



**BlueCross BlueShield
of Texas**

Telehealth FAQs

2021 – TEXAS



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Telehealth 2021- Provider and Network FAQs

In response to the COVID-19 pandemic, Blue Cross and Blue Shield of Texas (BCBSTX) expanded access to telehealth services to give our members greater access to care. The experience confirmed the importance of telehealth in health care delivery. Members can access their medically necessary, covered benefits through providers who deliver services through telehealth. Many of our members also have access to various telehealth vendors, such as MDLIVE®.

What's the difference in telehealth and telemedicine?

State and federal regulations frequently define telehealth and telemedicine. However, for purposes of general communications, the terms may be used interchangeably to refer to services provided by an eligible health care provider to a member when neither is present at the same physical location.

What's covered?

Telehealth services will be provided **consistent with the terms of the member's benefit plan**. From Jan. 1, 2021, through Dec. 31, 2021, for our **fully insured HMO** and **PPO** members and our **self-funded employer group members**, providers will be able to deliver expanded telehealth services to BCBSTX members. Services include but are not limited to:

- The Centers for Medicare and Medicaid Services (CMS) permanent and temporary telehealth code list
- The American Medical Association (AMA) telehealth code list
- Applied behavior analysis (ABA) services
- Intensive outpatient program (IOP) services
- Partial hospitalization programs (PHP)
- Physical therapy (PT)
- Occupational therapy (OT)
- Speech therapy (ST)

For a list of codes that are eligible for reimbursement, see our provider website.

Our **self-funded** employer group customers make decisions for their employee benefit plans. **Check eligibility and benefits** for any variations in member benefit plans.

Didn't BCBSTX say they were only covering codes on the CMS and AMA permanent telehealth code lists?

Yes, we did. However, in light of the new administration's expectation that the national public health emergency (PHE) will continue through 2021, we re-evaluated our position. Therefore, in support of our members and employer groups we expanded the telehealth services eligible for reimbursement through 2021. This means that we are no longer limiting coverage of telehealth services to the Centers for Medicare and Medicaid Services (CMS) and American Medical Association (AMA) permanent lists.

When does the expansion go into effect?

The change is **retroactive to Jan. 1, 2021**. It applies to our **fully insured** and **self-funded group** members. Self-funded groups could opt out of the expanded coverage. Always check eligibility and benefits to determine each member's options. Member **cost-share will still apply**.



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What about claims in January and February 2021?

We are **working as quickly as possible** to process new claims according to the expanded coverage and to adjudicate telehealth claims that may have been denied since Jan. 1, 2021.

Does the coverage apply to all members?

Our self-funded employer group customers make decisions for their employee benefit plans. They may have different coverage. **Check eligibility and benefits** for any variations in member benefit plans.

What about Medicare Advantage cost share?

For the duration of the PHE, we are waiving cost share for our Medicare Advantage members. This means these members will **not** owe any **copays, deductibles or coinsurance** for telehealth visits.

How can telehealth be conducted for Medicare members?

Providers should use an interactive audio and video telecommunications system that permits real-time interactive communication to conduct telehealth services. CMS permits audio only telehealth services in limited circumstances. See the CMS website for [designated audio-only codes](#).

When should care be delivered by telehealth versus in-person?

How care is delivered is a decision between the provider and the patient. However, when determining whether services should be delivered by telehealth or in-person, we **recommend** the following:

- Consider telehealth a mode of care delivery to be used when it can reasonably provide **equivalent outcomes** as face-to-face visits.
- Choose telehealth when it **enhances the continuity of care** and care integration if you have an established patient-provider relationship with members.
- **Integrate telehealth records into electronic medical record systems** to enhance continuity of care, maintain robust clinical documentation and improve patient outcomes.

Member cost share was waived during 2020, what about now?

As of Jan. 1, 2021, **copays, deductibles and coinsurance apply** to telehealth visits. The cost share varies according to the member's benefit plans. **Check eligibility and benefits** for each member for details.

Many of our members are covered under a health plan that is **self-funded by their employer**. Some of these members **may have cost share** for telehealth visits **waived**, depending on their employer's decision about its benefit plan. **Check eligibility and benefits** for each member for details.

Does telehealth require referrals or prior authorizations?

Some telehealth care will require **referrals** and **prior authorizations** in accordance with the member's benefit plan. **Check eligibility and benefits** for each member for details.



Which members can use telehealth?

Providers can use telehealth for members with the following types of benefit plans. Care must be consistent with the terms of the member’s benefit plan.

- Fully insured HMO and PPO plans
- Blue Cross Medicare Advantage (excluding Part D) and Medicare Supplement
- Self-funded employer group plans
- Medicaid STAR, CHIP and STAR Kids

Does BCBSTX policy supersede state and federal requirements?

No, we will continue to follow applicable state and federal requirements.

How can telehealth be delivered?

See our **Clinical Payment and Coding Policies (CPCP)** on our **provider website under Standards & Requirements**. Any changes to the information below will be reflected in our CPCP. Available telehealth visits with providers include the following delivery methods: synchronous, asynchronous and other methods allowed by state and federal laws.

Delivery Method	Definition
Synchronous	2-way, live interactive audio and video communications; requires digital video consultations
Asynchronous	Via image and video not provided in real-time (a service is recorded as video or captured as an image; the provider evaluates it later); must use in connection with a synchronous audio interaction between the provider and the patient in another location.
Other	Other methods allowed by state and federal laws

For Medicare members - interactive audio and video telecommunications system that permits real-time interactive communication to conduct telehealth services. CMS permits audio only in limited circumstances. See the CMS website for [designated audio-only codes](#).

Where can I find information on remote technologies?

Providers can find the latest guidance on acceptable Health Insurance Portability and Accountability Act (HIPAA) compliant remote technologies issued by the [U.S. Department of Health and Human Services’ Office for Civil Rights in Action](#).

Will audio-only codes be covered after Jan. 1, 2021?

Yes, BCBSTX covers certain audio-only codes. Claims should be coded using appropriate codes that describe the service rendered. For coding details, see our Clinical Payment and Coding Policies on our provider website under Standards & Requirements.

The [CMS code lists](#) specifies which codes can be delivered by audio-only. Are we required to follow their guidelines for all members?

Claims should be coded using appropriate codes that describe the service rendered. Medicare follows the CMS code list, including codes applicable during the PHE. Medicaid follows state guidelines. See our Clinical Payment and Coding Policies on our provider website for details.



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What about telehealth vendors?

For fully insured members, providers are not required to use a vendor for telehealth services.

For self-funded plans, members may be required to use specific vendors, such as MDLIVE® as outlined in the member's benefit plan.

Who can submit claims for telehealth?

The provider submitting the claim is responsible for accurately coding the service performed.

Are modifiers required on telehealth claims?

Submit claims for medically necessary services delivered via telehealth with the appropriate **modifiers (95, GT, GQ, G0) and Place of Service (POS) 02**. For coding details, see our Clinical Payment and Coding Policies on our provider website under Standards & Requirements.

If the claim is billed with a telehealth modifier or a telehealth procedure code without POS 02, it may be returned to the provider. The provider will need to resubmit with the appropriate POS.

What modifiers does BCBSTX accept?


We accept the following modifiers (see our CPCP for details):

- 95 – synchronous telehealth (two-way live audio visual)
- GT – interactive audio and video telecommunications
- GQ – asynchronous
- G0 – telehealth services for diagnosis, evaluation or treatment of symptoms of an acute stroke; G0 must be billed with one of the approved telehealth modifier (GT, GQ or 95)

How do I find out what benefits a member has?

Check eligibility and benefits for each member at every visit prior to rendering services. Providers may:

- Verify general coverage by submitting an **electronic 270 transaction through Availity®** or your preferred vendor.
- Connect with a Customer Advocate to check eligibility and telehealth benefits by **calling our Provider Customer Service Center at 1-800-451-0287**.

 By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use and privacy policy.

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