INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Telemedicine and Telehealth Services

Note: The IHCP telemedicine policy described in this module was revised in response to the coronavirus disease 2019 (COVID-19). The revised policy will be in place until the end of the public health emergency. To find the interim policy updates, providers can go to the Bulletin Search and Banner Page Search at in.gov/medicaid/providers and search by keyword: ***telemedicine****.*

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: September 20, 2016	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of October 1, 2017 Published: January 11, 2018	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of January 1, 2019 Published: March 14, 2019	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of October 1, 2019 Published: February 6, 2020	Scheduled update • Edited text as needed for clarity • Updated the initial note box with standard wording • Updated the list in the *Excluded Provider Types and Services* section to align with the IAC and added a reference to the telemedicine services code table • Clarified information about office visits in the *Special Considerations* section • Updated the *Billing and Reimbursement for Telemedicine Services* section and subsections to reflect new procedures • Added the *Out-of-State Telemedicine Providers* section	FSSA and DXC
4.1	Policies and procedures as of October 1, 2019 Published: March 30, 2021	Added note box to title page with information about temporary policies for the COVID-19 public health emergency	FSSA and Gainwell

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Telemedicine and Telehealth Services

> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.*
>
> *For updates to coding, coverage, and benefit information, see IHCP Banner Pages and Bulletins at in.gov/medicaid/providers.*

Introduction

Telemedicine services are defined as the use of videoconferencing equipment to allow a medical provider to render an exam or other service to a patient at a distant location. The Indiana Health Coverage Programs (IHCP) covers telemedicine services, including medical exams and certain other services normally covered by Medicaid, within the parameters specified in *Indiana Administrative Code 405 IAC 5-38.*

> *Note: Telemedicine is **not** the use of the following:*
>
> - *Telephone transmitter for transtelephonic monitoring*
> - *Telephone or any other means of communication for consultation from one provider to another*

Telehealth services are defined as the scheduled remote monitoring of clinical data through technologic equipment in the member's home. Data is transmitted from the member's home to the home health agency to be read and interpreted by a registered nurse (RN). The technologic equipment enables the home health agency to detect minute changes in the member's clinical status, which allows home health agencies to intercede before the member's condition advances and requires emergency intervention or inpatient hospitalization.

Telemedicine Services

In any telemedicine encounter, the following must be available:

- Distant site – Location of the provider rendering healthcare services
- Originating site – Location where the patient is physically located when services are provided through telemedicine
- Attendant to connect the patient to the provider at the distant site
- Videoconferencing equipment, such as a computer or television monitor, at the distant and originating sites to allow the patient to have real-time, interactive, and face-to-face communication with the distant provider via interactive television (IATV) technology

> *Note: The IHCP allows store-and-forward technology (the electronic transmission of medical information for subsequent review by another healthcare provider) to facilitate other reimbursable services; however, separate reimbursement of the originating-site payment is not provided for store-and-forward technology because of restrictions in 405 IAC 5-38-2(4). Only IATV is separately reimbursed by the IHCP.*

The member should always be given the choice between a traditional clinical encounter versus a telemedicine visit.

Telemedicine services may be rendered in an inpatient, outpatient, or office setting. All services that are available for reimbursement when delivered as telemedicine are subject to the same limitations and restrictions as they would be if *not* delivered by telemedicine. For service-specific limitations and restrictions, including prior authorization (PA) requirements, see the appropriate provider reference module, available from the *IHCP Provider Reference Modules* page at in.gov/medicaid/providers.

Excluded Provider Types and Services

The IHCP does not reimburse the following provider types or services for telemedicine, per *405 IAC 5-38-4(5):*

- Ambulatory surgical centers
- Outpatient surgical services
- Home health agencies or services *(For information about home health agency reimbursement for* ***telehealth*** *services, see the Telehealth Services section.)*
- Radiological services
- Laboratory services
- Long-term care facilities, including nursing facilities, intermediate care facilities, and community residential facilities for the developmentally disabled
- Anesthesia services or nurse anesthetist services
- Audiological services
- Chiropractic services
- Care coordination services
- Durable medical equipment (DME) and home medical equipment (HME) providers
- Optical or optometric services
- Podiatric services
- Physical therapy services
- Transportation services
- Services provided under a Medicaid Home and Community-Based Services (HCBS) waiver
- Provider-to-provider consultations

IHCP reimbursement for telemedicine is limited to the services listed in *Telemedicine Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers. No other services are reimbursed when delivered via telemedicine.

Conditions of Payment

For IHCP reimbursement of telemedicine services, the member must be physically present at the originating site and must participate in the visit.

The practitioner who will be examining the patient from the distant site must determine if it is medically necessary for a medical professional to be at the originating site. Separate reimbursement for a provider at the originating site is payable only if that provider's presence is medically necessary. Documentation must be maintained in the patient's medical record to support the need for the provider's presence at the originating site during the visit. Such documentation is subject to postpayment review. If a healthcare provider's presence at the originating site is medically necessary, billing of the appropriate evaluation and management code is permitted.

Special Considerations

The following special circumstances apply to telemedicine services:

- When ongoing services are provided, the member should be seen by a physician for a traditional clinical evaluation at least once a year, unless otherwise stated in policy. In addition, the distant provider should coordinate with the patient's primary care physician.
- Office visits conducted via telemedicine are subject to existing service limitations for office visits. Telemedicine office visits billed using applicable codes from *Telemedicine Services Codes* (accessible from the *Code Sets* page at in.gov/medicaid/providers) are counted toward the member's office visit limit. See the *Evaluation and Management Services* module for information about office visit limitations.
- Although reimbursement for end-stage renal disease (ESRD)-related services is permitted in the telemedicine setting, the IHCP requires at least one monthly visit for ESRD-related services to be a traditional clinical encounter to examine the vascular access site.
- A provider can use telemedicine to prescribe a controlled substance to a patient who has not been previously examined. Opioids, however, cannot be prescribed via telemedicine, except in cases in which the opioid is a partial agonist (such as buprenorphine) and is being used to treat or manage opioid dependence.

Documentation Standards

Documentation must be maintained at the distant and originating locations to substantiate the services provided. Documentation must indicate that the services were rendered via telemedicine and must clearly identify the location of the distant and originating sites.

All other IHCP documentation guidelines apply for services rendered via telemedicine, such as chart notes and start and stop times. Documentation must be available for postpayment review.

Providers should always give the member the choice between a traditional clinical encounter versus a telemedicine visit. Appropriate consent from the member must be obtained by the originating site and documentation maintained at both the distant and originating sites. Providers must have written protocols for circumstances when the member requires a hands-on visit with the provider.

Billing and Reimbursement for Telemedicine Services

When billing telemedicine services, providers must include ***all three*** of the following on the claim for dates of service on or after August 23, 2019:

- Valid procedure code from the telemedicine code set for the telemedicine service rendered (see *Telemedicine Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers)
- Place of service (POS) code 02 – *The location where health services and health related services are provided or received, through a telecommunication system*
- Modifier 95 – *Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system*

If a claim includes POS code 02 or modifier 95, but not both, the claim detail will deny for explanation of benefits (EOB) 3428 – *Telemedicine services require place of service 02 and modifier 95*.

> *Note: Modifier GT (Via interactive audio and video telecommunications system) is optional but can be used with the applicable procedure codes to denote telemedicine services.*

With the exception of services billed by an FQHC or RHC (see the *Telemedicine Services for FQHCs and RHCs* section), the payment for telemedicine services is equal to the current Fee Schedule amount for the procedure codes billed (see the *IHCP Fee Schedules* page at in.gov/medicaid/providers).

Additional billing information for distant and originating sites is provided in the following subsections.

Distant Site Services

Telemedicine Services Codes, accessible from the *Code Sets* page at in.gov/medicaid/providers, lists the Current Procedural Terminology (CPT®[1]) codes that are reimbursable when the services are rendered via telemedicine at the distant site, and billed with modifier 95 and POS code 02.

Originating Site Services

Healthcare Common Procedure Coding System (HCPCS) code Q3014 – *Telehealth originating site facility fee*, billed with modifier 95, is reimbursable for providers that render services via telemedicine at the originating site.

If the originating site is a hospital or other location that bills on an **institutional claim**, HCPCS code Q3014 is reimbursable when billed with revenue code 780 – *Telemedicine – General*. If a different, separately reimbursable treatment room revenue code is provided on the same day as the telemedicine service, the appropriate treatment room revenue code should also be included on the claim. Documentation must be maintained in the patient's record to indicate that services were provided separately from the telemedicine visit.

If the originating site is a physician's office, clinic, or other location that bills on a **professional claim**, and other services are provided on the same date as the telemedicine service, the medical professional should bill Q3014 as a separate line item from other professional services.

Telemedicine Services for FQHCs and RHCs

FQHC and RHC providers may bill for telemedicine services if the service rendered is considered a valid FQHC or RHC encounter (as defined in the *Federally Qualified Health Centers and Rural Health Clinics* module) and a covered telemedicine service (as defined in this module). Subject to the following criteria, reimbursement is available to FQHCs and RHCs when they are serving as either the distant site or the originating site for telemedicine services:

- When the FQHC or RHC is the *distant site* (the location of the provider rendering services), the service provided by the FQHC or RHC must meet the requirements both for a valid encounter and for an approved telemedicine service (as defined in this module). The claim must include the following:
  - Encounter code T1015 billed with POS code 11, 12, 31, 32, 50, or 72
  - An appropriate CPT code, billed with modifier 95 and POS code 02 – must be a code that appears both in the *Telemedicine Services Codes* (accessible from the *Code Sets* page at in.gov/medicaid/providers) and on the list of procedure codes allowable for an FQHC/RHC encounter (accessible from the Myers and Stauffer website at mslc.com/Indiana)
- When the FQHC or RHC is the *originating site* (the location where the patient is physically located), the FQHC or RHC may be reimbursed if it is medically necessary for a medical professional to be present with the member, and the service provided includes all components of a valid encounter code. The claim must include the following:
  - Encounter code T1015, billed with POS code 11, 12, 31, 32, 50, or 72
  - HCPCS code Q3014, billed with POS code 02 and modifier 95

[1] *CPT copyright 2019 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

In either case, reimbursement for the T1015 encounter code is based on the prospective payment system (PPS) rate specific to the FQHC or RHC facility. All other procedures codes on the claim will deny with EOB 6096 – *The CPT/HCPCS code billed is not payable according to the PPS reimbursement methodology.*

All components of the service must be provided and documented, and the documentation must demonstrate medical necessity. All documentation is subject to postpayment review.

Separate reimbursement for merely serving as the originating site is not available to FQHCs and RHCs. When the presence of a medical professional is not medically necessary at the originating site, neither the facility fee, as billed by HCPCS code Q3014, nor the facility-specific PPS rate is available, because the requirement of a valid encounter is not met. Pursuant to the *Code of Federal Regulations 42 CFR 405.2463*, an encounter is defined by the Centers for Medicare & Medicaid Services (CMS) as a face-to-face meeting between an eligible provider and a Medicaid member during which a medically necessary service is performed. Consistent with federal regulations, for an FQHC or RHC to receive reimbursement for services, including those for telemedicine, the criteria of a valid encounter must be met.

> *Note: FQHCs and RHCs may submit telemedicine claims to a member's MCE and receive reconciliation review through Myers & Stauffer, which, in coordination with the Family and Social Services Administration (FSSA), determines reimbursable and nonreimbursable services.*

Out-of-State Telemedicine Providers

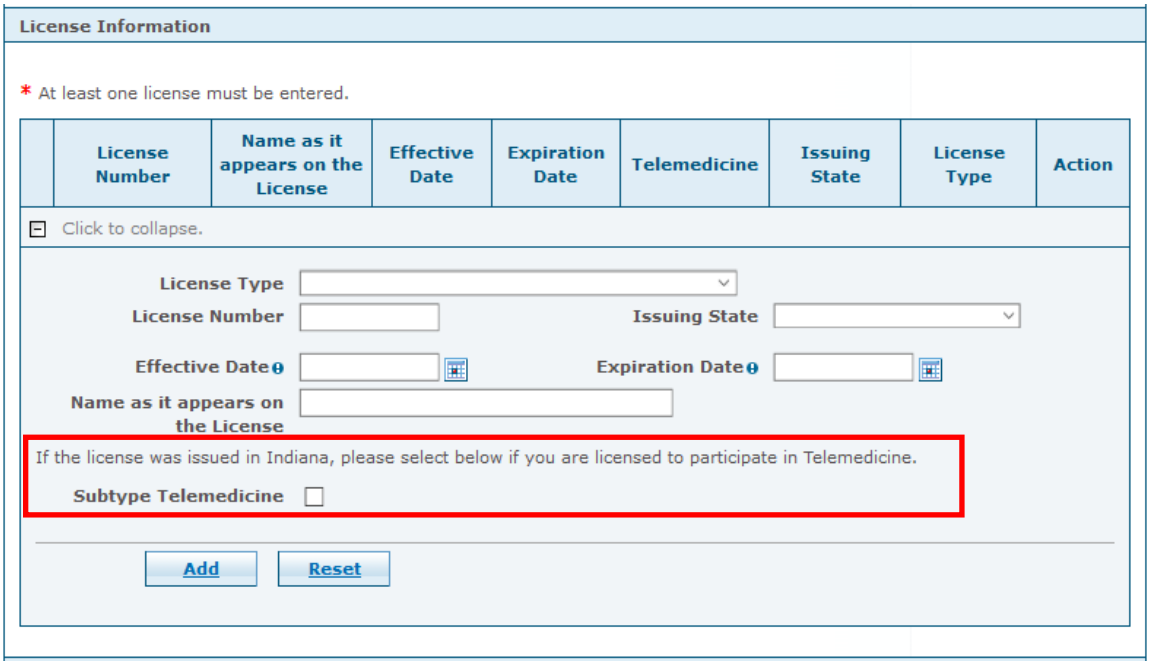
Effective September 26, 2019, out-of-state providers can perform telemedicine services without fulfilling the out-of-state prior authorization requirement if they have the subtype "telemedicine" attached to their enrollment.

The telemedicine subtype is available only to providers that meet all the following requirements:

- The enrollment must be for one of the following provider types:
  - 09 – Advanced practice registered nurse
  - 10 – Physician assistant
  - 14 – Podiatrist
  - 18 – Optometrist
  - 31 – Physician
- The enrollment must have one of the following classifications:
  - Rendering
  - Billing
- The provider must have a license issued from the Indiana Professional Licensing Agency (IPLA) with the Telemedicine Provider Certification.

Out-of-state providers that meet all the preceding requirements can add the telemedicine subtype during the initial enrollment process, at revalidation, or as an update to a current enrollment. During the enrollment application process on IHCP Provider Healthcare Portal (Portal), the option to add the telemedicine subtype appears in the *License Information* section of the *Provider Identification* panel (see Figure 1). Currently enrolled providers can access this option by logging in to their registered Portal account and selecting **Provider Maintenance > Provider Identification Changes** and scrolling to the *License Information* section. To add the telemedicine subtype to their out-of-state enrollment, providers must enter information about their IPLA license and select the Subtype Telemedicine checkbox. This option is displayed only for the five provider types listed and only for rendering or billing classifications.

Figure 1 – The Telemedicine Subtype Option for Out-of-State Providers



A copy of the IPLA license must also be submitted. On the *Attachments* page of the enrollment or provider maintenance process, select **Provider License** from the Attachment Type drop-down menu. From the Transmission Method drop-down box, select FT-File Transfer if attaching the license electronically, or select BM-By Mail if sending a copy of the license by mail. If FT-File Transfer was selected, use the **Upload File** field to attach the electronic copy of the license and then click **Add**.

After the enrollment or update is processed and approved, a telemedicine indicator will be added to the provider account in *Core*MMIS, allowing the out-of-state provider to be viewed as an in-state provider when billing telemedicine services.

Telehealth Services

The IHCP covers telehealth services provided by home health agencies to members who are approved for other home health services. The IHCP reimburses for telehealth services when the service is provided in compliance with all IHCP guidelines, including obtaining prior authorization (PA) as described in the following section.

In any telehealth services encounter, a licensed RN must read the transmitted health information provided from the member, in accordance with the written order of the physician. See *405 IAC 1-4.2-6*. The nurse must review all data on the day the ordered data is received or, in cases when the data is received after business hours, on the first business day following receipt of the data. Transmitted data must meet *Health Insurance Portability and Accountability Act* (HIPAA) compliance standards.

The home health agency will follow the monitoring criteria and interventions for the treatment of the member's qualifying condition, as outlined in the plan of care. Any potential medical concerns should be communicated to the ordering physician. Members who are unable or unwilling to use the telehealth equipment appropriately will be disenrolled from telehealth services.

Prior Authorization Requirements

PA is required for all for telehealth services, per *405 IAC 1-4.2-3* and *405 IAC 5-16-3*. Telehealth services are indicated for members who require scheduled remote monitoring of data related to the member's qualifying chronic diagnoses that are not controlled with medications or other medical interventions.

To initially qualify for telehealth services, the member must have had two or more of the following events within the previous 12 months:

- Emergency room visits
- Inpatient hospital stays

> *Note: An emergency room visit that results in an inpatient hospital admission does not constitute two separate events.*

The two qualifying events must be for the treatment of one of the following diagnoses:

- Congestive heart failure
- Chronic obstructive pulmonary disease
- Diabetes

Additionally, to qualify for telehealth services, the member must be receiving or approved for other IHCP home health services, as described in the *Home Health Services* module. The PA request for telehealth services must be submitted separately from other home health service PA requests.

Telehealth services may be authorized for up to 60 days per PA request. After initially qualifying, to continue receiving telehealth services, the member must have a current diagnosis of one of the previous qualifying diagnoses and continue to receive other home health services.

The following items must be submitted along with the telehealth PA request:

- A physician's written order, signed and dated by the physician.
- A plan of care (POC), signed and dated by the physician
- An attestation from the home health agency that the telehealth equipment to be placed in the member's home is capable of monitoring any data parameters included in the POC, and that the transmission process meets HIPAA compliance standards

Plan of Care Requirements

Monitoring criteria and interventions for the treatment of the member's qualifying conditions must be developed collaboratively between the member's physician and the home health agency and included in the member's POC. The monitoring criteria and interventions should be directly related to the member's qualifying diagnoses. Other monitoring criteria and interventions may be developed for other conditions the member may have, but the primary criteria and interventions must be for treatment of the qualifying diagnoses.

The POC must clearly outline the patient's health data and information to be monitored and measured, and the circumstances under which the ordering physician should be contacted to address any potential health concerns. The POC must also indicate how often an RN must perform a reading of transmitted health information.

The POC must be signed and dated by the physician and submitted with the PA request.

Billing and Reimbursement for Telehealth Services

Approved telehealth services are reimbursed separately from other home health services. The initial visit is limited to a one-time visit to educate the member or caregiver about how to properly operate the telehealth equipment. A remote skilled nursing visit cannot be billed on the same date that a member received a skilled nursing visit in the home. The telehealth reading should be included in the skilled nursing home visit when the reading and the home visit are performed on the same day.

All equipment and software costs associated with the telehealth services must be separately identified on the home health provider's annual cost report so that the equipment and software costs may be removed from the calculation of overhead costs.

Rates for telehealth services are not adjusted annually.

Home health agencies bill telehealth services using revenue code 780 along with CPT code 99600 and the appropriate modifiers, as follows:

- 99600 U1 – *Unlisted home visit service or procedure; one time initial face-to face visit necessary to train the member or caregiver to appropriately operate the telehealth equipment*
- 99600 U2 TD – *Unlisted home visit service or procedure; remote skilled nursing visit to monitor and interpret telehealth reading; RN*