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MEDICAID MEMO

TO: All Providers Participating in the Virginia Medical Assistance Program

FROM: Jennifer S. Lee, M.D., Director
Department of Medical Assistance Services (DMAS)

DATE: TBD

SUBJECT: 2019 Update Regarding DMAS Coverage of Telemedicine and Telehealth

The purpose of this memo is to update the Agency's policies regarding both telemedicine and telehealth coverage. DMAS last provided general guidance regarding Telemedicine in the May 13, 2014 Medicaid memo entitled, "Updates to Telemedicine Coverage." This memorandum builds on the previous memorandum, addressing both forms of technology for the delivery of health care services to members with fee-for-service coverage. For managed care enrolled members, the member's plan may cover additional telemedicine/telehealth services and have different requirements. Providers should direct specific telemedicine/telehealth coverage questions to the member's MCO.

Telemedicine

DMAS defines "Telemedicine" as a service delivery modality that is a real-time two-way transfer of medical data and information using an interactive audio and visual connection. The member is located at the originating site, and may be assisted by a service-appropriate provider, who functions as the "telepresenter." The telepresenter ensures the proper set up and use of the technology involved, and is available to the member throughout the encounter. The distant medical provider uses the transmitted information to deliver physical and/or behavioral health services from the distant site for the purposes of diagnosis and treatment of the member. Two-way, real-time interaction between the distant provider and the patient is the hallmark of telemedicine.

In broad terms, telemedicine is an alternative method of service delivery for services that are typically provided to patients through an in-person visit with the service provider - when those services can appropriately be delivered via telecommunications. All services that are available for reimbursement when delivered as telemedicine are subject to the same limitations and restrictions as if delivered in-person, and the payment rates are the same. Individuals must be given a choice to receive services either in-person or via telemedicine. DMAS covers telemedicine where the following requirements are met:

- The DMAS-enrolled provider is located at a distant site
- The provider is delivering medically necessary, covered services to a DMAS member
- The Member is located at DMAS-recognized originating site
- The originating site provider must be enrolled with DMAS in order to bill the originating site fee.
- The originating site provider cannot bill an originating site fee unless the Member is assisted by a telepresenter at the originating site. The telepresenter need not be a clinically trained individual, unless medical expertise is clinically indicated to address any patient needs that may arise during the telemedicine session. Where an originating site fee is not sought, a telepresenter need not be present for reimbursement of the telemedicine service fee.

For the purposes of reimbursement of the originating site fee, DMAS-recognized originating sites are those set out in the May 13, 2014 Telemedicine Update Provider Memorandum; they are as follows:

1. Offices of the following when appropriately licensed and acting as a distance provider:

   Physician, Nurse Practitioner, Clinical Nurse Specialist, Nurse Midwife, Psychiatrist, Clinical Social Worker, Professional Counselor, Psychiatric Clinical Nurse Specialist, Psychiatric Nurse Practitioner, Marriage and Family Therapist/Counselor, School Psychologist, and a Substance Abuse Treatment Practitioner.

2. Local Education Agency, when billing for speech therapy as a distance provider.

3. Rural Health Clinics; Federally Qualified Health Centers; Hospitals (includes general, state mental, private mental, long stay, rehabilitation); Nursing Facilities (includes skilled nursing, medical /intellectual disability, intermediate care); Health Department Clinics; Renal Units (dialysis centers); Community Services Boards (mental health-intellectual disability provider); and Residential Treatment Centers-C.

When these requirements are met, the distant provider may bill for the service, and the originating site may bill for the originating site fee. Distant providers shall use the appropriate service billing code, with the addition of the telemedicine modifier code. Originating site providers shall use the appropriate originating site facility fee code - Q3014 - and include the modifier GT for telemedicine. Telephone calls, e-mail, facsimile transmissions and similar electronic measures are not considered part of the telemedicine or telehealth coverage and shall not be reimbursed by DMAS or its subcontractors.

For covered services provided to students on school premises, and for which the school is not being reimbursed as the provider, enrolled providers may deliver telemedicine services to students in schools. Non-school providers may bill for telemedicine services in which the school is an appropriate setting, and that are delivered with the school's consent and in accordance with their procedures.

Telehealth

"Telehealth" is the use of telecommunications and information technology to support remote or long-distance physical and behavioral health care services. While it may include some of the critical components of telemedicine, it does not include all of them. Telehealth refers to the broader scope of remote health care services used to inform health assessment, diagnosis, intervention, consultation, supervision and information, across distance. It does not typically include real-time, two way interaction between the service provider and the member, and most of the service billing codes are not the same as those used for in- person services. Telehealth includes remote patient monitoring, as well as Store-and-Forward patient data transmissions, E-consultation between providers, and E-prescribing. Telehealth services utilize a different set of billing codes based upon the technology involved, which are not necessarily tied to traditional in-person services.

Agency Process for Determining New Coverage of Telemedicine and Telehealth

DMAS follows federal guidelines in making determinations regarding coverage of new telemedicine services. Regarding requests for new telemedicine coverage, the key point is whether the new service is the equivalent to in-person medical or behavioral health services DMAS currently covers, specifically with respect to the similarity of the interaction between the practitioner at the distant site and the patient at the originating site. In other words, for a telemedicine visit, the interaction between the practitioner at the distant site and the patient at the originating site is the equivalent of an in-person visit.

With respect to telehealth - those new services or modalities that are not similar to currently covered in-person services, the coverage determination process is more rigorous. In order to implement specific telehealth services, DMAS must first secure federal approval for the new service by submitting a Medicaid State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees Medicaid. The Agency must also obtain authority for the new services from the General Assembly. Without legislative authority and funding appropriations, DMAS cannot implement new telehealth services, require their coverage across all MCOs, or reimburse fee-for-service providers for their use in patient care.

In order to be considered for coverage under current authority, telehealth modalities must demonstrate the following:

1. The proposed use of a telecommunications system or other information technology to furnish the service is accurately described by the corresponding code when furnished via telemedicine or telehealth.
2. The proposed use of a telecommunications system or other information technology to furnish the service has been demonstrated to produce measurable clinical benefits to the patient.
    a. Evidence of demonstrated clinical benefit should include both a description of relevant clinical studies that demonstrate that the medical service furnished by telehealth improves the clinical progress or diagnostic status of an illness or injury.
    b. Demonstration of clinical benefit is not met by the provision of minor or incidental improvement; it is also not met by anecdotal evidence.

c. Evidence of clinical benefit may include a demonstration that the service or modality:
    i. was provided to a patient population without access to clinically appropriate, in-person diagnostic or treatment services;
    ii. measurably reduced rates of complications or escalations in the level of care;
    iii. decreased the need for subsequent diagnostic or therapeutic interventions;
    iv. decreased number of future hospitalizations or physician visits.

Those requesting Virginia Medicaid coverage of telehealth services or modalities should provide objective data findings and/or copies of published peer reviewed articles relevant to the service when furnished via telehealth.

If DMAS makes the determination to extend coverage of a specific telehealth modality, the Agency must then obtain federal and state legal authority for the new coverage, as described above. At the completion of that process, the Agency will provide public guidance regarding the date on which providers may begin bill for the new service.

Medicaid Expansion

New adult coverage begins January 1, 2019. Providers will use the same web portal and enrollment verification processes in place today to verify Medicaid expansion coverage. In ARS, individuals eligible in the Medicaid expansion covered group will be shown as "MEDICAID EXP." If the individual is enrolled in managed care, the "MEDICAID EXP" segment will be shown as well as the managed care segment, "MED4" (Medallion 4.0), or "CCCP" (CCC Plus). Additional Medicaid expansion resources for providers can be found on the DMAS Medicaid Expansion webpage at: http://www.dmas.virginia.gov/#/medex.

PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal Automated Response System (ARS) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-for-service members.	https://dmas.kepro.com/
Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE	

provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or call: 1-800-424-4046
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627