Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Telehealth

Policy Number: POLPP109 **Last Review:** 7/1/2019
Effective Date: 7/1/2019 **Next Review:** 7/1/2020

Description

Telehealth services are described as the delivery of healthcare services through the use of interactive audio -video, or other interactive electronic media for the purpose of diagnosis, consultation, and/or treatment of a patient in a location separate from the servicing provider. Telehealth services do not include the use of audio only telephone, facsimile machine, or electronic mail. Telehealth services are used to support health care when the provider and the patient are physically separated. Typically, the patient communicates with the telehealth provider via interactive means that are sufficient to establish the necessary link to the telehealth provider who is working at a different location ("distant site") from the patient.

Blue KC will reimburse for the following telehealth services;

CODE	DESCRIPTION
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth [problem focused history, problem focused examination, straightforward MDM]
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth [detailed history, detailed examination, moderate complexity MDM]
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth [comprehensive history,

	comprehensive examination, high complexity MDM]
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth [problem-focused history, problem-focused examination, straightforward medical decision making (MDM)]
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth [detailed history, detailed examination, moderate complexity MDM]
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth [comprehensive history, comprehensive examination, high complexity MDM]
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth

Whether reporting initial or follow-up services, the provider must meet all three required elements (History, Exam, MDM) to bill a particular level of service. For example, to report G0407, the provider must document at least a comprehensive history, a compressive exam, and high complexity MDM.

The “lowest” of the three key components determines the billable level of service.

Modifiers

The G codes listed above are specific to telehealth services, therefore the GQ and/or GT modifier is not needed.

Place of Service

Services would typically be reported as follows:

- When a telehealth provider is rendering a service via interactive means from a different location from the patient, the telehealth provider would report “02” to identify the place of service as “distant site” along with the appropriate procedure and any applicable modifier.
- Where the patient is located at the time of service (e.g., an FQHC, rural health clinic, other provider office, hospital) is referred to as the originating (or presentation) site.

The beneficiary must go to the originating site for the services;

- Physicians/practitioners office(POS 11)
- Hospital (POS 21, 22, 23)
- Critical access hospital (POS 21, 22, 23)
- Rural health clinic (POS 72)
- Federally qualified health centers (POS 50)
- Hospital-based or CAH-based renal dialysis center (including satellites) (POS 65)
- Skilled nursing facility (POS 31, 32)

Documentation Must Meet Consult Requirements

(G0406, G0407, G0408, G0425, G0426, G0427 G0508, G0509)

The intent of an inpatient or emergency department telehealth consultation service is that a physician or qualified NPP or other appropriate source is asking another physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional’s knowledge.”

Documentation should verify the following elements:

1. A **request** for opinion or advice, and a stated reason to substantiate the need for the service.

2. A **report** from the consulting provider back to the requesting provider. The consultant shall prepare a written report of his/her findings and recommendations, which shall be provided to the referring physician. The

service is justified only if the consulting physician gives his opinion and/or advice to the requesting provider. Without a report back to the requesting provider, a consultation hasn’t occurred.

Additional Documentation

1. A statement that the service was provided using telemedicine;
2. The location of the patient;
3. The location of the provider; and
4. The names of all persons participating in the telemedicine service and their role in the encounter.

Document Submission

Documentation must identify and describe the procedures performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

The following applies to all claim submissions:
All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue KC Medical Policy criteria, policies found under Provider Payment Policy, Provider Office Guide and all other provisions of the Provider Service Agreement. In the event that any new codes are developed during the course of the Provider's Agreement, such new codes will be paid according to the standard or applicable Blue KC fee schedule until such time as a new agreement is reached and supersedes the provider's current agreement. Eligible services will be subject to the subscriber benefits, Blue KC fee schedule amount, and any coding edits.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service

Policy History

DATE	DESCRIPTION
	Approval Date
7/1/2019	Effective Date