This document is intended as a guide to assist telehealth providers in obtaining information on reimbursement. The information should be used in consultation with your billing specialist and other advisers in initiating telehealth services billing. Reimbursement information can outdate quickly. We recommend review of this material on a regular basis to assure the information is up to date. CTEC does not guarantee payment for any service.

The California Telemedicine & eHealth Center is a leading source of expertise and comprehensive knowledge on the development and operation of telemedicine and telehealth programs. CTEC has received national recognition as one of ten federally designated Telehealth Resource Centers in the country.
Introduction

Telemedicine Reimbursement

Telehealth can play an important role in the provision of health care services, particularly in rural and remote locations. Telehealth can allow rural sites to recruit clinicians to their community offering consultative support and educational opportunities previously unavailable in these locations.

Communities are using telehealth technologies for medical specialty services, inpatient consultations, access to stroke consultations in emergency departments, support for local intensive care units and home monitoring programs to reduce readmission rates for individuals with chronic diseases.

Payment or reimbursement for telehealth services has been identified as a barrier for health systems to begin providing telehealth services. In the past year, substantial additions have been made in reimbursement for telehealth services at the federal level. The California Legislature is currently considering a bill that would substantially expand the services covered by telehealth reimbursement.

This Handbook covers the current reimbursement provisions for the major telehealth payers and provides an overview of reimbursement and program scenarios that may be appropriate for Northern Inyo Hospital District. This manual assumes a familiarity with billing processes and requirements in general. The manual provides information specific to telemedicine and telehealth services.

What Is Telemedicine?

Telemedicine generally refers to the provision of clinical services from a distance. The Institute of Medicine of the National Academy of Science defines telemedicine as “the use of electronic information and communication technologies to provide and support health care when distance separates the participants.”

Telemedicine uses video conferencing technologies and electronic communications to allow patients at one site to have a visit with a provider at a different site. Sometimes the distance is a few miles - other times telemedicine connects patients and providers that are thousands of miles apart.

The videoconferencing technologies used by telemedicine allows patients to see clinicians that are not at the same location. Videoconferencing allows the patient and doctor to see and talk to each other like a live television broadcast. The tools used by clinicians to observe and collect vital information, such as otoscopes and stethoscopes, have been adapted so the clinician and patient can see and hear as if they were in the same room.

How Does Telemedicine Work?

There are two basic approaches to providing telemedicine services. The first approach is live interactive where both the patient and provider site are available in real time and can communicate as though in the same room. Live interactive telemedicine is most like a regular on-site patient visit. Live interactive telemedicine is appropriate when the clinician needs to talk with the patient or when the clinician needs to observe motion or other characteristics of the patient. There are many telemedicine applications that can use live interactive telemedicine. In California, live interactive telemedicine has been used for over 50 specialty services. The most commonly provided specialties are dermatology, psychiatry, neurology, ENT, orthopedics, pain management, endocrinology, urology and rheumatology.
Introduction

The second technology approach, **store and forward**, is used when a face to face visit with the patient is not necessary. Store and forward systems allow a provider or technician at the patient site to capture diagnostic information using clinical instruments and send the digital image of the information to a clinician at a remote site. The remote site clinician retrieves the digital images, reviews them and sends a report back to the patient site. It is commonly used for dermatology, diabetic retinopathy screenings, radiology, and pathology. Store and forward allows specialists to review patient findings at convenient times without depending on the presence of the patient. Since there is no requirement to meet face to face with the patient, store and forward maximizes the time a clinician spends reviewing and reporting on findings.

**Is Telemedicine A Billable Service?**

In many cases telemedicine services are covered benefits and are billable by government programs and private payers. This Handbook provides information on major telemedicine reimbursement programs in California. As the field is rapidly expanding, it should be noted that more and more private and commercial payers may begin to cover telemedicine. It is important that you check with your major payers on a regular basis to see if additional services have been added or reimbursed. CTEC can provide updates on many of the major payers but may not be aware of all payer policies.

There is momentum within California and the nation to increase the coverage of and payment for telehealth services. As of August 2011, the California Legislature is considering a bill, AB 415, that would substantially increase telehealth reimbursement. This bill is attached as an Addendum to this report.

**Telemedicine – Telehealth: What’s the Difference?**

Telemedicine is usually defined as the provision of clinical services using telecommunication technologies. In California, this definition includes live interactive telemedicine and store and forward telemedicine.

**Major Payers for Telehealth Services in California**

Table I provides a list of major payers and programs in California that reimburse for telemedicine services. It should be noted that many insurers, health systems and employer self insurance programs are developing telemedicine programs. The number of payers is expected to increase substantially in the next few years.
### Table I

**Telehealth Services Reimbursement Summary of California Major Payers & Programs**

**Federal and State Programs Covering Telehealth Services**

- **Medicare Program** - Federal program covering health services to the elderly and disabled.

- **Medi-Cal Program** - California’s Medicaid Program, the federal/state program covering health services to certain low-income groups.

- **California Children’s Services (CCS)** - California’s Children’s Services is a program that treats children with certain physical limitations and chronic health conditions or diseases.

- **Medi-Cal Partnership** - California’s managed care program for Medicaid beneficiaries administered through Anthem Blue Cross.

- **Healthy Families** enrolled with Anthem Blue Cross. Healthy Families is California’s low cost health insurance for children and teens.

- **County Medical Services Program (CMSP)** – The County Medical Services Program covers health care services for certain low-income populations in small, rural communities.

- **Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)** - Federally qualified Health Center is a federal designation from a facility providing primary care and other services to underserved populations. Rural Health Clinics are the only national organization dedicated to improving the delivery of quality, cost-effective health care in rural underserved areas.

**Private Insurance Programs**

- **Anthem Blue Cross** – Anthem Blue Cross provides telemedicine services to Cal PERS Basic Plan and the Prudent Buyer PPO members residing in rural zip codes.

- **UnitedHealthcare** – UnitedHealthcare provides reimbursement for members who are at a originating site in either a rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA).
This Section provides details on reimbursement for many of the major payers within the state of California.

It should be noted that telemedicine is a rapidly expanding field and changes in telehealth covered services and reimbursement are expected to occur during the next few years. It will be necessary for programs to review new reimbursement provisions on a regular basis. CTEC publishes changes to reimbursement on our website and distributes them to those on the CTEC email list.
The Medicare Program

The Medicare Program, the government funded health insurance program for seniors and individuals with certain disabilities, is administered by the federal Center for Medicare and Medicaid Services (CMS). Currently Medicare provides coverage to over 42 million Americans. Eligible Medicare beneficiaries include:

- Individuals age 65 or older
- Individuals under age 65 with certain disabilities
- Individuals with End-Stage Renal Disease (ESRD)

CMS defines the patient site as the *originating site*. The site of the remote provider is called the *distant site*.

Medicare Coverage of Telehealth

*Live Interactive: covered service*

Medicare requires that an interactive audio and video telecommunications system be used that allows real time communication between the provider at the distant site and the patient (beneficiary) at the originating site. Reimbursement for Medicare telehealth has four additional criteria for payment of telehealth services.

The five criteria are summarized below:

- Use of live interactive
- Geographic location
- Type of institution delivering the services
- Type of health provider
- Type of services provided

The criteria for each area are described in sections that follow.

*Store and forward: covered in Alaska and Hawaii only*

Store and forward telehealth services are only permitted in federal demonstration programs currently conducted in Alaska and Hawaii. California Medicare sites are not eligible for reimbursement for store and forward telehealth services.

Conditions for Geographic Location

*Originating Sites: Must be Rural*

The Medicare Telehealth Program rules limit eligible services to *originating sites* (patient sites) that are located in:

- A Rural Health Professional Shortage Areas (HPSA) or
- A county located outside of a Metropolitan Statistical Area (MSA)
Medicare

- Special Provision: Organizations participating in a Federal telemedicine demonstration projects approved by DHHS as of December 31, 2000 are also eligible for telehealth reimbursement.

When a county is deemed rural for Medicare purposes, (a non-MSA county) any location in the county is considered to be a reimbursable patient site. However, when the county is considered urban for Medicare purposes (in an MSA), patient sites in that county are not eligible for telehealth reimbursement no matter how remote a individual area within that county may be unless the remote site is located in a HPSA.

Determining HPSA locations

The federal Health Resources and Services Administration maintain a webpage that provides listings of HPSAs by census tract. This can be found at [http://hpsafind.hrsa.gov/](http://hpsafind.hrsa.gov/). The Rural Assistance Center maintains a webpage that provides information on Medicare eligibility for telehealth by address or city. It is found at [http://ims2.missouri.edu/rac/amirural](http://ims2.missouri.edu/rac/amirural).

Distant Sites: No restrictions

There is no restriction on the location of the health professional delivering the telehealth services; however, there are limitations on the type of sites that can provide services (see below).

Eligible Originating Sites (Patient Site)

Only the following facilities are eligible to be an originating site under the rules of the Medicare Program:

- Office of a physician or practitioner
- Critical access hospital (CAH)
- Rural health clinic (RHC)
- Federal qualified health center (FQHC)
- Hospital (as defined by Medicare, including general acute care hospitals and acute psychiatric hospitals)
- Skilled Nursing Facilities (SNF)
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites) and
- Community Mental Health Centers (CMHC)

Eligible Distant Site Practitioners

The following practitioners are eligible to furnish and receive payment for covered telehealth services:

- Physicians
- Physician assistants
- Nurse practitioners
• Clinical nurse specialists
• Registered dietitians or nutrition professionals
• Nurse midwives
• Clinical psychologists*
• Clinical social workers*
• *Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for the following CPT codes: 90805, 90807, and 90809.

Billing and Reimbursement

Modifiers

Claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided and one of the following Telemedicine modifiers:
• GT for interactive audio and video telecommunications system or
• GQ for Store and forward applications.

Originating Site Fee

The originating site is eligible to receive a facility fee for providing services via telehealth. For 2012, the site facility fee is $24.24. The payment amount is “80% of the lesser of the actual charge or $24.24”. The patient site receives a flat reimbursement rate, outside of any other reimbursement arrangements such as inpatient DRGs or RHC per-visit payments. Sites are instructed to use HCPCS code Q3014 when submitting facility fee claims.

Medicare provides specific instructions for different facility types:

• For FQHC and RHCs: the originating site facility fee for Medicare telehealth services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.

• For Critical Access Hospitals, the payment amount is 80 percent of the originating site facility fee.

• In addition to FQHCs, RHCs and CAHs, Chapter 12 of the Medicare Claims processing Manual, Section 190.6 describes payment methodologies for hospital outpatient departments, hospital inpatient, Physicians’ and practitioners’ offices, renal dialysis centers, skilled nursing facilities and community mental health centers.

Clinical Services fees

Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided without telemedicine.

Table 2 provides a listing of all eligible services with CPT and HCPCS codes effective January 2011. Eligible services are usually updated once a year effective in January.
Table 2  
Medicare Eligible Services  
Effective January 1, 2012

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT or HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth Consultation, Inpatient or Emergency Department</td>
<td>G0425 – G0427</td>
</tr>
<tr>
<td>Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs</td>
<td>G0406 – G0408</td>
</tr>
<tr>
<td>Office or other outpatient visits</td>
<td>99201 – 99215</td>
</tr>
<tr>
<td>Subsequent hospital care services (1 telehealth visit every 3 days)</td>
<td>99231 – 99233</td>
</tr>
<tr>
<td>Subsequent nursing facility care services (1 visit every 30 days)</td>
<td>99307 – 99310</td>
</tr>
<tr>
<td>Individual and group kidney disease education services</td>
<td>G0420 – 0421</td>
</tr>
<tr>
<td>Individual and group diabetes self-management training services (minimum of 1 hour of in-person instruction to be furnished in the initial year training period)</td>
<td>G0108 – G0109</td>
</tr>
<tr>
<td>Individual and group health and behavior assessment and intervention</td>
<td>96150 – 96154</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>90804 – 90809</td>
</tr>
<tr>
<td>Pharmacologic management</td>
<td>90862</td>
</tr>
<tr>
<td>Psychiatric diagnostic interview examination</td>
<td>90801</td>
</tr>
<tr>
<td>End State Renal Disease related services included in the monthly capitation payment*</td>
<td>90951 – 90952; 90954 – 90955; 90957 – 90958; 90960 – 90961</td>
</tr>
<tr>
<td>Individual and group medical nutrition therapy</td>
<td>G0270; 97802 – 97804</td>
</tr>
<tr>
<td>Neurobehavioral status examination</td>
<td>96116</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>99406-99407</td>
</tr>
<tr>
<td></td>
<td>90436-90437</td>
</tr>
</tbody>
</table>

*Clinical psychologists and clinical social workers are not allowed to bill for CPT codes 90805, 90807, and 90809.

*ESRD related services at least on hands on visit (not telehealth) must be furnished each month to examine the vascular access site by a physician, NP, PA or CNS.

**Coverage for Home Telehealth**

In 2000, Medicare implemented home health services covered for 60 days under a fixed payment. Agencies providing services to Medicare beneficiaries are allowed to use telehealth services in providing care; however, no additional or separate payment beyond the fixed payment is allowable.

**Additional Resources**

CMS Telehealth Services, Rural Health Fact Sheet Series  

Medicare Benefit Policy Manual, Chapter 15, Section 270 Pub  

Medicare Claims Processing Manual, Chapter 12, Section 190  
The Medi-Cal Program

Medi-Cal is California’s Medicaid Program, providing a variety of services for children and adults with limited resources. Medi-Cal is available to individuals receiving assistance from SSI/SSP (Supplemental Security Income / State Supplemental Program), CalWORKs (California Work Opportunity and Responsibility to Kids, Refugee Assistance and Foster Care or Adoption Assistance Program).

A number of counties work with non-government health plans under the Medi-Cal Partnership, which provides Medi-Cal beneficiaries services through a managed care program. Currently managed care services are provided through Anthem Blue Cross, HealthNet, Molina Health Care, Kaiser and others.

Medi-Cal Coverage of Telemedicine

The Telemedicine Act of 1996, California’s enabling legislation, refers to telemedicine and does not use the term Telehealth. This guide is true to the legislation and regulations and uses the terminology telemedicine. A complete listing of California Telehealth Legislation is found on the CTEC website with links to the legislative language.

Medi-Cal defines the originating site as the location of an eligible recipient at the time service is furnished via telecommunications. Originating sites authorized by law are as follows: the offices of physicians or practitioners, critical access hospitals, rural health clinics, or Federally Qualified Health Center.

Medi-Cal defines the distant site as the location from where a physician or practitioner provides professional services via telecommunications.

*Live Interactive: Covered service*

A telemedicine service must be in real time interactive two way visit between patient and practitioners. Transmission quality, including transmission from diagnostic scopes, must be adequate to complete all necessary components for billed service.

The telehealth practitioner must be an enrolled Medi-Cal provider and be licensed in the State of California.

A Telemedicine consult in which there is no presenting provider present during the consult is not eligible for reimbursement of the patient site service.

*Store and forward: Limited to ophthalmology and dermatology*

Store and forward is defined as the asynchronous transmission of medical information to be reviewed at a later time at a distant site where the physician at the distant site reviews the medical information without the patient being present in real-time.

As of 2011, Store and forward technology is reimbursable when used for the following dermatology and ophthalmology services, including diabetic retinopathy screening.
Exclusions

A telephone conversation, e-mail, fax are not considered live interactive or Store and forward telehealth visits and are specifically excluded from the definition of telemedicine.

Conditions Required for Telehealth Use

Verbal and Written Patient Consent

Patient must provide verbal and written consent, including description of the risks, benefits and consequences of telemedicine, patient can withdraw consent at any time, confidentiality protections, patient access to medical information and no dissemination of information without further consent.

Documented Barrier to Care

Providers at the distant site are not required to document medical necessity or cost effectiveness. AB 415, which became effective January 1, 2012, removed the requirement to document a barrier to face to face care.

Requirements for Store and forward

- Images must be adequate for meeting the definition of the billed code
- Store and forward limited to ophthalmology and dermatology
- Distant site provider must have completed ACGME approved residency in ophthalmology or dermatology
- Optometrists are covered to read diabetic retinopathy
- A patient receiving teleophthalmology or teledermatology by Store and forward shall be notified of the right to receive interactive communication with the distant specialist physician consulted through Store and forward, upon request. If requested, communication with the distant specialist physician must occur within 30 days of the patient’s notification of the results of the consultation.

Eligible Originating Sites (Patient Site)

Only the following facilities are eligible to be an originating site under the rules of the Medi-Cal Program:

- Offices of physicians or practitioners
- Critical Access Hospitals
- Rural Health Clinics
- Federally Qualified Health Centers

Eligible Distant Site Practitioners (Provider Site)

No restrictions on types or locations; however, requires licensure in State of California and adherence to licensure scope of practice.
In addition, the distant (patient) site is only a billable visit if it meets all the requirements of the Medi-Cal program.

**Billing and Reimbursement**

*Modifiers*

Claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided and one of the following Telemedicine modifiers:

- GT for interactive audio and video telecommunications system (live interactive) or
- GQ for Store and forward applications. Only services rendered from the distant site are billed with modifier GQ.

*Originating Site Fee*

The originating site is eligible to receive a facility fee for providing services via telehealth. For 2011, the site facility fee is 80% of the lesser of the actual charge or $24.10. Sites are instructed to use HCPCS code Q3014 when submitting facility fee claims. **Sites fee are limited to once per day, same recipient, same provider.**

*Transmission Fee: Live Interactive*

Medi-Cal allows payment of transmission costs associated with live interactive services. This fee can be paid to originating and distant sites. It is limited to a maximum of 90 minutes per day, same recipient, and same provider. One unit of service is equal to one minute of transmission cost.

Sites are instructed to use code T1014: health transmission, per minute

*Clinical Fees: Live Interactive*

Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided without telemedicine.

Table 3 provides a listing of all eligible live interactive services with CPT and HCPCS codes effective 2008.
**Table 3**

Medi-Cal Eligible Telemedicine Services
Live Interactive

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT and HCPCS Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Diagnosis, Interview, Examination</td>
<td>90801 – 90802</td>
</tr>
<tr>
<td>Individual Psychotherapy, outpatient and inpatient, with and without</td>
<td>90804 – 90819</td>
</tr>
<tr>
<td>evaluation and management component</td>
<td>90821 – 90824</td>
</tr>
<tr>
<td></td>
<td>90826 – 90829</td>
</tr>
<tr>
<td>Group Psychotherapy</td>
<td>90853</td>
</tr>
<tr>
<td>Individual Medical Psychotherapy by a physician</td>
<td>Z0300</td>
</tr>
<tr>
<td>Office or Other Outpatient Visit – New or established patient</td>
<td>99201 – 99215</td>
</tr>
<tr>
<td>Initial Hospital Care or Subsequent Hospital Care – new or established</td>
<td>99221 – 99233</td>
</tr>
<tr>
<td>patient</td>
<td></td>
</tr>
<tr>
<td>Consultations – office or other outpatient, initial or follow-up patient, and confirmatory</td>
<td>99241 – 99275</td>
</tr>
</tbody>
</table>

**Clinical Fees: Store and forward**

Store and forward services are limited to dermatology and ophthalmology, including diabetic retinopathy.

Table 4 provides a listing of all eligible store and forward services with CPT and HCPCS codes effective 2008.

**Table 4**

Medi-Cal Eligible Telemedicine Services
Store and forward

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visit</td>
<td>99211 – 99214</td>
</tr>
<tr>
<td>Subsequent hospital care</td>
<td>99231 – 99233</td>
</tr>
<tr>
<td>Office consultation, new or established patient</td>
<td>99241 – 99243</td>
</tr>
<tr>
<td>Initial inpatient consultation</td>
<td>99251 - 99253</td>
</tr>
</tbody>
</table>

In addition to the previous codes, other codes as discussed below are being used when appropriate.

Medi-Cal continues to pay clinics for retinal photography with interpretation (CPT 92250) for services provided by optometrists whether performed on-site or remotely. An additional reimbursement for consultation via Store and forward telemedicine is now payable by Medi-Cal to ophthalmologists. The additional consultation can be billed only if done by an ophthalmologist, not an optometrist.

Ophthalmology and dermatology services provided at the originating site at the time of a Store and forward telemedicine transaction should continue to be billed without a GQ modifier.
Additional Resources

Medi-Cal Telemedicine Guidelines

Medi-Cal Professional Services: Teleophthalmology by Optometrists
California Children’s Services (CCS)

California Children’s Services (CCS) is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Services manages the CCS program. Larger counties operate their own CCS programs, while smaller counties share the operation of their program with state, county and federal tax monies, along with some fees paid by parents.

Telehealth Services

CCS follows Medi-Cal policies and procedures concerning coverage and reimbursement of telemedicine services. Provisions and requirements found under the Medi-Cal Section apply to the provision of CCS telehealth services. However,

- You must obtain authorization from the CCS program for telemedicine services in the same situations and process as non-telemedicine services.
- The patient site is only a billable visit if it meets all the requirements of the CCS program.
Federally Qualified Health Centers
Rural Health Clinics

CTEC has a special publication, FQHC Telemedicine Reimbursement Models, that was developed to provide guidance on the various reimbursement scenarios available to FQHC and RHCs. The link to this publication is found in the additional resources section.

There are a number of factors that determine how to bill for telemedicine services.

Two principles form the foundation for FQHC / RHC telehealth billing:
- Principle One: The place determined to be the provider site is the billing site
- Principle Two: A provider can, under certain circumstances, enter the four walls virtually using telemedicine

The factors that are used to determine the billing scenario are:
- Where is the patient is physically located
- Characteristics of the specialty provider
- Payment arrangement with the specialty provider
- If there is medical necessity for a provider at the patient site

The application of these factors creates six scenarios that are used to guide reimbursement. The Guide also provides an interactive tool for determining billing scenarios along with frequently asked questions. The six scenarios include:
1. FQHC Patient Site to Medical Specialist
2. FQHC Patient Site with Provider Present to Medi-Cal Specialist
3. FQHC Patient Site to FQHC Specialist Site
4. FQHC Patient Site 1 with Provider Present to FQHC Specialist 2
5. Medi-Cal (Fee-for-Service) Patient Site to FQHC Specialist Site
6. FQHC Patient Site to Other Specialist Site

Additional Resources
CTEC FQHC Telemedicine Reimbursement Models
www.cteconline.org
UnitedHealthcare Medicare Plans

United Healthcare offers telemedicine and telehealth services to UnitedHealthcare Medicare patients. Telemedicine and telehealth services are covered for patients under this plan when Medicare coverage criteria are met.

Originating site requirements and allowable practitioners listed in the Medicare section of this manual apply to all telemedicine visits. UnitedHealthcare also uses the same billing codes as Medicare for services.

See Medicare section of this manual for detail information on program restrictions.

Additional Resources
UnitedHealthcare Telemedicine Reimbursement Policies
https://www.unitedhealthcareonline.com/b2c/cmsIndexResult.do?channelId=422fe7a1e193b010VgnVC M100000c520720a___&htmlFilePath=/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesHtml/ReimbursementPolicies/TELE_Telemed_v2011B.htm
Anthem Blue Cross Telehealth Programs

Anthem Blue Cross has telehealth services available through a variety of programs administered and operated by Anthem Blue Cross. These programs are:

- California Healthy Families
- County Medical Services Plan (Inyo is a participating county)
- Medi-Cal Partnership
- Cal PERS
- Prudent Buyer PPO

This section outlines the Anthem Blue Cross Telehealth Program provisions and benefits. Full documentation that includes billing instructions, sample billing forms and other program documents can be found in the Anthem Blue Cross: Telemedicine Program Provider Operations Manual.

Anthem defines originating sites as the location where the patient or patient’s condition is presented by telemedicine.

- Office of a physician or practitioner
- HospitalCritical Access Hospital
- Rural Health Clinic
- Federally Qualified Health Center

Distant or patient sites are defined as:
A healthcare facility in which the patient is present and form which the patient, patient’s history, medical case and particular referral questions are presented to a specialist by telemedicine.

Anthem Blue Cross Coverage of Telehealth

- Live Interactive
- Store and forward

Service benefits are consistent across all programs with a couple of exceptions which will be identified in the materials below.

Conditions Required for Telehealth Use

**Verbal and Written Patient Consent**
Presentation (patient) sites are responsible for discussing the use of telemedicine with patients to obtain informed consent. The site should receive a complete Authorization and Consent to Participate in Telemedicine Consultation Form from the patient side prior to the consultation. This form is located in the Anthem Blue Cross: Telemedicine Program Provider Operations Manual.

**Documented Barrier to Care**
There is no requirement to document a barrier to care when utilizing telemedicine with Anthem Blue Cross.
**Anthem Blue Cross**  
**Healthy Families, County Medical Services, Medi-Cal Partnership, CalPERS, Prudent Buyer PPO**

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**Store and forward Requirements**
It is not necessary for the referring physician to be present during the consultation.

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**Exclusions**

County Medical Services Program (CMSP): Telemedicine should not be offered to CMSP members who have not yet met their Share of Cost.

---

**Eligible Member Populations**

- CalPERS Basic Plan Members residing in rural zip codes
- Prudent Buyer PPO Members residing in rural zip codes
- County Medical Service Program (CMSP) with claims administered by Anthem Blue Cross Life
- Healthy Families Program coverage from Anthem Blue Cross
- Medi-Cal plans from Anthem Blue Cross Partnership Plan

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**Eligible Originating and Distant Sites**

Anthem Blue Cross limits participation in its telemedicine program to members of the Blue Cross Open Access Network. All originating (patient) and distant (provider) sites must be a member of this network.

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**Billing and Reimbursement**

Anthem Blue Cross of California uses standardized billing procedures when submitting claims.

---

**Modifiers**

Live Interactive and Store and forward
Processing telemedicine claims for Anthem Blue Cross members is the same as processing standard office visit claims except a telemedicine modifier must be added to the CPT code.

- GT for Live Interactive telemedicine encounters
- GQ for Store and forward telemedicine encounters

---

Form Location Modifiers
Non-hospital billing entities: Use billing form CMS-1500, Box 24D
Hospital and Clinic billing entities: Use billing form CMS 1450, Box 44

---

Additional CMS-1450 Requirements
Two codes must be used on the CMS-1450 claim form to identify a clinical telemedicine encounter.

Type of bill: 130 (enter in CMS-1450, Box 4)
Revenue Code: 780 (enter in CMS-1450, Box 42)
**Originating Site Fee**

Billing entities serving Healthy Families members may also charge a Telemedicine Site Fee and should indicate the billing code in Box 24D of the CMS-1500 or Box 44 of the CMS-1450.

**Table 5**
Anthem Blue Cross Eligible Telemedicine Services
Site Fee Billing Codes

<table>
<thead>
<tr>
<th>Live Interactive</th>
<th>Presentation Site</th>
<th>Specialty Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS-1500</strong></td>
<td>Q3014</td>
<td>G9002</td>
</tr>
<tr>
<td><strong>CMS-1450</strong></td>
<td>Q3014</td>
<td>G9002</td>
</tr>
<tr>
<td>Rev Code 780</td>
<td></td>
<td></td>
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<tr>
<td>Bill Type 130</td>
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<table>
<thead>
<tr>
<th>Store and forward</th>
<th></th>
<th>Not Covered</th>
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<tbody>
<tr>
<td><strong>CMS-1500</strong></td>
<td>Q3014</td>
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<tr>
<td><strong>CMS-1450</strong></td>
<td>Q3014</td>
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<td>Rev Code 780</td>
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<td>Bill Type 130</td>
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</table>

**Transmission Fees**

- Anthem Blue Cross will pay claims for Blue Cross members’ telecommunication charges for Live interactive consultations only. This is limited to ISDN telecommunications only.
- A Live interactive consult requires using high-speed ISDN telecommunications lines, which are more expensive than a regular, long-distance call.
- Only the site that initiates the Live Interactive Telemedicine Encounter may bill. Table 6 below shoes the appropriate codes.
- Each minute (or part thereof) is equal to one (1) unit of occurrence.
- A maximum of 90 minutes of occurrence may be billed per Live Interactive Telemedicine encounter (1.5 hours billable maximum).

Store and forward is accomplished via secured email communication. As such, there are no telecommunication charges applicable. Therefore, there is no telecommunication reimbursement offered by Anthem Blue Cross.

**Table 6**
Anthem Blue Cross Eligible Telecommunications Codes

<table>
<thead>
<tr>
<th>Program</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prudent Buyer PPO and CalPers Basic Plan</td>
<td>99199-GT</td>
</tr>
<tr>
<td>County Medical Services Program, Healthy Families, and Medi-Cal</td>
<td>T1014</td>
</tr>
</tbody>
</table>
Anthem Blue Cross
Healthy Families, County Medical Services, Medi-Cal Partnership, CalPers, Prudent Buyer PPO

Clinical Fees: Live Interactive

Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided without telemedicine.

Table 7 provides a listing of all eligible live interactive services with CPT codes, effective 2009.

<table>
<thead>
<tr>
<th>Table 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem Blue Cross Eligible Telemedicine Services</td>
</tr>
<tr>
<td>Live Interactive</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
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</thead>
<tbody>
<tr>
<td><strong>Primary Care Providers</strong></td>
<td></td>
</tr>
<tr>
<td>New patient office visit</td>
<td>99201-99205</td>
</tr>
<tr>
<td>Established patient office visit</td>
<td>99211-99215</td>
</tr>
<tr>
<td><strong>Specialist</strong></td>
<td></td>
</tr>
<tr>
<td>Consultations</td>
<td>99241-99245</td>
</tr>
<tr>
<td>Follow-up visits</td>
<td>99211-99215</td>
</tr>
<tr>
<td><strong>Psychiatry</strong></td>
<td></td>
</tr>
<tr>
<td>Psychiatric diagnosis</td>
<td>90801-90809</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>90810-90815</td>
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<tr>
<td>Individual psychotherapy (inpt)</td>
<td>90816-90819</td>
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<tr>
<td>Individual psychotherapy (inpt)</td>
<td>90821-90829</td>
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<tr>
<td>Medical psychoanalysis</td>
<td>90853</td>
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<tr>
<td>Pharmacological psychiatric mgt</td>
<td>90862</td>
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<tr>
<td>Consultations</td>
<td>99241-99245</td>
</tr>
<tr>
<td>Established member office visits</td>
<td>99211-99215</td>
</tr>
</tbody>
</table>

Clinical Fees: Store and forward

Anthem Blue Cross pays for claims for the review of patient files for Store and forward under codes: 99241-99245 Consultants

The preparation of the Store and forward consult should be billed as part of the primary care provider’s office visit. Use the appropriate CPT code based on total amount of time necessary to complete the office visit and the Store and forward consultation preparation.

Additional Resources

Anthem Blue Cross: Telemedicine Program Provider Operations Manual

Anthem Blue Cross Telemedicine Website
http://w2.anthem.com/bcc_state/tm/info/index.asp

County Medical Services Program: Participating Counties Map
www.cmspcounties.org/about/participating_counties.html
## COMPARISON OF MEDICARE, MEDI-CAL and PRIVATE INSURANCE REIMBURSEMENT

<table>
<thead>
<tr>
<th></th>
<th>Medicare</th>
<th>Medi-Cal / CCS</th>
<th>Anthem Blue Cross</th>
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</thead>
<tbody>
<tr>
<td>Live Interactive</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Store and forward</td>
<td>Alaska and Hawaii only</td>
<td>Ophthalmology and Dermatology only</td>
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</tr>
<tr>
<td>Location Requirements</td>
<td>Rural county or rural HPSA only</td>
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<td>-</td>
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<tr>
<td>Originating Site Requirements</td>
<td>Physician or practitioner office Critical</td>
<td>Physician or practitioner office Critical</td>
<td>Blue Cross Open Access Network</td>
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<td>access hospital</td>
<td>Access Hospital</td>
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<td>Rural health clinic</td>
<td>Rural Health Clinic</td>
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<td></td>
<td>FQHC</td>
<td>FQHC</td>
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<td></td>
<td>SNF</td>
<td>SNF</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital or CAH based renal</td>
<td>Hospital or CAH based renal</td>
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<tr>
<td></td>
<td>dialysis center</td>
<td>dialysis center</td>
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</tr>
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<td></td>
<td>Community mental health center</td>
<td>Community mental health center</td>
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<tr>
<td>Distant Site Requirements</td>
<td>-</td>
<td>Clinician licensed in California</td>
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<tr>
<td>Originating Site Fee</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Transmission Fee</td>
<td>No</td>
<td>Yes</td>
<td>ISDN Only (live interactive)</td>
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## COMPARISON OF MEDICARE, MEDI-CAL and PRIVATE CPT BILLING CODES

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<th>Eligible Services</th>
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<td>99406 – 99407; G0436 – G0437</td>
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Useful References


5. Medicare Benefit Policy (CMS Publication 100-02), Internet publication only, Baltimore, Maryland, Centers for Medicare and Medicaid Services.

6. Medicare Claims Processing Manual (CMS Publication 100-04), Internet publication only, Baltimore, Maryland, Centers for Medicare and Medicaid Services.


10. Anthem Blue Cross of California, Anthem Blue Cross of California Telemedicine Program for Healthy Families and Medi-Cal Program – Telemedicine Billing Guidelines, no date or place of publication listed.