If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of Illinois may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSIL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Telemedicine and Telehealth/Virtual Health Care Services Policy

Policy Number: CPCP033

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: September 19, 2025

Plan Effective Date: September 26, 2025

Description

The purpose of the Telemedicine Services and Telehealth/Virtual Health Care Services policy is to provide guidance on payment and coding for services that are provided by an eligible health care professional to a member when neither is present at the same physical location. These services can be performed through various delivery methods. Codes referenced in this policy do not guarantee reimbursement for services.

State and federal regulations define telemedicine and telehealth, however for purposes in understanding the terms in this policy, Telemedicine and Telehealth may be used interchangeably. Virtual health care is used to describe a broader range of services.

The Plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement.

For additional information on telemedicine services or telehealth services or procedures, please check the Plan's website.

Terms/Descriptions

Audio only visits- The use of a telephone for visits without video.

Health care professional - A physician or an individual who is licensed, certified or authorized in the Plan's state to perform a health care service; and is authorized to perform a telemedicine service or is authorized to assist a provider in performing a telemedicine service that is delegated and supervised by the physician or a licensed or certified health care professional acting within the scope of the license or certification who does not perform the telemedicine service. Note, eligible providers performing telemedicine services must possess the necessary license to treat members of the Plan's state. Licensed providers must meet the health plans definition of eligible provider.

Live video- Often referred to as real time, a two-way, face-to-face interaction between a member and a provider using audiovisual communications technology.

Physician - A person who is licensed to practice medicine in the Plan's state. Note, eligible providers performing telemedicine services must possess the necessary license to treat members of the Plan's state. Licensed providers must meet the health plans definition of eligible provider.

Telehealth service - The use of electronic information and telecommunications technologies to support long distance clinical health care, patient and professional health-related education, public health, and health administration. Typically, telehealth describes provider to provider interaction, or indirect provider to patient interaction.

Telemedicine service - The use of a telecommunication system to provide services for the purpose of evaluation and treatment when the patient is at one location and the rendering provider is at another location.

Virtual Health Care- Encompasses care rendered by synchronous and asynchronous delivery methods. Virtual health care is expanding and includes a variety of services and applications using two-way video, email, smart phones, wireless tools, and other forms of telecommunications.

Delivery Methods

Delivery methods may include but are not limited to the following**:**

Interactive electronic telecommunications equipment includes audio and video equipment permitting two-way, or live video interactive communication between the member and physician or practitioner. Providers should utilize the appropriate methods for communication service described below depending on the type of service needed and as allowed by state and federal laws. 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.

- **Synchronous:** 2-way, live interactive audio and video communications
- **Asynchronous telecommunication** - 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)

    - **E-Visits**- Allow a member to communicate with a provider using an online patient portal to answer questions or decide if a visit needs to be scheduled.
    - **Mobile health**- Technology used to allow members to review personal health data via mobile devices from their own home and assists in communicating their health status and any changes.
    - **Store and forward** - Technology that stores and transmits or grants access to a member's clinical information for review by a health care professional at a different physical location than the person.
    - **Remote Monitoring Services -** Remote monitoring is a service that enables member's health monitoring as well as transfers the health data to an eligible physician or other qualified health care professional. Additional information for remote monitoring services for Intraoperative Neurophysiology Monitoring (IONM) can be found in *CPCP032 Intraoperative Neurophysiology Monitoring (IONM) Coding and Reimbursement Policy*, located on the Plan's website.

- **Virtual Check-ins-** Remote evaluations of recorded video or images submitted by a member followed by a brief 5–10-minute check-in with a healthcare professional via telephone or other telecommunications device to decide whether an office visit or other service is needed.

- Other methods allowed by state and federal laws, which can allow members to connect with physicians outside of a traditional provider office setting.

Reimbursement Information

For services appropriately provided through virtual health care, the following requirements must be met for eligible reimbursement, in addition to the requirements applicable to the service being rendered:

- The provider must maintain complete and accurate medical records including but not limited to start and end times of the telemedicine/telehealth or virtual health care service.
- The method of communication must be documented.
- Ensure HIPAA compliant and federal and state privacy laws are implemented for member communications, recordings, and member's records.
- Qualified providers providing telemedicine/telehealth or virtual health care services must possess the necessary license to treat members of the Plan's state.

Billing/Coding

Modifiers

The Plan will not accept asynchronous telecommunication services. Claims with lines of service submitted with modifier GQ will not be eligible for reimbursement.

Modifiers **FQ, FR, G0, GT, 93** and **95** are telemedicine service or telehealth service modifiers and must be appended to the HCPCS or CPT code(s), in conjunction with a place of service-POS code below, on telehealth or telemedicine claims unless a telemedicine procedure code is billed.

- Only non- telemedicine procedure codes require a telemedicine modifier.
- Modifier G0 will only be accepted by the Plan when modifier GT, and/or modifier 95 are appended to the service.

Modifier FQ: The service was furnished using audio-only communication technology.
Modifier FR: The supervising practitioner was present through two-way, audio/video communication technology.
Modifier G0: Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke.
Modifier GT: Via interactive audio and video telecommunications systems
Modifier 93: Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system. Modifier 93 is applicable to certain codes that can be found in AMA, CPT documents. Check current CPT documents for the appendix on ***CPT Codes That May Be Used for Synchronous Real-Time Interactive Audio-Only Telemedicine Services***. These procedure codes are billed when electronic communication using interactive telecommunications equipment, include, at a minimum audio. Codes that are appropriate for use with modifier 93 are indicated with the audio symbol throughout the AMA, CPT codebook.
Modifier 95: Synchronous telemedicine services rendered via real-time interactive audio and video telecommunications system. Modifier 95 is applicable to certain codes that can be found in AMA, CPT documents. Check current CPT documents for the appendix on ***CPT Codes That May Be Used for Synchronous Telemedicine Services***. These procedure codes are billed when electronic communication using interactive telecommunications equipment include, at a minimum, audio and video. In addition, codes that are appropriate for use with modifier 95 are indicated with a star (★) throughout the AMA, CPT codebook.

Place of Service (POS) Codes

Telehealth or telemedicine professional claims submitted on a CMS 1500 form must be submitted with Place of Service (POS) Code '**02**' **or '10'**. Providers should submit the most appropriate place of service code that accurately describes where the services were rendered. POS 02 does **not** apply to originating site facilities when billing a facility fee.

Place of Service (POS) Code 02 (Telehealth Provided Other than in Patient's Home): The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
Place of Service (POS) Code 10 (Telehealth Provided in Patient's Home): The location where health services and health related services are provided or received, through telecommunications technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunications technology.

The following is used to determine eligibility for **HCPCS Q3014** (Telehealth originating site facility fee):

Appropriate billing of Q3014 (To transmit data between unaffiliated providers):

- The provider who is supplying the room and telecommunication equipment with the member physically present, may submit Q3014.

- The member visits their PCP's office, and the PCP helps to initiate a telehealth appointment with an outside specialist (not employed/contracted with the PCP or their practice) located in another office location.
    - PCP's office can submit **Q3014** for physically hosting the patient (member).
    - The outside specialist located in another office location may not bill code Q3014 since they are not the originating site.

Inappropriate billing of Q3014 (Not to be used for virtual type visits or use of equipment for those purposes):

- The member is in their home and initiates telehealth visit with their PCP.
    - Since the PCP is not physically hosting the patient (member), they cannot bill **Q3014** as the patient (member) is not present at their facility.
    - The PCP is acting as a distant site provider to the member who is at home.
- The member visits their PCP's office and initiates a telehealth or virtual-type visit with their PCP, regardless of whether the PCP is onsite or offsite at the time of the visit.
    - The PCP can bill the CPT/HCPCS code reflecting the service rendered and would append the appropriate telehealth modifier if the PCP was offsite. The PCP cannot also bill Q3014.

Effective January 1, 2025, AMA has established new evaluation and management telemedicine services codes. These services are similar to office/outpatient visits except they require a communication-based technology. Providers should take notice that the telemedicine symbol "★" has been removed from E/M CPT codes 99202-99205, and 99212-99215. The telemedicine symbol remains for E/M CPT code 99211. Providers must continue to append an appropriate telehealth modifier if billing services with 99202-99205 and 99212-99215.

Unless otherwise noted in the code descriptor, the new telemedicine services codes are based on the level of medical decision making (MDM), or the total time for the

E/M service rendered on the date of the encounter. Codes listed below may not be reported on the same calendar date as another E/M service. If another E/M service is rendered on the same calendar date, the elements and time of these services are totaled and reported in aggregate. The minimum time for reporting a telemedicine service, if not reached, may count towards the total time spent in an in-person E/M visit on the same date from a separate encounter.

These telemedicine services codes should not be used to report any routine telecommunications that is related to a previous encounter but may be reported when a follow-up E/M service is required.

Note, if audio-video connection is lost during an encounter and only audio is restored, providers should report the service that attributed to the majority of the time of the interactive portion of the service. For audio-only services, ten minutes of medical discussion or patient observation must be exceeded.

For additional information, providers should refer to *Table 2: Telemedicine and Non-Face-to-Face Services* and guidance in the parenthetical notations for codes in the most recent AMA, CPT codebook.

Services are broken down into **1)** Synchronous Audio-Video E/M Services new patients/established patients, **2)** Synchronous Audio-Only E/M Services new patients/established patients, and **3)** Brief Synchronous Communication Technology Service (e.g., Virtual Check-In) established patient.

1. Synchronous Audio-Video E/M Services CPT Codes	
New Patient	**Established Patient**
98000: Straightforward MDM- For total time, 15 mins must be met or exceeded.	**98004**: Straightforward MDM- For total time, 10 mins must be met or exceeded.
98001: Low MDM- For total time, 30 mins must be met or exceeded.	**98005**: Low MDM- For total time, 20 mins must be met or exceeded.
98002: Moderate MDM- For total time, 45 mins must be met or exceeded.	**98006**: Moderate MDM- For total time, 30 mins must be met or exceeded.
98003: High MDM- For total time, 60 mins must be met or exceeded.	**98007**: High MDM- For total time, 40 mins must be met or exceeded.

2. Synchronous Audio-Only E/M Services CPT Codes	
New Patient	**Established Patient**
98008: Straightforward MDM and more than 10 mins of medical discussion- For total time, 15 mins must be met or exceeded.	**98012:** Straightforward MDM and more than 10 mins of medical discussion- For total time, 10 mins must be met or exceeded.
98009: Low MDM and more than 10 mins of medical discussion- For total time, 30 mins must be met or exceeded.	**98013**: Low MDM and more than 10 mins of medical discussion- For total time, 20 mins must be met or exceeded.
98010: Moderate MDM and more than 10 mins of medical discussion- For total time, 45 mins must be met or exceeded.	**98014:** Moderate MDM and more than 10 mins of medical discussion- For total time, 30 mins must be met or exceeded.
98011: High MDM and more than 10 mins of medical discussion- For total time, 60 mins must be met or exceeded.	**98015:** High MDM and more than 10 mins of medical discussion- For total time, 40 mins must be met or exceeded.

3. Brief Synchronous Communication Technology Service CPT Code	
98016- Established Patient Only	• Patient initiated. • Not to be reported with codes listed above (98000- 98015). • Not to be reported for services less than 5 minutes of medical discussion. • Video technology not required. • If check-in leads to an E/M service on same calendar date, and if time is used to select the level of E/M service, time from 98016 may be added to the time of the E/M service for total time on the date of the encounter. • Does not lead to E/M service within next 24 hours or soonest available appointment. • Does not originate from related E/M service from previous 7 days.

CPT codes 99421, 99422, 99423 (Online Digital E/M Services), 98970, 98971, 98972 (Nonphysician Qualified Health Care Professional Online Digital Assessment and Management Service), and 98016 (Brief Synchronous Communication Technology Service (e.g., Virtual Check-in)) are appropriate to report when all the requirements are met. Text messaging alone does not meet the requirements of a digital E/M, assessment and management, or virtual check-in service.

Additional Resources

Clinical Payment and Coding Policy
CPCP024 Evaluation and Management Coding- Professional Provider Services

References

www.cms.gov

Healthcare Common Procedure Coding System (HCPCS)

Policy Update History

Approval Date	Description
03/28/2022	New policy
12/01/2023	Annual Review
02/26/2024	Annual Review
02/20/2025	HCPCS code termed, G2012; New telemedicine services codes and language added (98000- 98016); Modifier 93 appendix information added; Additional Resources added.
09/19/2025	Ad Hoc update, clarification and examples added to HCPCS Q3014 section of the policy.