Telehealth / Telemedicine

I. Policy

University Health Alliance (UHA) will reimburse for Telehealth / Telemedicine (hereto referred to in this policy as Telemedicine) for benefit payment in accordance with Medicare guidelines when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

For the purpose of these guidelines, telemedicine is the practice of healthcare delivery, diagnosis, consultation, treatment, and transfer of medical data, using interactive audio, video or data communications. This technology enables healthcare practitioners to deliver care to patients separated by distance. Standard telephone calls, fax transmissions and email, in the absence of other integrated information and data, do not qualify for benefit payment under UHA plans.

A. For Consultation services, the following definitions and guidelines apply:

An interactive video consultation allows a practitioner to consult with a specialist when they are separated by distance. This type of consultation generally involves a local “presenting” or referring practitioner, who presents and examines the patient while communicating with a distant specialist concerning the patient’s condition and course of treatment. In some cases, the presenting party may not be a medical professional. In such cases, the presenting party may not bill for his or her services.

To be eligible for benefit payment, a telemedicine consultation must meet the following criteria:

1. The patient must be present during the examination.
2. The examination must be performed using multimedia communications that include, at a minimum, audio-video equipment permitting two-way, real-time communications.
3. The examination must be an interactive medical examination and clinical assessment directed by the specialist/consultant.
4. The examination must include the participation of the presenting party, who provides information to, and at the direction of, the specialist and who is available to receive the specialist’s immediate feedback or assessment.
5. If a medical examination is performed by a practitioner at the originating site during the telemedicine consultation, the practitioner must be an eligible provider to receive payment for the service.
6. The specialist/consultant must be an eligible provider and the services performed must be eligible services.
7. The distant site of the services must be of a sufficient distance from the originating site to provide services to patients who do not have readily available access to such specialty services.
8. A permanent record of online communications relevant to the ongoing medical care of the patient should be maintained as part of the patient’s medical record and available for UHA review if requested.
B. For Procedural Services, the following definitions and guidelines apply:

1. For procedural services that are performed under the direction of the specialist/consultant, the physician who actually performs the service should bill using standard procedure codes. It is not necessary to use a GT modifier. Benefits will be paid based on the fee schedule for the procedural service.

2. The specialist/consultant physician (who monitors the procedure and advises the attending physician via video) should bill for a consultation, not for the procedure. The consultation should be billed using modifier code GT. Plan benefits will be paid based on the fee schedule for the consultation.

C. For Emergency Room services, the following guidelines apply:

1. An emergency room physician may bill for a consultation if a physician in an outlying area requests a telemedicine consultation. The consultation should be billed using modifier code GT. Plan benefits will be paid based on the fee schedule for the consultation.

2. If the patient eventually is taken to the consulting physician's emergency room for treatment, the physician may only bill for the resulting emergency room visit. The physician should not bill both a telemedicine consultation and an emergency room visit for the same patient on the same date or for the same encounter.

D. “Store and Forward” Technology will be reimbursed within the following definitions and guidelines:

1. “Store and Forward” technology is defined as the transmission of medical information via telecommunications media to be reviewed at a later time by a practitioner at the distant site. The information is then available at the new location for viewing and interpretation. The patient does not need to be present. The medical information may include, but is not limited to, video clips, still images, X-rays, MRIs, EKGs, and EEGs, laboratory results, audio clips and text. Photographs must be specific to the patient’s condition and adequate for rendering or confirming a diagnosis and/or treatment plan.

2. The interpretation only of stored diagnostic tests or images may be billed using standard CPT codes followed by modifier code 26.

3. If the receiving specialist interprets the data and writes a consultation report, the service can be billed using modifier code GQ.

E. Special Considerations

All plan provisions, exclusions, payment guidelines and negotiated agreements apply to services delivered through telemedicine.

Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided. Claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided and the telemedicine modifier GT for interactive audio and video telecommunications system or GQ for store-and-forward applications.

Originating Site:
The originating site receives a flat reimbursement rate. There must be a separate bill for this service. The billing code is HCPCS code Q3014 “telehealth originating site facility fee” and is used by any approved providers to bill for their service.
Consult site:
Reimbursement for the consult site provider is the regular reimbursement amount for the service. The appropriate CPT code is billed along with the GT modifier for live interactive telemedicine and GQ for store and forward applications.

F. NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members’ individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Administrative Guidelines

A. Prior authorization is not required.

B. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record and must be made available to UHA upon request. UHA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria and to ensure proper reimbursement is made.

C. This policy may apply to the following codes. Inclusion of a code in the table below does not guarantee that it will be reimbursed.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241-99275</td>
<td>Consultations</td>
</tr>
<tr>
<td>90806</td>
<td>Individual psychotherapy</td>
</tr>
<tr>
<td>90862</td>
<td>Pharmacologic management</td>
</tr>
</tbody>
</table>

IV. Policy History

Policy Number: M.MIS.16.120515
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Original Document Effective Date: 05/15/2012
Previous Revision Dates: N/A

References: