Telemedicine/Telehealth Services

Policy Number: MCS092.01
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Instructions for Use

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Related Policies
None

Coverage Guidelines

Telemedicine and telehealth services are covered when Medicare coverage criteria are met.

COVID-19 Public Health Emergency Waivers and Flexibilities: In response to the COVID-19 Public Health Emergency, CMS has updated some guidance for certain telehealth/telemedicine services. For details, refer to the following Coronavirus Waivers/Flexibilities:

- Medicare Telemedicine Healthcare Provider Fact Sheet
- Covered Telehealth Services for PHE for the COVID-19 pandemic, effective March 1, 2020 (updated 10/14/2020)

For a comprehensive list of coronavirus waivers and flexibilities, refer to https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers. (Accessed February 8, 2021)

Note: When deciding coverage for this service, the member specific document must be referenced. Coverage must comply with all applicable network and benefit limitations.

Telemedicine/telehealth services including consultation, office visits, individual psychotherapy and pharmacologic management delivered via a telecommunications system are covered when the following criteria are met:

- Member requires services that telecommunication system can be substituted for a face to face “hands on” encounter for services within the Medicare scope of coverage
  - The use of a telecommunications system may substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other physician fee schedule (PFS) services. The various services and corresponding current procedure terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes are listed on the CMS website at www.cms.gov/Medicare/Medicare-General-Information/Telehealth/.
    For additional information refer to the MLN Matters Number: MM8553 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8553.pdf.
    (Accessed February 8, 2021)
    Note: Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer recognizes office/outpatient or inpatient consultation CPT codes for payment of office/outpatient or inpatient visits. Instead, physicians and practitioners are instructed to bill a new or established patient office/outpatient visit CPT code or appropriate hospital or nursing facility care code, as appropriate to the particular patient, for all office/outpatient or inpatient visits. For detailed instructions regarding reporting these and other telehealth services. Refer to the Medicare Claims Processing Manual, Chapter 12, § 190.3 – List of Medicare Telehealth Services. (Accessed February 8, 2021)

- Members are eligible for telehealth services only if they are presented from an originating site located in either a rural health professional shortage area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA) set by the Health Resources and Services Administration (HRSA).
  Notes:
  - For telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke (acute stroke telehealth services), as determined by the secretary. Specifically, section 1834(m)(6)(A) of the Act removes the restrictions on the geographic locations and the types of originating sites where acute stroke telehealth services can be furnished. Section 1834(m)(6)(B) of the Act specifies that acute stroke telehealth services can be furnished in any hospital, critical access hospital, mobile stroke units or any other site determined appropriate by the Secretary, in addition to the current eligible telehealth originating sites. For additional information refer to the Medicare Claims Processing Manual, Chapter 12, § 190.3.7 – Payment for Telehealth for Individuals with Acute Stroke. (Accessed February 8, 2021)
  - Effective January 1, 2014, rural HPSAs include HPSAs located outside of a county outside of an MSA as well as those located in rural census tracts as determined by the Office of Rural Health Policy. Also, effective January 1, 2014, geographic eligibility for an originating site is established for each calendar year based upon the status of the area as of December 31st of the prior calendar year. For specific requirements, refer to the Medicare Claims Processing Manual, Chapter 12, § 190.2. (Accessed February 8, 2021)
  - For HPSA shortage statistics as of December 31, 2019, refer to the HRSA website at: https://data.hrsa.gov/data/download?data=SHORT#SHORT. (Accessed February 8, 2021)

Telemedicine/telehealth services using non-interactive telecommunications systems that do not permit real-time communication between the member and distant site provider are not covered.

Medicare practitioners who may bill for a covered telehealth service are listed below (subject to state law):
- Physician
- Nurse practitioner
- Physician assistant
- Nurse midwife
- Clinical nurse specialist
- Clinical psychologist*
- Clinical social worker*
- Registered dietitian or nutrition professional
- Certified registered nurse anesthetist

*Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare.

Refer to the Medicare Claims Processing Manual, Chapter 12, § 190-190.7. (Accessed February 8, 2021)

Policy History/Revision Information

Date	Summary of Changes
05/01/2021	Template Update • Reformatted policy; transferred content to new template
02/16/2021	• Routine review; no change to coverage guidelines

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This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy

and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).