

Commercial Reimbursement Policy	
Subject: Telehealth Services	
Policy Number: C-08002	Policy Section: Evaluation and Management
Last Approval Date: 07/19/2019	Effective Date: 07/19/2019

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member’s Anthem Blue Cross and Blue Shield (Anthem) benefit plan. The determination that a service, procedure, item, etc., is covered under a member’s benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member’s state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and non-participating providers and facilities. This reimbursement policy also applies to Employer Group Retiree Medicare Advantage programs. If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- *Reject or deny the claim*
- *Recover and/or recoup claim payment*

These policies may be superseded by provider or state contract language, or state, federal requirements or mandates. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. Anthem reserves the right to review and revise these policies periodically when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan reimburses for telehealth services when interactive services occur between the patient and the remote provider. Reimbursement for the rendering provider is based on:

- services provided through a telehealth program with a secure and private data connection
- or-
- telehealth services mandated by state or federal law
- reporting place of service “02” to indicate “distant site”
- the appropriate telehealth specific CPT /HCPCS code or applicable telehealth modifier

A provider rendering in-person services at the patient’s location should report:

- the appropriate code for the in-person services
- reporting appropriate place of service to indicate the originating site

The following services are not eligible for reimbursement as telehealth services:

- in person services not rendered in an office or facility setting
- non-direct patient services
- services rendered by audio-only telephone communication, facsimile, e-mail, instant messaging, or other electronic communication

- services rendered as a telehealth service that are not eligible for reimbursement when rendered to the patient in-person

Related Coding

Code	Description	Comments
Modifier 95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System	Required when no telehealth specific code has been reported
Modifier GQ	Via asynchronous telecommunications system	Required when no telehealth specific code has been reported
Modifier GT	Via interactive audio and video telecommunication systems	Required when no telehealth specific code has been reported

Exemptions

Connecticut	Does not allow reimbursement for modifier GQ
Maine	Does not allow reimbursement for modifier GQ
New Hampshire	Does not allow reimbursement for modifier GQ
Nevada	Does not allow reimbursement for modifier GQ

Policy History

01/01/2020	Review approved 01/01/2020: Removed NH exemption “Telehealth services appended with modifier 95 or GT are reimbursed at 70% of the maximum allowable benefit”.
07/19/2019	Biennial Review approved 07/19/2019: removed language “health plan approved” telehealth program and example “Livehealth Online”, added “instant messaging or other electronic communication” to the not eligible for reimbursement list
01/10/2019	Review approved effective 01/10/2019: Updated Policy to new template, removed informational coding tables, condensed policy language
07/11/2017	Revised: added brackets in policy language, updated language on modifiers
12/06/2016	Revised: added place of service code “02” effective 01/01/17
10/04/2016	Revised: added Modifier 95 effective 01/01/17
03/01/2016	Revised: add codes
10/06/2015	Revised: minor update, bracketing codes based on local policies
08/04/2015	Annual Review: revising document based on state mandates, removed telemedicine information, changed policy statement to comply with mandates, modifiers GQ, GT updated, CPT & HCPC codes moved to table format, removed all codes not related to telehealth
08/05/2014	Annual Review: minor updates including copyright date
08/06/2013	Revised: Minor language updates and spelling corrections
04/02/2013	Revised: added codes eff 01/01/13

01/08/2013	Revised: removed deleted CPT codes, added new 2013 CPT codes. Updated language CPT codes that are not eligible for reimbursement
09/11/2012	Annual Review with Revisions: Updated HCPC descriptions to match 2012 HCPC language update, updated code not eligible for separate reimbursement, added brackets for pilot program
09/13/2011	Revised: CPT added to Bundled Services Policy and moved as 2 nd bullet point
01/04/2011	Annual review: no changes
12/17/2008	Revised: Definitions revised, policy section updated to add covered and non-covered services, new HCPC codes added eff. 01/01/10
11/24/2008	Revised: Policy format revised, added new CPT and HCPC codes eff 07/01/08
03/10/2008	Initial policy approval and effective date

References and Research Materials

<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> American Medical Association (AMA) Current Procedural Terminology (CPT®) Professional Edition 2017 Healthcare Common Procedure Coding System (HCPCS Level II) CMS (42 CFR 410.78)

Definitions

Store and Forward	The transmission of a member’s medical information from an originating site to the physician or practitioner at the distant site. The physician or practitioner at the distant site can review the medical case without the member being present.
Telehealth services	The use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations between provider and patient) that states may choose to cover.
General Reimbursement Policy Definitions	

Related Policies and Materials

Bundled Services and Supplies
Documentation and Reporting Guidelines for Evaluation and Management Services
Place of Service
Scope of License

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member’s benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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