South Carolina Tobacco Quitline (Cont'd.)

available 24 hours a day, seven days a week. Additional information is available at:

http://www.scdhec.gov/Health/TobaccoCessation/HelpYourPatientsQuit/

Telemedicine

Telemedicine is the use of medical information about a patient that is exchanged from one site to another via electronic communications to provide medical care to a patient in circumstances in which face-to-face contact is not necessary. In this instance, a physician or other qualified medical professional has determined that medical care can be provided via electronic communication with no loss in the quality or efficacy of the care. Electronic communication means the use of interactive telecommunication equipment that typically includes audio and video equipment permitting two-way, real-time interactive communication between the patient and the physician or practitioner at the referring site.

Telemedicine includes consultation, diagnostic, and treatment services. Telemedicine as a service delivery option, in some cases, can provide beneficiaries with increased access to specialists, better continuity of care, and eliminate the hardship of traveling extended distances.

Telemedicine services are not an expansion of Medicaid-covered services but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective through medical assessment or problems in beneficiaries' understanding of telemedicine, hands-on or direct face-to-face care must be provided to the beneficiary instead. Quality of health care must be maintained regardless of the mode of delivery.

Consultant Sites

A consultant site means the site at which the specialty physician or practitioner providing the medical care is located at the time the service is provided via telemedicine. The health professional providing the medical care must be currently and appropriately licensed in South Carolina and located within the South Carolina Medical Service Area (SCMSA), which is defined as the state of South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina state border.

Referring Sites

A referring site is the location of an eligible Medicaid beneficiary at the time the service being furnished via a telecommunication system occurs. Medicaid beneficiaries are eligible for telemedicine services only if they are presented from a referring site located in the SCMSA. Referring site presenters may be required to facilitate the delivery of this service. Referring site presenters should be a provider knowledgeable in how the equipment works and can provide the clinical support if needed during a session.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Referring Sites (Cont'd.)

Covered referring sites are:

- The office of a physician or practitioner
- Hospital (Inpatient and Outpatient)
- Rural Health Clinics
- Federally Qualified Health Centers
- Community Mental Health Centers
- Public Schools
- Act 301 Behavioral Health Centers

Telemedicine Providers

Providers who meet the Medicaid credentialing requirements and are currently enrolled with the South Carolina Medicaid program are eligible to bill for telemedicine and telepsychiatry when the service is within the scope of their practice.

The referring provider is the provider who has evaluated the beneficiary, determined the need for a consultation, and has arranged the services of the consulting provider for the purpose of consultation, diagnosis, and/or treatment.

The consulting provider is the provider who evaluates the beneficiary via telemedicine mode of delivery upon the recommendation of the referring provider. Practitioners at the distant site who may furnish and receive payment of covered telemedicine services are:

- Physicians
- Nurse practitioners
- Physician Assistants

Covered Services

Services that are eligible for reimbursement include consultation, office visits, individual psychotherapy, pharmacologic management, and psychiatric diagnostic interview examinations and testing, delivered via a telecommunication system. A licensed physician and/or nurse practitioner are the only providers of telepsychiatry services. As a condition of reimbursement, an audio and video telecommunication system that is HIPAA compliant must be used that permits interactive communication between the physician or practitioner at the consultant site and the beneficiary at the referring site.

Office and outpatient visits that are conducted via telemedicine are counted towards the applicable benefit limits for these services.

Medicaid covers telemedicine when the service is medically necessary and under the following circumstance:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Covered Services (Cont'd.)

- The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's need; and
- The medical care can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide.

The list of Medicaid telemedicine services includes:

- Office or other outpatient visits (CPT codes 99201 – 99215)
- Inpatient consultation (CPT codes 99251-99255)
- Psychotherapy, (CPT codes 90832, 90834, and 90837)
- Psychiatric diagnostic interview examination (CPT code 90791 and 90792)
- Neurobehavioral status examination (CPT code 96116)
- Electrocardiogram interpretation and report only (CPT code 93010)
- Echocardiography (CPT code 93307, 93308, 93320, 93321, and 93325)

Non-Covered Services

The following interactions do not constitute reimbursable telemedicine or telepsychiatry services and will not be reimbursed:

- Telephone conversations
- Email messages
- Video cell phone interactions
- Facsimile transmissions
- Services provided by allied health professionals

Coverage Guidelines

The following conditions apply to all services rendered via telemedicine.

1. The beneficiary must be present and participating in the telemedicine visit.
2. The referring provider must provide pertinent medical information and/or records to the consulting provider via a secure transmission.
3. Interactive audio and video telecommunication must be used; permitting encrypted communication between the distant site physician or practitioner and the Medicaid beneficiary. The telecommunication service must be secure and adequate to

Coverage Guidelines (Cont'd.)

protect the confidentiality and integrity of the Telemedicine information transmitted.

4. The telemedicine equipment and transmission speed and image resolution must be technically sufficient to support the service billed. Staff involved in the telemedicine visit must be trained in the use of the telemedicine equipment and competent in its operation.
5. An appropriate certified or licensed health care professional at the referring site is required to present (patient site presenter) the beneficiary to the physician or practitioner at the consulting site and remain available as clinically appropriate.
6. If the beneficiary is a minor child, a parent and/or guardian must present the minor child for telemedicine service unless otherwise exempted by State or Federal law. The parent and/or guardian need not attend the telemedicine session unless attendance is therapeutically appropriate.
7. The beneficiary retains the right to withdraw at any time.
8. All telemedicine activities must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996: Standards for Privacy of individually identifiable Health Information and all other applicable state and federal laws and regulations.
9. The beneficiary has access to all transmitted medical information, with the exception of live interactive video, as there is often no stored data in such encounters.
10. There will be no dissemination of any beneficiary's images or information to other entities without written consent from the beneficiary.
11. The provider at the distant site must obtain prior approval for service when services require prior approval, based on service type or diagnosis.

Reimbursement for Professional Services

Reimbursement to the health professional delivering the medical service is the same as the current fee schedule amount for the service provided. Consulting site physicians and practitioners submit claims for telemedicine or telepsychiatry services using the appropriate CPT code for the professional service along with the telemedicine modifier GT, "via interactive audio and video telecommunications system" (*e.g.*, 99213 GT). By coding and billing the "GT" modifier with a covered telemedicine procedure code, the consulting site physician and/or

Reimbursement for Professional Services (Cont'd.)

practitioner certifies that the beneficiary was present at originating site when the telemedicine service was furnished. Telemedicine services are subject to copayment requirements. Fee schedule are located on the SCDHHS Web site at http://www.scdhhs.gov.

Reimbursement for the Originating Site Facility Fee

The **referring site** is only eligible to receive a facility fee for telemedicine services. Claims must be submitted with HCPCS code Q3014 (Telemedicine originating site facility fee).The reimbursement is $14.96 per encounter. If a provider from the referring site performs a separately identifiable service for the beneficiary on the same day as telemedicine, documentation for both services must be clearly and separately identified in the beneficiary's medical record, and both services are eligible for full reimbursement.

Reimbursement for FQHCs and RHCs

Referring Site

RHCs and FQHCs are eligible to receive reimbursement for a facility fee for the telemedicine services when operating as the referring site. Claims must be submitted with HCPCS code Q3014 (Telemedicine originating site facility fee). The reimbursement is $14.96 per encounter. When serving as the referring site, the RHCs and FQHCs cannot bill the encounter T1015 code if these are the only services being rendered.

Consulting Site

The RHCs and FQHCs would bill a T1015 encounter code when operating as the consulting site. Only one encounter code can be billed for a date of service. Both provider types will use the appropriate encounter code for the service along with the "GT" modifier (via interactive audio and video telecommunications system) indicating interactive communication was used.

Hospital Providers

Hospital providers are eligible to receive reimbursement for a facility fee for telemedicine when operating as the referring site. Claims must be submitted with revenue code 780 (Telemedicine). There is no separate reimbursement for telemedicine services when performed during an inpatient stay, outpatient clinic or emergency room visit, or outpatient surgery, as these are all-inclusive payments.

Documentation

Documentation in the medical records must be maintained at the referring and consulting locations to substantiate the service provided. A request for a telemedicine service from a referring provider and the medical necessity for the telemedicine service must be documented in the beneficiary's medical record. Documentation must indicate the services were rendered via telemedicine. All other Medicaid documentation guidelines apply to the services rendered via telemedicine. Examples include but are not limited to:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Documentation (Cont'd.)

- The diagnosis and treatment plan resulting from the telemedicine service and progress note by the health care provider
- The location of the referring site and consulting site
- Documentation supporting the medical necessity of the telemedicine service
- Start and stop times

Unusual Travel

Procedure code 99082 is compensable only when a patient must be transported to a medical facility and is accompanied by a physician because there is no other recourse available based on the necessary medical skills and expertise required for the patient's condition. Documentation must be submitted with the claim. Coverage and reimbursement will be determined on a claim-by-claim basis.

Unlisted Services or Procedures

A service or procedure may be provided that is not listed in the CPT. When reporting such a service; the appropriate "unlisted" procedure code may be used to indicate the service, identifying it by special report.

Appropriate records to justify the use of the unlisted code, the complexity of the service, and the charge must accompany the unlisted procedures. The reimbursement will be directly related to the support documentation submitted with the claim. To ensure proper interpretation and payment, a complete description of the performed service is required.

Procedures that are considered an integral part of an examination should not be charged separately (*i.e.,* simple vision test, blood pressure check, ophthalmoscopy, otoscopy). Charges for these services in addition to an E/M visit will be denied.

Non-Covered Services

CPT procedure codes 99075, 99078, 99080, and 99090 indicating medical testimony, special reports for insurance, educational services for groups, and data analysis are non-compensable by Medicaid.

Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)

Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) are provided to support primary medical care in patients who exhibit risk factors that directly impact their medical status. These services are designed to help the physician maximize the patient's treatment benefits and outcomes by supplementing routine medical care.

These services can be provided by public health nurses, social workers, dieticians, health educators, home economists, and public health assistants who have special training and experience in working in the home or other community setting to assist the client in meeting mutually developed health care objectives.