Payment Policy | Temporary Telemedicine/Telehealth Services Provided Via Telephone Only

EFFECTIVE DATE: 03|05|2020
POLICY LAST UPDATED: 03|05|2020

OVERVIEW

In the event that the State of Rhode Island declares a state of emergency due to a pandemic health concern such as COVID-19 or if Blue Cross & Blue Shield of Rhode Island (BCBSRI) elects to enact this policy outside of a declared state of emergency, **BCBSRI will temporarily allow for telemedicine/telehealth services to be provided by telephone only.**

This policy applies to BCBSRI participating providers only.

This policy is outside of Chapter 27-81 "The Telemedicine Coverage Act."

BCBSRI reserves the right to implement and revoke this policy without the contractual sixty-day (60) notification for a change in policy that is normally required under BCBSRI contracts with its providers. This would apply both for the effective date, due to the urgent and emergent nature of a pandemic, as well as for the withdrawal of the policy.

Notice of the implementation and withdrawal of this policy will be communicated to BCBSRI providers via a notice on BCBSRI's provider website/portal under Alerts and Updates.

For telemedicine/telehealth services for which a video component and a compliant secure electronic communication is used, e.g., traditional telemedicine/telehealth services, please refer to BCBSRI's ***Telemedicine/Telehealth Services Policy***, which will remain in effect during the timeframe this policy is in effect. There is no waiver of member cost share related to non-telephone only telemedicine/telehealth services.

MEDICAL CRITERIA

Not applicable

PRIOR AUTHORIZATION

Not applicable

POLICY STATEMENT

BlueCHiP for Medicare and Commercials Products

Telemedicine services (provided via telephone only) are covered when all of the following criteria are met:

1. The patient is present/participates at the time of service.
2. Services should be similar to in-person services with a patient.
3. Services must be medically necessary and otherwise covered under the member's benefit booklet or subscriber agreement.
4. Services must be within the provider's scope of license.
5. A permanent record of the telephonic communication(s) must be documented/maintained as part of the patient's medical record.

Non-Behavioral Health Providers

For non-behavioral health providers, telemedicine services provided via telephone only during a state of emergency or implementation of this policy by BCBSRI are limited to the following provider types/primary care physician and midlevel primary care providers, and must be filed under CPT code 99211 and 99212 (See Coding Section for details). **No other CPT codes will be acceptable for reimbursement from BCBSRI for telephone only services.**

Reporting codes 99211 and 99212 include the assessment and/or triage of a patient and/or communication with a patient to inform them related to a decision to seek face-to-face services at the provider's practice or other location, e.g., ER or Urgent Care as well as communicating with a patient related to the status of their condition while they are sequestered in their home or other location.

Please refer to the Coverage section below for details related to BCBSRI's waiver of subscriber cost share for telephone only telemedicine/telehealth during the time-period of heightened concerns related to COVID-19.

Behavioral Health Providers

For behavioral health providers, telemedicine services provided via telephone during a state of emergency or implementation of this policy by BCBSRI are limited to the following providers and must be filed with the CPT codes found in the Behavioral Health Coding Section below.

- Clinical nurse specialist
- Psychiatrist
- Psychologist
- Clinical social worker
- Licensed Marriage and Family Therapist (not allowed for BC for Medicare)
- Licensed Mental Health Counselor (not allowed for BC for Medicare)

Only the provider rendering the services via the telephone may submit for reimbursement for telemedicine services.

BlueCHiP for Medicare and Commercial Products
The following services are excluded from reimbursement:

- Services rendered through email, text or by fax.
- Telemedicine that occurs the same day as a face-to-face visit, when performed by the same provider and for the same condition.
- Patient communications incidental to E&M services, including, but not limited to reporting of test results or provision of educational materials.
- Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for applicable telemedicine services benefits/coverage.

BCBSRI Cost Share Waiver for Primary Care Physicians and Midlevel Primary Care Providers

BCBSRI will waive all member cost share for BCBSRI subscribers (waiver of the cost share does not apply to BlueCard HOST members/those members of other Blue Cross Blue Shield Plans nationally) telephone only telemedicine/telehealth services as outlined in this policy, during the time period of heightened concerns related to COVID-19. Primary care providers should NOT collect cost share from a member in accordance with this policy.

For all services provided by behavioral health providers all applicable member cost share applies.

CODING

For Non-Behavioral Health Providers

BlueCHiP for Medicare and Commercial Products
The following codes are covered as telemedicine services when filed with modifier CR and place of service 02 and the telemedicine criteria set forth in this policy are met:

99211 Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

Modifier CR: Catastrophe/Disaster Related

Place of Service (POS) 02: Telehealth: The location where health services and health related services are provided or received, through telehealth telecommunication technology.

Note: Any claim filed with a code NOT listed above with POS 02 will deny as invalid POS as a provider liability.

For Behavioral Health Providers

BlueCHiP for Medicare and Commercials Products
The following codes are covered as telemedicine services when filed with modifier CR and POS 02 and the telemedicine criteria set forth in this policy are met:

90791 Psychiatric diagnostic evaluation
90792 Psychiatric diagnostic evaluation with medical services
90832 Psychotherapy, 30 minutes with patient
90833 Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90834 Psychotherapy, 45 minutes with patient
90836 Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90837 Psychotherapy, 60 minutes with patient
90838 Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90839 Psychotherapy for crisis; first 60 minutes
90840 Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)
99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused

examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

Modifier CR: Catastrophe/Disaster Related

Place of Service (POS) 02: Telehealth: The location where health services and health related services are provided or received, through telehealth telecommunication technology.

Note: Any claim filed with a code NOT listed above with POS 02 will deny as invalid POS as a provider liability.

REIMBURSEMENT

As with traditional telemedicine/telehealth services, all BCBSRI standard reimbursement rules/reductions related to telemedicine/telehealth services as well as midlevel reductions will apply to all services referenced in this policy.

BCBSRI reserves the right to audit medical records related to adherence to all the requirements of this policy e.g. to verify the nature of the phone call etc.

RELATED POLICIES

Telemedicine/Telehealth Services

PUBLISHED

BCBSRI's website under Alerts and Updates
An FAQ document is available at https://www.bcbsri.com/providers/faq
[link to be determined]

REFERENCES

Not applicable

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.