face-to-face consultation.
- Store and Forward – Electronic transmission of medical information for subsequent review by another health care provider.

Only IATV is separately reimbursed by the IHCP. Store and forward technology to facilitate other reimbursable services is allowed; however, separate reimbursement of the spoke site payment will not be provided for this technology because of restrictions in *405 IAC 5-38-2(4)*.

> *Note: Telemedicine is not the use of the following.*
>
> *(1) Telephone transmitter for transtelephonic monitoring; or*
>
> *(2) Telephone or any other means of communication for consultation from one provider to another.*

Provider/Service Requirements

The following service or provider types are **not** permitted to be reimbursed for telemedicine per *405 IAC 5-38:*

- Ambulatory surgical centers.
- Outpatient surgical services.

- Home health agencies or services.
- Radiological services.
- Laboratory services.
- Long term care facilities, including nursing facilities, intermediate care facilities, or community residential facilities for the developmentally disabled.
- 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.
- Services billed by school corporations.
- Physical or speech therapy services.
- Transportation services.
- Services provided under a Medicaid waiver.

Conditions of Payment

1. IHCP reimburses for telemedicine services, only when the hub and spoke sites are greater than **20 miles** apart.
2. The member must be present and able to participate in the visit.
3. 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 post-payment review.
4. 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®) codes are reimbursable for providers that render services via telemedicine at the hub site. Modifier *GT – Via interactive audio and video telecommunications system* must be used to denote telemedicine services. The payment amount is equal to the current fee schedule amount for the following services:

- Consultations – 99241 to 99245 and 99251 to 99255
- Office or other outpatient visit – 99201 to 99205 and 99211 to 99215
- Individual psychotherapy – 90804 to 90809
- Psychiatric diagnostic interview – 90801
- Pharmacologic management – 90862
- End stage renal disease services (ESRD) – G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318

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. Modifier *GT – Via interactive audio and video telecommunications system* must be used to denote telemedicine services. The payment amount is equal to the current fee schedule amount for HCPCS code Q3014 *Telehealth originating site facility fee*.

1. Spoke services are reimbursed using HCPCS code Q3014 *Telehealth originating site facility fee.* The GT modifier must be used to denote telemedicine services.
2. 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.
3. 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.

Documentation Standards

1. Documentation must be maintained at the hub and spoke locations to substantiate the services provided. Documentation must indicate the services were rendered via telemedicine.
2. Documentation must clearly indicate the location of the hub and spoke sites.
3. All other IHCP documentation guidelines for services rendered via telemedicine apply, for example chart notes and start and stop times. Documentation must be available for post-payment review.
4. Providers must have written protocols for circumstances when the member must have 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

1. 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.

2. The existing service limitations for office visits are applicable. All telemedicine consultations billed using these codes will be counted against the office visit limit. Third-party liability (TPL), spend-down, managed care and all other considerations apply.
3. Reimbursement for ESRD-related services under HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 is permitted in the telemedicine setting. The IHCP expects at least one monthly visit for ESRD-related services to be a traditional clinical encounter to examine the vascular access site.
4. Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC) are only reimbursed for hands-on services and are therefore not permitted to bill for telemedicine services.

Managed Care Considerations

Refer questions to the appropriate managed care organization (MCO) for risk-based managed care considerations.

FQHCs and RHCs may submit claims to an MCO as fee-for-service and receive reconciliation review through Myers & Stauffer who, in coordination with the Office of Medicaid Policy and Planning (OMPP), determines billable and non-billable services.

Appendix A – Indiana Administrative Code (IAC)

Rule 38. Telemedicine Services

405 IAC 5-38-1 General provisions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3

Affected: IC 12-13-7-3; IC 12-15

Sec. 1. (a) Telemedicine services refer to a specific method of delivery of certain services, including medical exams and consultations, which are already reimbursed by Medicaid. Telemedicine uses videoconferencing equipment allowing a medical provider to render an exam or other service to a patient at distant location. Telemedicine services are covered by Medicaid within the parameters specified in this rule.

(b) Telemedicine is not the use of a:

(1) telephone transmitter for transtelephonic monitoring; or

(2) telephone or any other means of communication, consultation from one (1) doctor to another.

(Office of the Secretary of Family and Social Services; 405 IAC 5-38-1; filed Feb 28, 2007, 2:42 p.m.: 20070328-IR-405060029FRA readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-38-2 Definitions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3

Affected: IC 12-13-7-3; IC 12-15

Sec. 2. The following definitions apply throughout this rule:

(1) "Hub site" means the location of the physician or provider rendering consultation services.

(2) "Interactive television" or "IATV" means the videoconferencing equipment at the hub and spoke site that allows real time, face-to-face consultation.

(3) "Spoke site" means the location where the patient is physically located when services are provided.

(4) "Store and forward" means the electronic transmission of medical information for subsequent review by a health care provider at the hub site. Restrictions placed on store and forward reimbursement in this rule shall not disallow the permissible use of store and forward technology to facilitate reimbursable services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-38-2; filed Feb 28, 2007, 2:42 p.m.: 20070328-IR-405060029FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

405 IAC 5-38-3 Description of service

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3

Affected: IC 12-13-7-3; IC 12-15

Sec. 3. (a) In any telemedicine encounter, there will be the following: (1) A hub site.

(2) A spoke site.

(3) An attendant to connect the patient to the specialist at the hub site.

(4) A computer or television monitor to allow the patient to have:

(A) real-time;

(B) interactive; and

(C) face-to-face; communication with the hub specialist/consultant via IATV technology.

(b) Services may be rendered in an inpatient, outpatient, or office setting. *(Office of the Secretary of Family and Social Services; 405 IAC 5-38-3; filed Feb 28, 2007, 2:42 p.m.: 20070328-IR-405060029FRA; readopted filed Sep 19, 2007, 12:16 p.m.:*

20071010-IR-405070311RFA)

405 IAC 5-38-4 Limitations

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3

Affected: IC 12-13-7-3; IC 12-15

Sec. 4. Telemedicine shall be limited by the following conditions:

(1) The patient must be:

(A) physically present at the spoke site; and

(B) participate in the visit.

(2) The physician or practitioner who will be examining the patient from the hub site must determine if it is medically necessary for a medical professional to be at the spoke site. Separate reimbursement for a provider at the spoke site is payable only if that provider's presence is medically necessary. 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. Such documentation is subject to postpayment review. If a health care provider's presence at the spoke site is medically necessary, billing of the appropriate evaluation and management code is permitted.

(3) Reimbursement for telemedicine services is available only when the hub and spoke sites are greater than twenty (20) miles apart. Adequate documentation must be maintained as service is subject to postpayment review.

(4) Store and forward technology is not reimbursable by Medicaid. The use of store and forward technology is permissible as defined under section 2(4) of this rule.

(5) The following service or provider types may not be reimbursed for telemedicine:

(A) Ambulatory surgical centers.

(B) Outpatient surgical services.

(C) Home health agencies or 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) 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.

(Office of the Secretary of Family and Social Services; 405 IAC 5-38-4; filed Feb 28, 2007, 2:42 p.m.: 20070328-IR-405060029FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)