IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201453 OCTOBER 28, 2014

IHCP to cover telehealth services by home health agencies

Effective December 1, 2014, the Indiana Health Coverage Programs (IHCP) will cover telehealth services provided by home health agencies. Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages, for dates of service (DOS) on or after December 1, 2014.

Description of service

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 allows the home health agency to detect minute changes in the member's clinical status that allow home health agencies to intercede before the member's condition advances and requires emergency intervention or inpatient hospitalization.

Reimbursement requirements

The IHCP provides reimbursement for telehealth services when the service is provided in compliance with all IHCP guidelines, including obtaining prior authorization (PA). Telehealth services are considered medically necessary for individuals with uncontrolled chronic conditions, as evidenced by emergency room visits and inpatient hospital stays directly related to the chronic condition.

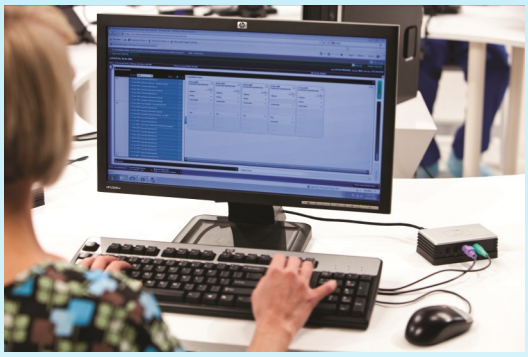
In any telehealth services encounter, a licensed RN must read the transmitted health information provided from the member, in accordance with the written order of the physician. The nurse must review all data on the day the ordered data is received or, in cases when the data is received after business hours, on the first business day following receipt of the data. Transmitted data must meet *Health Insurance Portability and Accountability Act* (HIPAA) compliance standards.

The home health agency will follow the monitoring criteria and interventions for the treatment of the member's qualifying condition, as outlined in the plan of treatment. Any potential medical concerns should be communicated to the ordering physician and, for individuals enrolled in Hoosier Healthwise or *Care Select,* to the member's health plan. Members who are unable or unwilling to use the telehealth equipment appropriately will be disenrolled from telehealth services.

Prior authorization

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

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

Additionally, to qualify for telehealth services, the member must be receiving or approved for other IHCP home health services. The PA request for telehealth services must be submitted separately from other home health service PA requests. Once 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 treatment, and that the transmission process meets HIPAA compliance standards.

A plan of treatment 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 plan of treatment. The plan of treatment 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 plan of treatment must also indicate how often an RN must perform a reading of transmitted health information.

Billing guidance

Reimbursement requires compliance with all IHCP guidelines, including obtaining appropriate referrals for members enrolled in IHCP managed care programs. Home health agencies must bill using the appropriate procedure codes using the *UB-04* claim form.

Per *405 IAC 1-4.2-6*, the IHCP will cover the Current Procedural Terminology (CPT®[1]) codes with the appropriate modifiers and revenue codes in Table 1. This information will be reflected on the next monthly update to the Fee Schedule at indianamedicaid.com.

Table 1 – Telehealth procedure codes covered for DOS on or after December 1, 2014

CPT Code	Description	Rate	Revenue Code
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	$14.45	780
99600 U2 TD	Unlisted home visit service or procedure; remote skilled nursing visit to monitor and interpret telehealth reading; RN	$9.84	780

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 DOS 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. The home health agency cost report forms and instructions have been revised to accommodate the changes for telehealth services. For revised forms and instructions, see the *Long Term Care* web page of the Myers and Stauffer LC website at in.mslc.com (select **Home Health Agency** > **Forms**).

QUESTIONS?

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