Telemedicine Communication

Origination: 08/05/14	**Revised:** 03/15/23	**Annual Review:** 12/08/22

Purpose:

To provide Telemedicine Communication guidelines for Population Health and Provider Alliances associates to reference when making benefit determinations.

Definitions

- Telemedicine: Telemedicine services are medical services provided via telephone, the Internet, or other communications networks or devices that do not involve direct, in-person Member contact.
- Asynchronous Telecommunication: Medical information is stored and forwarded to be reviewed at a later time by a physician or health care practitioner at a distant site. The medical information is reviewed without the Member being present. Also referred to as store-and- forward telehealth or non-interactive telecommunication.

Additional Information

- Telemedicine consists of services where the independent practitioner or other health care professional and the Member are not at the same site are potentially reimbursable. Examples of such services are those that are delivered over the phone, via the Internet, or using other communication devices.

Coverage Guidelines

Only if the provider is contracted for telemedicine services, evaluation, management, and consultation services using secure email or telephone may be considered medically necessary when **all** of the following conditions apply:

1. MD or other health care professional responds within 24 hours with the exception of weekends.
2. MD or other health care professional is giving substantive medical advice, revising treatment plan, prescribing/revising medication, recommending additional testing, and/or providing self-care/Member education information for new and/or chronic health problem.
3. A permanent record of online communications relevant to the ongoing medical care of the Member should be maintained as part of the Member's medical record and must include the date of the consult and all decisions made.
4. Services should not be billed more than once per day for the same episode of care.

Covered CPT codes:

- Charges submitted with CPT codes 98969, 99444, 98966-98968 or 99441-99443

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Non-Covered Services include, but are not limited to:

- Radiology interpretations
- Refilling or renewing existing prescriptions without substantial change in clinical situation
- Scheduling appointments
- Reporting test results
- Providing educational materials
- Reminders of scheduled office visits
- Requests for a referral

Guidelines for Remote physiologic monitoring (RPM) services (CPT codes 99453 and 99454)
RPM is the use of connected electronic tools to record personal health and medical data in one location for review by a provider in another location, usually at a different time. RPM can monitor daily health parameters (such as weight, heart rate, blood pressure and blood oxygen levels) using a scale, heart rate monitor, blood pressure monitor and pulse oximeter.

- Physiologic data must be electronically collected and automatically uploaded to the secure location where the data can available for analysis and interpretation by the billing practitioner.
- The device used to collect and transmit the data must meet the definition of a medical device as defined by the FDA.
- Remote physiologic monitoring data must be collected for at least 16 days out of 30 days.
- Remote physiologic monitoring services must monitor an acute care or chronic condition.
- The services may be provided by auxiliary personnel under the general supervision of the billing practitioner.
- Report codes only once per 30 days regardless of the number of parameters measured.

References:

1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services.

2. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.

3. Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets.

4. Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files.

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Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed's benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.