Telehealth – Medical Services

Payment policy

MASSACHUSETTS

Policy

Blue Cross Blue Shield of Massachusetts (Blue Cross*) reimburses contracted health care providers for covered, medically necessary telehealth services.

This payment policy describes reimbursement for telehealth (telemedicine) and other electronic communication services in line with Chapter 260 of the Acts of 2020: The Patients First Act, which occur when the physician or other qualified health care professional and the patient are not at the same site. Examples of such services are those that are delivered via the telephone or using other communication devices. Any and all parts of this payment policy may be changed to comply with regulations or guidance from the Division of Insurance.

Blue Cross providers must deliver telehealth and telephone services via a secure and private data connection. All transactions and data communication must comply with the Health Insurance Portability and Accountability Act (HIPAA). For more information on HIPAA and electronic protected health information (EPHI) compliance, please see: https://www.hhs.gov/hipaa/for-professionals/index.html

Telehealth services are reimbursed when:

- The provider is contracted with Blue Cross Blue Shield of Massachusetts or is providing services through a telehealth or telemedicine vendor contracted with another Blue Cross Blue Shield Plan and meets all terms and conditions of the applicable contracts, including credentialing and licensure.
- The provider renders care from the location listed in his or her contract with Blue Cross Blue Shield of Massachusetts or other appropriate location(s), in a professional, non-public space.
- The provider must be licensed in accordance with applicable state law in the state where the member is physically located during the telehealth visit. It is up to the provider to comply with Federal and state legislative rules on telehealth.

Documentation requirements for telehealth:

- For an initial appointment with a new patient, the provider must review the patient's relevant medical history and medical records with the patient before initiating the delivery of any service.
- For existing provider-patient relationships, the provider must review the patient's medical history and any available medical records with the patient during the service.
- Before each appointment, the provider must ensure that they are able to deliver the services to the same standard as in-person care and in compliance with their licensure regulations and requirements, programmatic regulations, and performance specifications related to the service (e.g., accessibility and communication access).
- If the provider cannot meet appropriate standard of care or other requirements for providing requested care via telehealth, then they must make this determination before delivering treatment. They must also notify the patient, and advise the patient to seek appropriate in-person care.
- To the extent feasible, providers must ensure patients the same rights to confidentiality and security as provided in face-to-face services, and providers must inform patients of any relevant privacy considerations prior to providing services via telehealth.
- Providers must follow consent and patient information protocols consistent with the protocols followed during in-person visits.
- Providers must inform patients of the location of the provider rendering services via telehealth (i.e., distant site) and obtain the location of the patient (i.e., originating site).
- Providers must inform the patient how to see a clinician in-person in the event of an emergency or otherwise.
- Evaluation and management documentation requirements must be met as outlined in the Evaluation and Management payment policy.
- Telehealth services including evaluation and management services must meet the documentation standards to support the level of service provided.

General benefit information

Covered services and payment are based on the member's benefit plan and provider Agreement. Providers and their office staff may use our online tools to verify effective dates and member copayments before providing services. Visit our eTools page for information on member eligibility and benefits. Member liability may include, but is not limited to: copayments,

deductibles, and co-insurance. Members' costs depend on member benefits. Certain services require prior authorization or referral.

Reimbursement information

Except as specifically noted below, Blue Cross reimburses health care providers based on your contracted rates and member benefits. Blue Cross reserves the right to perform post-payment audits and recover payments retrospectively if found to be inconsistent with Blue Cross policies.

Claims are subject to payment edits, which Blue Cross updates regularly.

Face-to-face medical services delivered via telehealth or telephone

- Primary care providers and chronic diagnosis claims will be reimbursed at parity and no reduction will apply. Please refer to the CMS List of Chronic Condition Categories.
- Non-primary care providers and non-chronic diagnosis claims, a 20% reduction will apply to telehealth visits. (Reduction will not apply to services with site of service payment differential in a facility place of service)
- Report modifier GT, 95, G0 or FR for services delivered via telehealth.
- Report modifier 93, FQ for services delivered via telephone.
- Report modifier GQ for services delivered via asynchronous telecommunications system
- Telephonic and telehealth services are subject to frequency editing as indicated in the code description for these services. For example, Blue Cross will not reimburse a telephonic code if there was a **related** Evaluation and Management (E/M) service provided in the previous 7 days or leading to an E/M service or procedure within the next 24 hours or an E/M service or procedure provided on the same day. See coding grid for additional information.
    - Frequency editing does not apply for face-to-face behavioral health services performed via telephone.

Medicare Advantage Product: Services provided via telephone/audio only may not be reimbursed beyond public health emergency (PHE).

Telephonic and telehealth services inherent in the code descriptions per AMA and CPT

- Blue Cross will reimburse telephonic and telehealth services inherent in the code descriptions per AMA and CPT at the standard BCBSMA rate or relative value unit rate.
- A telehealth modifier is not required for codes in which a telehealth/telephonic service is inherent in the code description. For example: telephonic codes 98966, 98967, 98968, 99441, 99442, and 99443 do not require a modifier.
- Telephone evaluation and management service report under HCPC code (99441-43) will apply at 20% reduction. (reduction will not apply to Primary care physicians and chronic diagnosis claims)
- Telephonic and telehealth services are subject to frequency editing as indicated in the code description for these services. For example, Blue Cross will not reimburse a telephonic code if there was a **related** Evaluation and Management (E/M) service provided in the previous 7 days or leading to an E/M service or procedure within the next 24 hours or an E/M service or procedure provided on the same day. See coding grid for additional information.
    - Telephonic and telehealth services will be reimbursed when there is an **unrelated** E/M reported in the previous 7 days or leading to an E/M service or procedure within the next 24 hours or an E/M service or procedure provided on the same day.

Medicare Advantage Product: Services provided via telephone/audio only may not be reimbursed beyond public health emergency (PHE).

Reimbursable Services

Please refer to the following for a list of face-to-face medical services eligible to be performed via telehealth and/or telephone and a list of reimbursable telephonic and telehealth services: Face-to-Face medical services eligible to be performed via telehealth and/or telephone & reimbursable telephonic and telehealth services.

- Services not listed will not be reimbursed. The list of codes is included for *informational purposes only*. Whether or not a code is listed here does not guarantee coverage or reimbursement.

Professional Non-Facility (office) Reimbursement versus Professional Facility Reimbursement

Professional Non-Facility (office) Reimbursement & Place of Service (POS) Billing

Professional Non-Facility (office) reimbursement will be made under the following circumstances:

- If the member is at **home/domicile or other non-facility place of service**, and the provider is in a **private practice** performing telehealth in the **home or office,** the provider should report the appropriate **non-facility** POS code. For example: POS 11 (office), POS 02* (telehealth other than patient's home), or POS 10* (telehealth in patient's home)
- ***Note:** Providers reporting industry standard POS 02 (telehealth other than patient's home) or 10 (telehealth in patient's home) are attesting that the telehealth service was performed when the member is in a **home/domicile or other non-facility place of service** setting and the provider is in a **private practice performing telehealth in the home or office**, reimbursement will be at the professional non-facility (office) rate.

Professional Facility- Site of Service Differential Reimbursement & Place of Service (POS) Billing
Professional Facility reimbursement/site of service differential reimbursement will be made under the following circumstances:

- **Professional Billing 1500 Claim form**
    - If the member is at a **facility**, and the provider is in **any location**, the provider should report the appropriate **facility** POS code. For example: POS 22 (on campus outpatient hospital) or POS 21 (inpatient hospital).
    - If the member is at **home**, and the provider is in a **hospital-based clinic (not in a private office)**, the provider should report the appropriate **facility** POS code. For example: POS 22 (on campus outpatient hospital) or POS 21 (inpatient hospital).

- **Acute Care Facility UB04 Claim Billing**
    - Telehealth services billed on a **facility claim** will be reimbursed only when submitted with a professional revenue code. There is no **telehealth** reimbursement for any facility overhead.
        - For physical and occupational therapy telehealth services, bill using the appropriate treatment revenue code and HCPCS/CPT code combination as if you were performing a face-to-face service
    - One of the following telehealth modifiers must be billed on all lines submitted: GT, 93, 95, G0, GQ, FQ or FR.
    - Medicare Advantage acute care facilities follow CMS guidelines for telehealth services.

Acute Care Facility Reimbursement

- There is no **telehealth** reimbursement for any facility overhead.
    - Q3014 (originating site fee) is not reimbursed in any circumstances.
    - If the member is at **home/domicile**, and the provider is in a private **office,** there is no reimbursement for the facility as the member is not in the facility.
    - If the member is at a **facility**, and the provider is in **any location,** there is no **telehealth** reimbursement for any facility overhead/clinic.
    - If the member is at **home**, and the provider is in a **hospital-based clinic (not in a private office),** there is no **telehealth** reimbursement for any facility overhead.
    - Medicare Advantage acute care facilities follow CMS guidelines for telehealth services.

Non-Reimbursable Services
Non reimbursable services include but are not limited to the following:

- Interprofessional telephone/Internet/electronic health record assessment and management service
- A telehealth/telephonic code when there is a **related** Evaluation and Management (E/M) service provided in the previous 7 days or, when there is a related E/M billed one day after or, when there is a related global procedure (0,10, 90-day code) billed one day after or, when there is a related E/M or global procedure (0,10, 90-day code) billed on the same day.
- Services in which the documentation of the service is not equivalent to the code reported.

Scenarios

Telehealth place of service billing examples

Member	**Provider**	**Place of Service (POS) Billing**	**Non-Facility (office) / Facility Reimbursement Level Site of Service Differential**
Member at home/domicile or other non-facility place of service	-Provider in a private practice/office	POS 11, POS 02, POS 10, (any non-facility POS)	Non-Facility/Office

Member at a facility	-Any location	POS 22, POS 21, (any facility POS)	Facility
Member at home	-Provider is NOT in a private practice/office -Hospital-based clinic	POS 22, POS 21, (any facility POS)	Facility

Related policies

Note: Log into Provider Central before clicking Payment Policy links.

COVID-19 Provider Information Page
COVID-19 Public Health Emergency
CPT and HCPCS Modifiers
General Coding and Billing
Non-Reimbursable Services
Outpatient Rehabilitation Services

Policy update history

12/31/21	Documentation of policy effective April 1, 2022
01/24/22	Edits for clarity in telehealth services reimbursement section
01/31/22	Edits for clarity in the *Professional Non-Facility (office) Reimbursement versus Professional Facility Reimbursement* section; addition of place of service billing scenarios
02/17/22	Edits for clarity; removal of examples of HIPAA compliant technology; added clarification on provider licensing requirements
03/31/22	Edits for clarity on Medicare Advantage statement; added link to CMS list of chronic condition categories

Payment policies are intended to help providers obtain Blue Cross Blue Shield of Massachusetts' payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy development takes into consideration a variety of factors, including: the terms of the participating provider's contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.