



Easy Choice Health Plan

Missouri Care

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona

OneCare (Care1st Health Plan Arizona, Inc.)

Staywell of Florida

WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

WellCare Prescription Insurance

WellCare Texan Plus (Medicare – Dallas & Houston markets)

Telehealth, Telemedicine, And Telemonitoring

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APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

BACKGROUND

Telehealth and telemedicine are often used interchangeably; WellCare uses the following distinction:

Telemedicine. Remote communication using voice and visual technology between a provider and a member used for health check-up and diagnostic purposes. Telemedicine is often used as a substitute for an in-office visit and does not involve continuous monitoring of the member.

Telehealth. A robust continuous monitoring of the member's health (see information in the criteria set). Telehealth allows providers to maintain consistent contact with clients at reduced costs. As expenses escalate, there is significant pressure on providers to lower costs and maintain quality of care, while increasing client satisfaction. In order to meet these challenges, providers are utilizing telehealth technologies. Studies demonstrate remote monitoring with telehealth serves as an extremely useful healthcare delivery tool that improves quality of care for those who require or benefit from close monitoring by their provider organization.

Operational Modes of Telehealth

There are two primary modes of telehealth - real-time (synchronous) and store-and-forward (asynchronous). Real-time telehealth sessions are live and interactive, and frequently use videoconferencing technologies. Often, special telehealth-enabled instruments (peripherals), such as a video otoscope (to examine the ear) or an electronic stethoscope, are operated by a nurse or technician at the consulting provider's direction to remotely perform a physical examination. In store-and-forward telehealth, data (such as digital photographs) are captured locally, then temporarily stored (cached) for transfer at a later time, either via a secure web server, encrypted e-mail, specially-designed store-and-forward software, or electronic health record. The consulting provider then reviews the stored data and makes diagnosis, treatment, and planning recommendations that are electronically transferred or faxed back to the referring provider.

Provider benefits of telehealth include:

- Improve quality care through improved assessment and monitoring capabilities
- Reduce current operating costs
- Efficient and improved use of caregiver/care manager time
- Enhance and embellish current service offerings with new value added features
- Develop new marketing opportunities that attract and maintain clients and customers
- Create a new revenue stream

Member benefits of telehealth include:

- Earlier recognition and intervention
- Improved quality of life
- Decreased ER visits and hospital re-admissions
- Member and care giver support
- Reduced anxiety
- Increased compliance in medication and treatments
- Improved empowerment and self-management skills
- Increased independence

Privacy and Consent

Prior to receiving telehealth or telemedicine services the member must agree to participate and sign an informed consent. For members who are minors, their parent or guardian must sign the consent form unless exempted by State or Federal Law. The minor's parents or guardian need not be present for the telehealth or telemedicine appointment unless it is deemed therapeutically appropriate.³

Member has the right to withdraw from the telehealth or telemedicine appointment at any time during the session.³

The telehealth or telemedicine appointment must meet all confidentiality requirements required in HIPAA ([here](#)) and HITECH ([here](#)) regulations and the sessions may not be recorded. All telehealth and telemedicine services must be performed using a secure line including and encryption process to ensure confidentiality. There can be no use of the member's images or information without the member's written consent.^{3,4}

POSITION STATEMENT

Applicable To:

- Medicaid – Florida, Georgia, Illinois, Nebraska, New Jersey, New York, South Carolina

NOTE: SEE BELOW FOR MEDICARE COVERAGE ITEMS

Florida^{5, 6}

Per Florida Statute 59G-1.057, coverage is applied to the practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment.⁵

Practitioners licensed within their scope of practice to perform the service.

Florida Medicaid reimburses for telemedicine services using interactive telecommunications equipment that includes, at a minimum audio and video equipment permitting two-way, real time, interactive communication between a recipient and a practitioner, and meet the technical safeguards by 45 CFR 164.312⁶, where applicable. The services must comply with all HIPAA and other state and federal laws pertaining to privacy.

The following applies to practitioners rendering services in the fee-for-service delivery system:

- Florida Medicaid reimburses the practitioner who is providing the evaluation, diagnosis, or treatment recommendation located at a site other than where the recipient is located.
- Provider shall ensure the enrollee has a choice of whether to access services through a face-to-face or telemedicine encounter, and shall document such choice in the enrollee's medical/case record.
- Providers must include modifier GT on the CMS-1500 claim form, incorporated by reference in Rule 59G-4.001, F.A.C.
- WellCare shall provide coverage for services provided through telemedicine, when appropriate, for services as covered under the State Contract, to the same extent the services would be covered if provided through a face-to-face (in-person) encounter with a practitioner.
- WellCare is not more restrictive in the coverage requirements for services provided through telemedicine than those established for services provided in-person.
- WellCare shall ensure the enrollee has a choice of whether to access services through a face-to-face or telemedicine encounter and will include documentation, as applicable, in the Member's record when telemedicine services are provided

Georgia³

Telemedicine consultations are covered when medically necessary and when the following requirements are met:

1. The referring provider must be licensed and practicing within the state of Georgia; **AND**,
2. The member must be present and participating in the visit; **AND**,
3. The referring provider must be the members attending provider in charge of their care and the request must be documented in the member's record. Pertinent medical information and/or records must be transmitted to the distant site provider via a secure transmission; **AND**,
4. The referring provider must be requesting the opinion, advice or service of another provider for a specific medical problem, illness or injury; **AND**,
5. The consulting provider be licensed in the state of Georgia and must document all findings and recommendations in writing, in the format normally used for recording services in the patients' medical records; **AND**,
6. The referring health care practitioner must obtain written consent from the eligible Georgia Medicaid member prior to rendering service. The consent form must include a description of the risks, benefits and consequences of telemedicine and be included in the member's medical record; **AND**,
7. If the member is a minor child, a parent/guardian must present the child for telemedicine services and sign the consent form unless otherwise exempted by State or Federal law.

All telemedicine activities must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA): Standards for Privacy of individual identifiable health information and all other applicable state and federal laws and regulations. By coding and billing the GT modifier with a covered telemedicine procedure code, you are certifying that the beneficiary was present at an eligible originating site when you furnished the telemedicine service. By coding and billing the GT modifier with a covered ESRD-related service telemedicine code, you are certifying that you furnished one "hands on" visit per month to examine the vascular access site.

Exclusions

1. Telephone conversations.
2. Electronic mail messages.
3. Facsimile.
4. Services rendered via a webcam or internet based technologies (i.e., Skype, Tango, etc.) that are not part of a secured network and do not meet HIPAA encryption compliance.
5. Video cell phone interactions.
6. The cost of telemedicine equipment and transmission.
7. Store and forward transactions (as defined below).
8. Failed or unsuccessful transmissions.

Hawaii

Exclusions

- Standard telephone contact, facsimile transmission, or email — in combination or individually.
- Issuing a prescription based solely on an online questionnaire.

Coverage

The use of telecommunications services to transmit patient medical information through store and forward technologies, remote monitoring, live consultation, and mobile health when a Member and Provider are unable to meet face-to-face **is a covered benefit** when the following are met:

1. Services are provided by a licensed health care provider working within the scope of their practice including ALL of the following:
 - Telehealth may be used to establish a primary care provider (PCP)-patient relationship when a PCP has a license to practice in Hawaii and is in-network; **AND**
 - In-network provider-patient relationships may be established via telehealth if the patient is referred by the patient's established PCP, unless excluded by the patient's health plan; **OR**
 - Out-of-network telehealth services will only be covered if the health plan referral requirements of the patient's plan are met prior to the services being rendered.

AND

2. Service is covered if it would have been covered for an in-person encounter; **AND**
3. Services are provided through one of the following methods, including but not limited to:
 - Real-time video conferencing-based communication; **AND/OR**
 - Secure interactive and non-interactive web-based communication; **AND/OR**
 - Secure asynchronous information exchange to transmit patient medical information; **AND/OR**
 - Including diagnostic quality digital images and laboratory results for medical interpretation and diagnosis.

AND

4. Services must include a documented patient evaluation (including history and a discussion of physical symptoms adequate to establish a diagnosis and treatment plan and documentation consistent with standards as defined by Current Procedural Terminology (CPT)); **AND**
5. Services are covered (subject to Limitations and Administrative Guidelines) without geographic restrictions on a patient's or health care provider's location; **AND**
6. Use of a telehealth modality to prescribe controlled substances or medical marijuana is covered (subject to

Limitations and Administrative Guidelines) only when a physician-patient relationship has been previously established through an in-person encounter:

- An in-person visit is required at least every six months for opioid prescriptions for chronic conditions; **AND**
- Telehealth prescriptions for doses beyond plan formulary quantity limits are not allowed.

Illinois

Exclusions

Group psychotherapy is not a covered telepsychiatry service.

Coverage

Telemedicine Consultations are covered when medically necessary and when the following requirements are met:

1. A physician or other licensed health care professional must be present at all times with the patient at the originating site; **AND**,
2. The distant site provider must be a physician, physician assistant, podiatrist or advanced practice nurse who is licensed by the State of Illinois or by the state where the patient is located; **AND**,
3. The originating and distant site provider must not be terminated, suspended or barred from the Department's medical programs; **AND**,
4. Medical data may be exchanged through a telecommunication system; **AND**,
5. The interactive telecommunication system must, at a minimum, have the capability of allowing the consulting distant site provider to examine the patient sufficiently to allow proper diagnosis of the involved body system. The system must also be capable of transmitting clearly audible heart tones and lung sounds, as well as clear video images of the patient and any diagnostic tools, such as radiographs.

Telepsychiatry Consultations are covered when medically necessary and when the following requirements are met:

1. A physician, licensed health care professional or other licensed clinician, mental health professional (MHP), or qualified mental health professional (QMHP), as defined in 59 Ill. Adm. Code 132.25, must be present at all times with the patient at the originating site; **AND**,
2. The distant site provider must be a physician licensed by the State of Illinois or by the state where the patient is located and must have completed an accredited general psychiatry residency program or an accredited child and adolescent psychiatry residency program; **AND**,
3. The originating and distant site provider must not be terminated, suspended or barred from the Department's medical programs; **AND**,
4. The distant site provider must personally render the telepsychiatry service; **AND**,
5. Telepsychiatry services must be rendered using an interactive telecommunication system.

Kentucky⁸

Exclusions

If a service is not covered in a face-to-face setting, it is also not covered if provided through telehealth. A service provided through telehealth is subject to the same program restrictions, limitations and coverage which exist for the service when not provided through telehealth.

Coverage

1. The provider must be enrolled in the KY Medicaid Telehealth Network;

AND

2. The agency requires the following for a telehealth consult:
 - Kentucky's Medicaid program (state agency) does not currently cover store and forward telehealth;

AND

3. A telehealth consultation shall require:
 - The use of two (2) way interactive video; **AND**
 - A referral by a health care provider; **AND**
 - A referral by a recipient's lock-in provider if the recipient is locked in pursuant to
 - 42 C.F.R. 431.54; **AND**
 - 907 KAR 1:677.

Nebraska

Coverage

Tele-monitoring involves easy-to-use equipment to help members track their vital signs at home. Vitals are transmitted automatically to a provider and monitored by a nurse. WellCare has begun discussions with several tele-monitoring companies and is currently evaluation platforms and services for tele-monitoring. WellCare believes that tele-monitoring can be used to prevent hospital admissions and readmissions. At a minimum, WellCare will cover tele-monitoring services when the following conditions have been met:

Adults (20 and over)

1. Member is cognitively capable of operating the equipment or has a willing and able person to assist in the transmission of the electronic data; **AND**,
2. Originating site has space for all program equipment and full transmission capability; **AND**,
3. Provider's record contains data that supports the medical necessity of the service, all transmissions, and subsequent review received from the member, and how the data transmitted from the member is used in the continuous development and implementation of the member's plan of care.

Children (Age < 19)

In addition to the above criteria, for services related to members \leq age 19, the following also applies:⁹

1. An appropriately trained staff member or employee familiar with the child's treatment plan or familiar with the child shall be immediately available in person to the child receiving a telehealth behavioral health service in order to attend to any urgent situation or emergency that may occur during provision of such service. This requirement may be waived by the child's parent or legal guardian; **AND**,
2. In cases in which there is a threat that the child may harm himself or herself or others, before an initial telehealth service the health care practitioner shall work with the child and his or her parent or guardian to develop a safety plan. Such plan shall document actions the child, the health care practitioner, and the parent or guardian will take in the event of an emergency or urgent situation occurring during or after the telehealth session. Such plan may include having a staff member or employee familiar with the child's treatment plan immediately available in person to the child, if such measures are deemed necessary by the team developing the safety plan; **AND**,
3. Services provided by means of telecommunications technology, other than telehealth behavioral health services received by a child, are not covered if the child has access to a comparable service within thirty miles of his or her place of residence.

New Jersey ⁴

Coverage

Telepsychiatry is defined as a psychiatric service provided by a psychiatrist or psychiatric advance practice nurse from a remote location over secure, two-way, interactive, audiovisual equipment. Telepsychiatry may be utilized by mental health clinics and/or hospital providers of outpatient mental health services to meet their physician related requirements including but not limited to intake evaluations, periodic psychiatric evaluations, medication management and/or psychotherapy sessions for clients of any age. Telepsychiatry consultations are covered when medically necessary and when the following requirements are met:

1. Member must provide informed consent to participate in any service utilizing telepsychiatry; **AND**,
2. All telepsychiatry transmissions must be on a secure line which utilizes an encryption process that ensures confidentiality and the integrity of the information being transmitted; **AND**,
3. Telepsychiatry services must be provided from, and in, a location that is properly lit allowing for clear visual contact; **AND**,
4. The Medicaid client must receive services at the mental health clinic or outpatient hospital program and the mental health clinic/hospital must bill for all services under their Medicaid provider number; **AND**,
5. The psychiatrist or psychiatric APN may be off-site but must be a practitioner currently licensed to practice within the State of New Jersey; **AND**,
6. In the event that the psychiatrist or psychiatric APN require a physical evaluation as part of their clinical assessment, the hosting provider shall have an RN available to complete and share the results of the physical evaluation.

New York ¹²

Exclusions

- Provider **CANNOT** bill for telehealth services provided to members who have Medicare, commercial insurance or are insured through other payers, during the time period or episode in which the provider is billing or is being paid by another insurer.
- Telehealth services are **NOT** a covered benefit for Family Health Plans or Child Health Plus enrollees.

Coverage

When the criteria below are met, home telehealth home care services are eligible for coverage when provided to assist in the effective monitoring and management of members whose medical, functional, and/or environmental needs can be appropriately and cost-effectively met at home through the application of telehealth intervention. Conditions and clinical circumstances eligible for telehealth services shall include, but are not limited to, congestive heart failure, behavioral problems limiting self-management, and technology-dependent care (e.g., continuous oxygen, ventilator care, total parenteral nutrition and enteral feeding).

The following are required before the initiation of telehealth home care services:

- A request for initial certification should be submitted. Recertification will be required quarterly, with member specific documentation and physician orders, thereafter.; **AND**,
- Only members who qualify for home care services will be considered for telehealth home services; **AND**,
- Members whose risks are assessed in-person prior to the receipt of telehealth services will be eligible.

The following documentation is required for considerations of services:

- A physician order for telehealth services; **AND**,
- An approved member risk assessment is required to be performed by the agencies to assess high-risk members. The tool must incorporate such variables as whether the member:
 - Is at risk for hospitalization or emergency care visits; **AND**,
 - Lives alone; **AND**,

- Has a documented history of or is at high risk of requiring nursing visits or interventions; **AND**,
- Has a history of non-compliance adhering to disease management recommendations; **AND**,
- Requires on-going symptom management related to dyspnea, fatigue, pain, edema, or medication side effects or adverse effects; **AND**,
- Resides in a medically under-served, rural, or geographically inaccessible area: **AND**,
- Has difficulty traveling to and from home for medical appointments; **AND**,
- Has the functional ability to work with telehealth monitoring equipment, in terms of sight, hearing, manual dexterity, comprehension and ability to communicate.

Home telehealth services **are a New York Medicaid covered benefit** when provided by one of the following:

- Certified Home Health Agencies (CHHAs); **OR**,
- Long-term health care programs; **OR**,
- AIDS home care programs.

Telehealth services account for daily variation in the intensity and complexity of the member's telehealth service needs. Rates should include the following functions:

- Monitoring of member vital signs; **AND**,
- Medication management; **AND**,
- Member education; **AND**,
- Equipment management; **AND**,
- Review of member trends and/or changes in member condition necessitating intervention; **AND**,
- Such other activities deemed necessary and appropriate by the plan.

Retroactive to February 1, 2010, Medicaid is expanding coverage for physician specialist telemedicine consultations to patients in hospital outpatient departments. Additionally, physicians may bill separately for their hospital services using the physician fee schedule in both the inpatient and outpatient setting, including for telemedicine consultations. Physician reimbursement for the telemedicine consultation will be for the same amount as an in-person specialist consultation. Telemedicine consultations are not limited to any specific physician specialty. Covered physician specialties include, but are not limited to, neurology, endocrinology, oncology, etc. Telemedicine consultations must be conducted using a real-time fully interactive, secure two-way audio and video telecommunications system that supports review of diagnostic tests integral to the consultation.

Reimbursement is based on a tier-pricing system. The tier-pricing system is determined by the level of system interoperability.

- **Tier 1.** Class 2 Medical Device that is FDA approved with interoperability
- **Tier 2.** Tier 1, plus a standard interconnection with a home care point of care system.
- **Tier 3.** Tier 2, plus a standard interconnection with electronic health record and statewide health information network.

Coverage Requirements (per New York Department of Health 2011 Update)

Telemedicine consultations are covered when medically necessary and when the following requirements are met:

- Member must be physically present at the originating "spoke" site; the physician specialist and/or CDE/CAE is located at the "hub" site.
- Physician specialist at the "hub" site, who is performing the consult, must be licensed in New York State, enrolled in New York State Medicaid and be credentialed and privileged at both the "hub" and "spoke" site hospital and/or D&TC.
- The CDE/CAE at the "hub" site must be enrolled in New York State Medicaid as either a billing provider (i.e., MD, Nurse Practitioner, and Licensed Midwife) or a non-billing provider. CAEs and CDEs, who are non-billing providers, cannot bill Medicaid directly. They must enroll as non-billing Medicaid providers and be employed by or contracted with a billing Medicaid provider. A complete listing of professional entities that are qualified to provide CDE/CAE services is available in the October 2008 Medicaid Update at the following Website: http://nyhealth.gov/health_care/mcicaid/program/update/2008/2008-10.htm#dia.

- The request and medical need for the telemedicine consult and the findings of the consulting physician or CDE/CAE must be documented in the patient's medical record.
- The telemedicine consultation must be "real time," and provided via a fully interactive, secure two-way audio visual telecommunication system ("store and forward" is not covered by Medicaid).

Medicaid currently covers medically necessary physician specialist consultations provided via telemedicine to patients in Article 28 emergency rooms, hospital outpatient departments and hospital inpatient settings. In response to a Medicaid Redesign Team (MRT) initiative, Medicaid has taken steps to expand and enhance coverage of telemedicine. The goal of this undertaking is to provide Medicaid enrollees with greater access to specialty care by reducing the barriers encountered by providers requesting and delivering care via telemedicine.

Telemedicine "hub" sites will include:

- Article 28 Hospitals;
- Article 28 Diagnostic and Treatment Centers (D&TCs); and
- Federally Qualified Health Centers (FQHCs) that have "opted into" APGs.

Telemedicine originating "spoke" sites will include:

- Article 28 Hospitals (Emergency Room, Outpatient Department, Inpatient);
- Article 28 Diagnostic and Treatment Centers (D&TCs); and

FQHCs that have "opted into" APGs and non-FQHC School Based Health Centers (SBHCs).

- Rate codes are being developed to permit FQHCs that have not "opted into" APGs, as well as SBHCs that are FQHCs, to bill for the administrative costs associated with telemedicine. Providers will be notified when these rate codes become active.

Practitioners, who may provide telemedicine services at the "hub" site will include:

- Physician Specialists (including Psychiatrists);,
- Certified Diabetes Educators (CDEs); and
- Certified Asthma Educators (CAEs or A-ECs).

Physician specialist telemedicine consultations are covered when medically necessary and when the:

- Patient is located at the spoke site and the physician specialist is located at the hub site;
- Spoken site is the hospital where the patient and referring physician are located;
- Hub site is the office or other hospital where the physician specialist is located;
- Patient is present during the telemedicine consultation;
- Specialist is not available at the spoke site to provide a timely consultation;
- Physician specialist is not conducting the telemedicine consultation at the spoke site;
- Telemedicine consult request and the rationale for the request are documented in the patient's medical record;
- Patient record includes documentation that the telemedicine consultation occurred and that the results and findings were communicated to the requesting provider;
- Consulting physician is licensed in NYS; is practicing within his/her scope of specialty practice; is enrolled in New York Medicaid; and is credentialed and privileged at the spoke site hospital.

Physician Billing Requirements

- Physicians billing for telemedicine consultations must include the modifier - GT "via interactive audio and video telecommunications systems" with the appropriate consultation E&M code to indicate services were performed via telemedicine;
- The place of service entered on the claim is the location of the patient. Use "21" for hospital inpatient, "22" for hospital outpatient, or "23" for hospital emergency room.
- The attending physician bills the appropriate E&M code without the GT modifier;
- Payment will be made to only one physician for the professional component (reading and interpretation) of diagnostic tests such as radiological procedures and diagnostic assessments.

Telepsychiatry

Medicaid will reimburse for consultations provided by a psychiatrist through an audio/visual link as well as ongoing therapy provided by a psychiatrist. As with all other telemedicine services, if the originating "spoke" site is an Article 28 facility (hospital outpatient department or diagnostic and treatment center), the "spoke" site is directly responsible for all patient care, and is also required to credential and privilege the psychiatrist who is located at the distant "hub" site (see the information below on credentialing/privileging requirements). In addition to psychiatric consultations, ongoing therapy provided by the psychiatrist at the distant "hub" site may be billed to Medicaid.

Diabetes Self-Management Training (DSMT) / Asthma Self-Management Training (ASMT)

Medicaid will reimburse for CDE/CAE diabetes and asthma self-management training services provided through telemedicine. As with all other telemedicine services, if the distant "spoke" site is an Article 28 facility (hospital outpatient department or diagnostic and treatment center), the "spoke" site is directly responsible for all patient care. The decision whether a medical practitioner needs to be present to assist the patient receiving CDE/CAE services through telemedicine rests with both the practitioner at the "spoke" site as well as the CDE/CAE providing the education, e.g., it may be advantageous for a practitioner (physician, physician assistant, nurse practitioner, or RN) to be physically present with the patient when certain procedures are taught or presented such as insulin injection, use of an insulin pump, appropriate and effective use of a nebulizer, etc.

South Carolina ¹³

Exclusions

The following interactions do not constitute reimbursable telemedicine or telepsychiatry services and will not be reimbursed:

- Video cell phone interactions
- Telephone Conversations
- E-mail messages
- Facsimile transmissions
- Services provided by allied health professionals
- CPT procedure codes 99075, 99078, 99080, and 99090 indicating medical testimony, special reports for insurance, educational services for groups, and data analysis are non-compensable by Medicaid.

Coverage

Services that are eligible for reimbursement include consultation, office visits, individual psychotherapy, pharmacologic management, and psychiatric diagnostic interview examinations and testing, delivered via a telecommunication system. A licensed physician and/or nurse practitioner are the only providers of telepsychiatry services. As a condition of reimbursement, an audio and video telecommunication system that is HIPAA compliant must be used that permits interactive communication between the physician or practitioner at the consultant site and the beneficiary at the referring site. Office and outpatient visits that are conducted via telemedicine are counted towards the applicable benefit limits for these services. Medicaid covers telemedicine when the service is medically necessary and under the following circumstance:

- The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's need; and
- The medical care can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide.

Telemedicine services are covered when the following requirements are met:

1. The beneficiary must be present and participating in the telemedicine visit, **AND**
2. The referring provider must provide pertinent medical information and/or records to the consulting provider

- via a secure transmission, **AND**
3. Interactive audio and video telecommunication must be used; permitting encrypted communication between the distant site physician or practitioner and the Medicaid beneficiary. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the Telemedicine information transmitted, **AND**
 4. The telemedicine equipment and transmission speed and image resolution must be technically sufficient to support the service billed. Staff involved in the telemedicine visit must be trained in the use of the telemedicine equipment and competent in its operation, **AND**
 5. An appropriate certified or licensed health care professional at the referring site is required to present (patient site presenter) the beneficiary to the physician or practitioner at the consulting site and remain available as clinically appropriate, **AND**
 6. If the beneficiary is a minor child, a parent and/or guardian must present the minor child for telemedicine service unless otherwise exempted by State or Federal law. The parent and/or guardian need not attend the telemedicine session unless attendance is therapeutically appropriate, **AND**
 7. The beneficiary retains the right to withdraw at any time, **AND**
 8. All telemedicine activities must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996: Standards for Privacy of Individually Identifiable Health Information and all other applicable state and federal laws and regulations, **AND**
 9. The beneficiary has access to all transmitted medical information, with the exception of live interactive video, as there is often no stored data in such encounters, **AND**
 10. There will be no dissemination of any beneficiary's images or information to other entities without written consent from the beneficiary, **AND**
 11. The provider at the distant site must obtain prior approval for service when services require prior approval, based on service type or diagnosis.

CODING

CPT®* Codes – No applicable codes.

HCPCS ®* Level II Codes

Q3014 Telehealth originating site facility fee **** (NMN)**

T1014 Telehealth transmission, per minute, professional services bill separately **** (NMN)**

****Codes are not medically necessary (NMN) except for Managed Medicaid Members.**

ICD-10-CM Diagnosis Codes – Diagnoses are covered when the above criteria is met.

Market Specific Codes

HAWAII

Covered CPT Codes

0188T, 0189T	Remote real-time interactive video-conferenced critical care, evaluation and management of the critically ill or critically injured patient
90791 – 90792	Psychiatric diagnostic interview examination
90832 – 90834, 90836 – 90838	Individual psychotherapy
90845, 90846, 90847	Family psychotherapy
90863	Pharmacologic management
90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961	End Stage Renal Disease (ESRD) related services
90963 – 90966	End Stage Renal Disease (ESRD) related services for home dialysis per month
90967 – 90970	End Stage Renal Disease (ESRD) related home services
92227, 92228	Remote imaging detection of retinal disease
93228	External mobile cardiovascular telemetry with electrocardiographic recording
93229	Technical support for connection and patient instructions for use

93268, 93270 – 93272	External patient and, when performed, auto activated electrocardiographic rhythm
93298, 93299	Implantable loop recorder system
96040	Medical genetics and genetic counseling services
96116	Neurobehavioral status examination
96150 – 96154	Individual and group health and behavior assessment and intervention
97802 – 97804	Medical nutrition therapy face-to-face with patient, each 15 minutes
98960 – 98962	Education and training for patient self-management
99201 – 99215	Office or other outpatient visits
99231 – 99233	Subsequent hospital care services
99241 – 99245	Office consultation for a new or established patient
99251 – 99255	Inpatient consultation for a new or established patient
99307 – 99310	Subsequent nursing facility care services
99354 – 99357	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service
99406, 99407	Smoking cessation services
99408, 99409	Alcohol and substance abuse services
99495, 99496	Transitional care management services
99497, 99498	Advanced care planning

Covered HCPCS Codes

G0108 – G0109	Individual and group diabetes self-management training services
G0270	Individual and group medical nutrition therapy
G0396 – G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services
G0406 – G0408	Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs
G0420 – G0421	Individual and group kidney disease education services
G0425 – G0427	Telehealth consultations, emergency department or initial inpatient
G0438 – G0439	Annual wellness visit
G0442	Annual alcohol misuse screening
G0443	Brief face-to-face behavioral counseling for alcohol misuse
G0444	Annual depression screening
G0445	High-intensity behavioral counseling to prevent sexually transmitted infection
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease
G0447	Face-to-face behavioral counseling for obesity
G0459	Telehealth pharmacologic management
G0508	Telehealth consultation, initial critical care
G0509	Telehealth consultation, subsequent critical care

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

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MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
9/6/2018	<ul style="list-style-type: none"> • Approved by MPC. Inclusion of items for Florida, Hawaii, and Nebraska.
7/12/2018	<ul style="list-style-type: none"> • Approved by MPC. No changes.
8/18/2017	<ul style="list-style-type: none"> • Approved by MPC. Updated Florida specific criteria.
6/1/2017	<ul style="list-style-type: none"> • Approved by MPC. Added additional lines of business.
1/12/2017	<ul style="list-style-type: none"> • Approved by MPC. Inclusion of Nebraska and Illinois coverage language.
1/7/2016, 1/8/2015	<ul style="list-style-type: none"> • Approved by MPC. No changes.
11/6/2014	<ul style="list-style-type: none"> • Approved by MPC. Inclusion of KY HIX criteria. Policy previously applied to NY only.
1/9/2014, 12/6/2012	<ul style="list-style-type: none"> • Approved by MPC. No changes since 2011 update.
1/5/2012	<ul style="list-style-type: none"> • Approved by MPC. Reformatted references. Added NY DOH coverage update re: expanded coverage (2011) and specialist consultations (2010). Two new references added.
12/1/2011	<ul style="list-style-type: none"> • New template design approved by MPC.