# Telehealth/Telemedicine Payment Policy

Applies to the following Tufts Health Plan products:

- ☒ Tufts Health Plan Commercial[1]
- ☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☒ Tufts Medicare Preferred PPO (a Medicare Advantage product)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

Applies to the following Tufts Health Public Plans products:

- ☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- ☒ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

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The following payment policy applies to Tufts Health Plan contracting providers who render telehealth services **effective for dates of service on or after September 1, 2022**. For telehealth services prior to this date, refer to the Temporary COVID-19 Telehealth/Telemedicine Payment Policy.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

**Note:** Audit and disclaimer information is located at the end of this document.

## POLICY

Tufts Health Plan covers medically necessary telehealth and/or telemedicine services consistent with applicable state mandates and in accordance with the member's benefit plan document. Services covered under telehealth should be clinically appropriate and not require in-person assessment and/or treatment. Tufts Health Plan defers to the provider to make this determination.

All Tufts Health Plan contracting providers, including specialists and urgent care facilities, may provide telehealth/telemedicine services to members for medical, behavioral health, ancillary health, and home health care visits (i.e., skilled nursing, PT, OT, and ST) for new and existing patients. For more information on provider telehealth responsibilities, refer to the *Telehealth Responsibilities* section of the Providers chapter in the Provider Manuals for Commercial and Tufts Health Public Plans.

### Documentation Requirements

Documentation requirements for telehealth/telemedicine services are the same as those required for any face-to-face encounter, with the addition of the following:

- A statement that the service was provided using telehealth/telemedicine consult;
- The location of the patient;
- The location of the provider; and
- The names of all persons participating in the telehealth/telemedicine service or telephone consultation service and their role in the encounter.

**Note:** Providers do not need to use the Teladoc platform to provide services to members. Teladoc is an additional benefit available to some Commercial members that is outside the scope of this payment policy.

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[1] Commercial products include HMO, POS, PPO, and CareLink℠ when Tufts Health Plan is the primary administrator.
[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

## GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics, including cost share, should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Provider Services.

**Note:** There is no member responsibility for covered services for Tufts Health Plan SCO, Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

## REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization, and Notification Policy.

The same referral requirements apply for telehealth/telemedicine services for Commercial and Tufts Health Direct products as for in-person visits. Referral requirements continue to be waived for Senior Products, Tufts Health Together, and Tufts Health Unify.

All plans requiring a referral or prior authorization to receive OON services should refer to the Referring to Out-of-Network Providers Policy.

## BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry-standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

**POS Codes**

- **02:** Patient is not located in their home
- **10:** Patient is in their home (a location other than a hospital or other facility where the patient receives care in a private residence)

**Modifiers**

- **93:** Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system; may only be appended to services listed in Appendix T of the AMA CPT Manual
- **95:** Synchronous telemedicine service rendered via a real-time interactive audio/video telecommunications system
  - Append to services listed in Appendix P of the AMA CPT Manual
  - May be appended to MassHealth-covered BH alcohol and drug treatment HCPCS codes (Tufts Health Plan SCO, Tufts Health Together, and Tufts Health Unify only)
- **FQ:** Audio-only communication technology (to be used with BH services)
- **FR:** Supervising practitioner was present through two-way, audio/video communication technology
- **GT** Interactive audio/video telecommunication systems
  - Required on the institutional claim for the distant-site provider when there is an accompanying professional claim containing POS 02 or 10
- **GQ:** Asynchronous telecommunications system
- **G0:** Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke
- **V3:** services rendered via audio-only telehealth; may only be billed for DOS through March 31, 2023
- Providers should bill with the appropriate license-level modifier and all other billing guidelines, as specified in the applicable payment policies
- Do not append modifiers to procedure codes that are inherently telehealth services (e.g., Q3014, 98966, or 99441) as this is indicated by the appropriate POS code. Claims incorrectly billed with these modifiers may result in a denial.

**Professional Claims**

- Telehealth/telemedicine claims must be reported with the appropriate Place of Service (POS) code, CPT/HCPCS code(s), and applicable modifier(s)

**Facility Claims**

- Claims must be reported with the appropriate CPT/HCPCS code(s), modifier(s), and the appropriate revenue code(s)
- Modifier GT is required on the institutional claim for the distant-site provider when there is an accompanying professional claim containing POS 02 or 10 (effective for DOS on or after April 1, 2023 for Tufts Health Plan SCO, Tufts Health Together, and Tufts Health Unify claims)
  - **Note:** Modifier GT may only be appended to institutional claims for Tufts Health Plan SCO, Tufts Health Together, or Tufts Health Unify members

Providers must bill the following code combination(s) for telehealth services:

| Product(s) | POS | Modifier(s) |
|---|---|---|
| Commercial<br>Tufts Health Direct<br>Tufts Health RITogether | 02 or 10 | 93<br>95<br>GT |
| Tufts Medicare Preferred HMO/PPO | 02 or 10 | 95 GQ<br>FQ GT<br>FR G0 |
| Tufts Health Plan SCO<br>Tufts Health Together<br>Tufts Health Unify | 02 or 10 | 93 GQ<br>95 GT (institutional claims only)<br>FQ V3 (only for DOS through 3/31/23)<br>FR<br>*Effective for DOS on or after April 1, 2023, claims billed without a required modifier will deny* |

## COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable network contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For additional information, refer to the Professional Services and Facilities Payment Policy.

Effective for DOS on or after March 1, 2023, telehealth/telemedicine services rendered to Commercial members will be subject to a 20% reduction, unless otherwise specified in the provider's health services agreement and/or applicable state regulations. Behavioral health providers in M.A. and R.I. as well as PCPs and registered dieticians/nutritionists in R.I. will continue to be compensated at the applicable in-person fee schedule/allowable amount.

Effective for DOS on or after August 1, 2023, telehealth/telemedicine services rendered to Tufts Health Direct members will also be subject to a 20% reduction of the in-person rate (**Note:** this does not apply to BH providers).

**Note:** For Medicare products, under CMS rules, special codes already exist for certain telephonic services and those codes will be paid at the CMS fee schedule.

Services provided outside usual office hours through interactive mechanisms are not eligible for the addition of a 99050, 99051, 99053, 99056, 99058, or 99060 code, since interactive services are not limited to standard office hour time frames.

Communication with the member's PCP and other treating providers is expected as part of the service and is not compensated separately. Provider-to-provider discussions without the member being present are not separately compensated.

## ADDITIONAL RESOURCES

- Evaluation and Management Professional Payment Policy
- Provider Resource Center

## DOCUMENT HISTORY

- October 2023: Clarified modifier GT institutional claims billing instructions for Tufts Health Together, Tufts Health Unify, and Tufts Health Plan SCO claims
- June 2023: Updated compensation amount for services rendered to Tufts Health Direct members, effective for DOS on or after August 1, 2023
- March 2023: Updated modifier information for Tufts Health Together, Tufts Health Unify, and Tufts Health Plan SCO, effective for DOS on or after April 1, 2023

- February 2023: Clarified provider exceptions for 20% fee schedule decrement, effective for DOS on or after March 1, 2023
- December 2022: Updated compensation amount for services rendered to Commercial members, effective for DOS on or after March 1, 2023; added billing instructions for modifier 93
- September 2022: Policy created to reflect non-COVID-state billing and coverage guidelines effective for dates of service on or after September 1, 2022

## AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. Tufts Health Plan reserves the right to amend a payment policy at its discretion.