



CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all health benefit plans administered by CIGNA Companies including plans formerly administered by Great-West Healthcare, which is now a part of CIGNA.

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Subject Telemedicine

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Hyperlink to Related Coverage Policies

Cardiac Event Monitors
Retinal Imaging for Diabetic Retinopathy

INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2011 CIGNA

Coverage Policy

Certain specific telemedicine services are expressly covered under some benefit plans. Other benefit plans exclude all forms of telemedicine from coverage. Coverage of telemedicine services may also be governed by state mandates. Please refer to the applicable benefit plan document to determine the terms, conditions and limitations of coverage.

If telemedicine services are not expressly covered nor specifically excluded under the applicable benefit plan, then the following conditions of coverage apply.

CIGNA covers ANY of the following telemedicine services between a provider and individual as medically necessary when integrated with individual health data for diagnosis and treatment of individuals either located in geographically remote areas, or who cannot access direct patient-provider healthcare:

- specialist referrals/consultation (e.g., telephone, electronic mail [email] or audio/video conferencing)
- evaluation and management services (e.g., electronic office visits, electronic hospital visits)
- remote monitoring services when standard home health services are not available

Telemedicine services (other than those expressly covered by a benefit plan) provided solely for the convenience of the individual or the provider, are not considered medically necessary.

Radiology, pathology and cardiology services that do not require direct patient-provider interaction

(e.g., x-rays, EKG, pacemaker monitoring) are not considered telemedicine.

General Background

Telemedicine may be defined as the use of electronic information and telecommunications technologies to support long-distance clinical healthcare, patient and professional health-related education, public health and health administration. Essentially, telemedicine combines traditional medicine and modern technology to extend the capabilities of the traditional healthcare system for provision of direct clinical services by way of telecommunications (i.e., diagnosing, treating or following up with a patient at a distance). Technologies used for electronic communication may include: videoconferencing, store-and-forward imaging, the Internet, streaming media, satellite and wireless communications.

An umbrella term often used in conjunction with telemedicine is "telehealth." Telehealth, also referred to as "e-health" however is intended to include a much broader range of services involving multiple variations of electronic transmission (e.g., videoconferencing and transmission of still images), and may not necessarily be for the provision of direct clinical services. For example, telehealth generally includes patient portals and remote monitoring of vital signs, email communications and the use of electronic prescriptions.

The main proposed advantage of both telemedicine and telehealth services is their capability of delivering medical services to distant areas with limited access to medical specialists or primary care physicians (e.g., geographically remote areas, areas designated as health professional shortage areas). Health professional shortage areas are defined by the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA). The HRSA has developed specific criteria and procedures for designation of geographic areas, population groups, medical and other public facilities in the United States as health professional(s) shortage areas. Some of the criteria include whether the area is considered a rational area for the delivery of primary medical services; if primary medical care professionals in contiguous areas are overutilized, excessively distant, or inaccessible to the population of the area under consideration; and if at least one of the following exists:

- The area has a population to full-time-equivalent primary care physician ratio of at least 3,500:1.
- The area has a population to full-time-equivalent primary care physician ratio of less than 3,500:1 but greater than 3,000:1 and has unusually high needs for primary care services or insufficient capacity of existing primary care providers.
- Primary medical care professionals in contiguous areas are overutilized, excessively distant, or inaccessible to the population of the area under consideration.

Telemedicine services have also been proposed as a method of increasing communication for patients who have existing access to care, in hopes of improving patient outcomes, although data comparing outcomes of these services to those of traditional face-to-face encounters is limited. This type of encounter is most effective where previous relationships with the provider have been established and are provided in an ongoing manner to ensure that comprehensive, coordinated care is being delivered. However, a previous relationship may not always be practical, for example, when a patient in a remote area is seeking consultation with a specialist at a tertiary care center.

Practitioners who utilize telemedicine services should be compliant with online secure transmission of private patient health information (e.g., Health Insurance Portability and Accountability Act [HIPAA] regulations, encryption). The handling of electronic patient information is considered the same as for an in-office environment, and patient privacy must be maintained. Informed patient consent regarding electronic transmission is recommended at the point-of-care. The criteria for providing evaluation and management services as telemedicine are considered the same as those provided for a standard in-office environment. As such, an effective evaluation and management encounter should contain at least two of the three following key components:

- history
- examination
- medical decision-making

Telemedicine encompasses a broad variety of medical and health services and according to the American Telemedicine Association (ATA), services generally include the following:

- **Specialist referral services:** These typically involve the assistance of a specialist to a general practitioner in rendering a diagnosis. These services may involve a patient "seeing" a specialist over a live, remote consult or the transmission of diagnostic images and/or video along with patient data to a specialist for later viewing.
- **Patient consultations:** These consults transmit medical data between a patient and a primary care or specialty physician by audio, video or other electronic formats for use in rendering a diagnosis and/or treatment plan. The consult may use a direct transmission link originating from a remote clinic to a physician's office or may include communicating with a physician over the Internet.
- **Remote patient monitoring:** This type of monitoring uses electronic devices to collect data remotely and sends them to a monitoring station for interpretation. Such "home telehealth" applications might involve a specific vital sign, such as blood glucose or heart electrocardiogram (ECG or EKG), or a variety of indicators for homebound patients. Such services can supplement the use of visiting nurses.
- **Medical education:** In remote locations, these services can provide continuing medical education credits for health professionals and special medical education seminars for targeted groups.
- **Consumer medical and health information:** This includes providing consumers with specialized health information and online discussion groups with peer-to-peer support through use of the Internet.

In addition, various delivery mechanisms are available and include:

- **Hub-and-spoke networks:** These integrated networks link large tertiary centers with outlying clinics.
- **Point-to-point connections:** Used for services provided to airlines, overseas workers and telepharmacy centers; such connections involve private networks and contracting of services to independent providers.
- **Health provider to the home connections:** This links primary care providers, specialists, and home health nurses with patients over single-line phone-video systems for interactive consults. These services can also be extended to residential care centers such as nursing homes.
- **Direct patient to monitoring center:** These links provide care, such as cardiac, pulmonary and fetal monitoring, to patients in the home setting and help to maintain independent lifestyles.
- **Web-based e-health patient service sites:** These links provide direct consumer outreach and services over the Internet.

Telemedicine Technologies

Telecommunication technology provides media to transmit information and includes standard telephone service, wide bandwidth transmission of digitized signals, computers, fiber optics, satellites and software. There are two basic forms of telemedicine technologies: one for concurrent (real-time) consultations, most often through video conferencing, and a second, consisting of store-and-forward consultations. Concurrent consultation (i.e., clinician interactive) refers to the communication between two physicians or between patient and physician, as a real-time interaction and allows more direct feedback between sources. Concurrent consultation services may include online office visits, consultations, hospital visits, home visits and other specialized examinations and procedures. A store-and-forward service (i.e., noninteractive) collects clinical data and then forwards the data to be reviewed at a later date. This type of telemedicine service is used frequently for clinical areas such as teleradiology or telepathology, in which information can be stored and viewed at a later time, most often in the form of digital images. This form of telemedicine service may also be utilized for clinical consultations in some cases, and eliminates the need for the patient and physician to be available at the same time.

A third form, referenced in the scientific literature but used less frequently than the first two, includes self-monitoring/testing telemedicine services. In this type of telemedicine, providers monitor physiological measurements, test results, images and sounds that are collected in the patient's residence. This type of program eliminates the need for face-to-face visits that may be inconvenient or costly to the patient and theoretically allows better care by enabling earlier detection of problems, thus potentially resulting in reduced healthcare costs. In the general population however, access to electronic communication technology varies.

Applications for Telemedicine Technologies

Telemedicine technologies have been utilized in rural areas as a method of improving access to care, in nonrural areas as an alternative to standard healthcare, and in daily clinical practice. The applications for telemedicine include but are not limited to, cardiology (e.g., EKGs, pacemaker monitoring), radiology (e.g., x-rays, computerized axial tomography [CAT] scans, magnetic resonance imagery [MRI]), pathology, dermatology (e.g., digital images), ophthalmology (e.g., retinal imaging) and psychiatry (e.g., telepsychiatric interviews). While telecardiology, teleradiology and telepathology have been widely used for several years, in general, these types of services do not require direct patient-provider contact. In other medical specialties where telemedicine is often utilized such as dermatology, psychiatry and ophthalmology, telemedicine services are frequently utilized to replace direct patient-provider contact. Telemedicine interventions have also been utilized in other clinical areas, such as emergency rooms, intensive care units, and for endoscopy. Telemedicine may be provided as home-based care encompassing both interactive and noninteractive technologies; these services typically include remote monitoring for chronic diseases such as congestive heart failure, diabetes mellitus, coronary heart disease and hypertension.

Literature Review

Evidence in the published peer-reviewed scientific literature evaluating telemedicine consists of technology assessments, systematic reviews and meta-analysis, case studies, comparative trials and few randomized clinical trials ((Scherr, et al., 2009; Myer, et al., 2008; Schwab, et al., 2007; Mareno-Ramirez, et al., 2007; Hersh, et al., 2006; de Lange, et al., 2006; Lang, et al., 2006; Barnason, et al., 2006; Rasmussen, et al., 2005; Hyler, et al., 2005; Balas, et al., 2004; Hailey, et al., 2004; Curell, et al., 2004; Whitten, et al., 2002; Roine, et al., 2002; Haley, et al., 2002; Hersch, et al., 2001). The authors of some systematic reviews conclude there is a lack of strong evidence that telemedicine is a cost-effective means of delivering healthcare (Curell, et al., 2004; Whitten, et al., 2002; Roine, et al., 2002). When compared to traditional face-to-face contact with treating practitioners, overall the literature lacks sufficient evidence to support improved patient outcomes. The Agency for Healthcare Research and Quality (AHRQ) conducted an evidence report/technology assessment for telemedicine for the Medicare population and summarized the evidence regarding safety, efficacy, and cost-effectiveness. According to the report, the evidence for efficacy was unclear; the sample size of clinical studies reviewed were small (precluding statistical power) and the studies were conducted in various types of settings consisting of varied patient populations (Hersh, et al., 2001). In a 2006 update to the original report the AHRQ (Hersh, et al., 2006), concluded that that were still significant gaps in the evidence base, particularly evidence addressing where telemedicine is used, and more specifically where its use is supported by high-quality evidence. According to the 2006 publication further well-designed studies are needed to understand how to best use these technological resources in healthcare.

Nevertheless, there is evidence that lends support to some clinical benefit for providing telemedicine services in various circumstances. Improvement in functional outcomes following stroke has been reported (Schwab, et al., 2007) as well as improvements in treatment decisions related to stroke care (Myers, et al., 2008). In addition, evidence suggests computer-assisted care for diabetic patients improves diabetic-related outcomes (Balas, et al., 2004). Physician-managed online monitoring tools have been shown to significantly improve clinical outcomes such as lung function, airway responsiveness, quality of life and overall asthma symptoms in asthmatic patients (Rasmussen, et al., 2005). Furthermore, home health telemedicine services have been studied in the literature, and some sources have reported improved health outcomes for specific subgroups of patients, such as those with cardiac conditions (Barnason, et al., 2006; New England Healthcare Institute, 2004). Some data indicate online interactive monitoring has improved patient compliance and confirms patient satisfaction with telemedicine services overall. Despite these encouraging outcomes however, concerns regarding physician-patient confidentiality and security remain, and further improvements in technologies are required to support widespread use.

Professional Societies/Organizations

Several guidelines and/or resource documents for the use of telemedicine are available. Special Interest Groups formulated under the American Telemedicine Association have provided various recommendations for the utilization of telemedicine technologies (e.g., home telehealth, telepathology). In addition, professional organizations such as the American Dermatology Association, the American Psychiatric Association, and the Society of American Gastrointestinal and Endoscopic Surgeons have provided guidelines regarding the use of telemedicine.

In regards to electronic communications, the American Medical Association (2004) developed guidelines for Physician-Patient Electronic Communications. According to this guideline, new communication technologies

must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, the guideline states electronic mail and other forms of Internet communication should be used to enhance such contacts. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient's care.

Summary

The scope of telemedicine applications continues to expand, and there is a broad but varying base of literature to support improvement in clinical outcomes for some applications. Some of the clinical studies had small numbers of patients, short-term follow-up and used a variety of telecommunication methods, making comparisons difficult. Authors of the studies indicate that telemedicine can enhance the quality and efficiency of healthcare and increase the fairness and equality of the distribution of services in remote areas, yet data is insufficient to support that telemedicine is better than standard healthcare delivery. Few of the studies report a controlled comparison of telemedicine application to conventional means of providing services. Additionally, other areas of concern noted in the published literature include interstate practice of medicine, liability issues, security, and patient confidentiality. At present, the cost-effectiveness of these services compared to standard care has not been proven in the medical literature. Further large, well-designed, randomized clinical trials would be helpful to substantiate the use of telemedicine as a substitute for direct patient-provider interaction. Nevertheless, when there is no access to direct patient-provider interaction for healthcare services, such as in remote geographical areas or health professional shortage areas, telemedicine services may be of benefit and improve access to care.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary:

| CPT®* Codes | Description |
|-------------|---|
| 0188T | Remote real-time interactive videoconferenced critical care, evaluation and management of the critically ill or critically injured patient; first 30- 74 minutes |
| 0189T | Each additional 30 minutes (List separately in addition to code for primary service) |
| 93012 | Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), 24-hour attended monitoring, per 30 day period of time; tracing only |
| 93014 | Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), 24-hour attended monitoring, per 30 day period of time; physician review with interpretation and report only |
| 93293 | Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with physician analysis, review and report(s), up to 90 days |
| 98969 | On-line assessment and management service provided by a qualified non-physician health care professional to an established patient, guardian, or health care provider not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network |
| 99091 | Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time |
| 99444 | Online evaluation and management service provided by a physician to an established patient, guardian, or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network |

| HCPCS Codes | Description |
|--------------------|--|
| Q3014 | Telehealth originating site facility fee |
| T1014 | Telehealth transmission, per minute, professional services bill separately |

| ICD-9-CM Diagnosis Codes | Description |
|---------------------------------|--|
| V63.0 | Residence remote from hospital or other health care facility |
| | Multiple/varied codes |

***Current Procedural Terminology (CPT®) © 2010 American Medical Association: Chicago, IL.**

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Policy History

| Pre-Merger Organizations | Last Review Date | Policy Number | Title |
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| CIGNA HealthCare | 12/15/2007 | 0194 | Telemedicine |

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