# MISSISSIPPI INSURANCE DEPARTMENT

**MIKE CHANEY**
Commissioner of Insurance
State Fire Marshal

**J. MARK HAIRE**
Deputy Commissioner of Insurance

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November 30, 2022

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**CERTIFIED MAIL**
**RETURN RECEIPT REQUESTED**

Ms. Carol Pigott, President & CEO
Blue Cross Blue Shield of Mississippi, A Mutual Insurance Company
3545 Lakeland Drive
Flowood, MS 39232

**RE: Target Market Conduct Report of Examination as of July 12, 2022**

Dear Ms. Pigott:

In accordance with Miss. Code Ann. §§ 83-5-201 et seq. (Rev. 2022), a target market conduct examination of Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company has been completed. Enclosed is the Order adopting the report and a copy of the final report as adopted.

Pursuant to Miss. Code Ann. § 83-5-209(6)(a) (Rev. 2022), the Mississippi Department of Insurance shall continue to hold the content of said report as private and confidential for a period of ten (10) days from the date of the Order. After the expiration of the aforementioned 10-day period, the Department will open the report for public inspection.

If you have any questions or comments, please contact me.

Sincerely,

MIKE CHANEY
COMMISSIONER OF INSURANCE

MC/CJK
Encls. Order w/exhibit

**BEFORE THE COMMISSIONER OF INSURANCE**
**OF THE STATE OF MISSISSIPPI**

**IN RE: REPORT OF EXAMINATION OF BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, A MUTUAL INSURANCE COMPANY**

**CAUSE NO. 22-7734**

## ORDER

**THIS CAUSE** came on for consideration before the Commissioner of Insurance of the State of Mississippi ("Commissioner"), in the Offices of the Commissioner, 1001 Woolfolk Building, 501 North West Street, 10th Floor, Jackson, Hinds County, Mississippi, Mississippi Insurance Department ("MID"), pursuant to Miss. Code Ann. §§ 83-5-201 et seq. (Rev. 2022). The Commissioner, having fully considered and reviewed the Target Report of Examination ("Examination Report") concerning whether Blue Cross Blue Shield of Mississippi, Inc. a Mutual Insurance Company ("BCBSMS") or ("Company") complied with MID Bulletin 2020-1[1] and Miss. Code Ann. § 83-9-351 (Rev. 2019)[2], together with the submissions or rebuttals of BCBSMS, and any relevant portions of the Examiner's work papers, makes the following findings of fact and conclusions of law in accordance with Miss. Code Ann. §§ 83-5-209(3), (4).

## JURISDICTION

**I.**

BCBSMS is a Mississippi domiciled company licensed to write Accident and Health insurance coverages.

**II.**

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1 Bulletin 2020-1 was subsequently extended by subsequent issuances (*i.e.*, progeny). Bulletin 2020-1, as used in this Order, shall include its progeny.

2 Section 83-9-351 was amended in 2022. The 2019 version was applicable for the true period when Bulletin 2020-1 was in effect.

The Commissioner has jurisdiction over this matter under Miss. Code Ann. §§ 83-5-201 et seq. (Rev. 2022).

## FINDINGS OF FACT

**III.**

The Commissioner, or his appointee, under Miss. Code Ann. §§ 83-5-201 et seq. (Rev.2022), called for a Target Examination of BCBSMS ("Exam") and appointed Risk & Regulatory Consulting, LLC, to conduct said examination. Risk & Regulatory Consulting, LLC is a company qualified to conduct the examination and is composed of independent examiners with great experience in the relevant subject matter.

**IV.**

On or about August 22, 2022, the Examination Report concerning BCBSMS was submitted to the Department by the Examiner-In-Charge, Marc Springer.

**V.**

On or about August 30, 2022, under Miss. Code Ann. § 83-5-209(2) (Rev. 2022), the Department forwarded to the Company a copy of the Examination Report and allowed BCBSMS a 30-day period to submit a written submission or rebuttal to the Examination Report.

**VI.**

Following discussions between MID and BCBSMS which served to toll the running of the 30-day timeframe, on or about November 9, 2022, BCBSMS timely submitted a rebuttal to the Examination Report.

**VII.**

In the Rebuttal submitted by BCBSMS, the Company raised several points, one of which is the argument that equitable estoppel negates the Examination Report. BCBSMS asserts that the

Commissioner is estopped from addressing the omission of CPT Code 99214 from BCBSMS's telemedicine policy (issued to comply with Bulletin 2020-1) because MID approved the Company's policy in view of a March 23, 2020 email to the Attorney General's Office ("Attorney General") in which the Commissioner told the Attorney General that there was no longer a need for a temporary restraining order ("TRO") against BCBSMS for not submitting a revised telemedicine policy pursuant to MID Bulletin 2020-1.

**VIII.**

BCBSMS misinterprets the March 23, 2020 email and takes the email out of context. The Commissioner issued Bulletin 2020-1 on March 16, 2020, as an emergency measure under Miss. Code Ann. § 33-15-11 to address acute health needs arising because of the COVID-19 pandemic. Bulletin 2020-1 ultimately was in effect until November 20, 2021. Bulletin 2020-1 ordered health insurance companies to revise their telemedicine policies to, among other things, cover telemedicine services to the same extent as in-person services. This was in the context of the COVID-19 pandemic when going for an in-person physician visit created a major health hazard. Bulletin 2020-1 was within the Commissioner's authority and was an Order that had the full force and effect of law. When BCBSMS failed to revise its telemedicine policy in accordance with Bulletin 2020-1, MID consulted the Attorney General about seeking a TRO to compel BCBSMS to comply with Bulletin 2020-1. Only after BCBSMS learned that MID planned to seek a TRO did the Company then submit a revised telemedicine policy, purportedly complying with Bulletin 2020-1. As a result, the Commissioner informed the Attorney General, via the March 23 email, that a TRO was unnecessary. The email was not addressed to BCBSMS, though an official of

BCBSMS was copied as a courtesy.

**IX.**

As noted, the Commissioner's email was to the Attorney General to tell the Attorney General that a TRO was unnecessary because the Commissioner believed BCBSMS had adopted a telemedicine policy/telemedicine procedures as required by Bulletin 2020-1. The email did not speak on whether specific CPT Codes should or should not be included in the BCBSMS telemedicine policy or whether the details of BCBSMS' telemedicine policy violated Mississippi law. MID does not employ coding specialists with the expertise to make such determinations. It was also the responsibility of BCBSMS, not MID, to comply with Bulletin 2020-1 and Mississippi law. BCBSMS was not told that its omission of CPT Code 99214 from the revised telemedicine policy was acceptable nor did the Commissioner comment on such exclusion.

**X.**

Shortly after BCBSMS adopted its revised telemedicine policy, MID received numerous complaints from multiple providers regarding the omission of CPT Code 99214. BCBSMS was deliberately (and automatically) downcoding telemedicine claims submitted with a CPT Code of 99214 to the CPT Code 99213, which resulted in less reimbursement to providers and increased net income to BCBSMS. These complaints immediately were forwarded to BCBSMS for review and action. BCBSMS took no action. Thus, the Commissioner reminded BCBSMS that MID's acceptance of the revised BCBSMS policy did not negate MID's ability to address issues about the application of the policy, and that MID would conduct a targeted Market Conduct Exam to determine whether the claims with the 99214/99213 CPT codes were properly administered and

paid in accordance with Bulletin 2020-1 and Mississippi law.

**XI.**

Bulletin 2020-1 placed BCBSMS on notice of the requirement to cover telemedicine visits the same as in-person visits. The Exam determined that BCBSMS failed to do this with regard to CPT Code 99214 without a legitimate basis, despite other insurers covering CPT Code 99214 in their plans (including Blue Cross plans from other states in which BCBSMS covered such claims for the Company's Mississippi insureds that received services from providers contracted with such other Blue Cross plans). It was not MID's intent with the March 23, 2020 email to inform BCBSMS that BCBSMS' omission of CPT 99214 was proper; instead, it was only MID's intent to inform the Attorney General that MID did not believe a TRO would be necessary because BCBSMS had finally submitted a revised telemedicine policy. Thus, BCBSMS is in error to say that MID intended the March 23, 2020 email to say that excluding CPT Code 99214 was proper and appropriate. *Wilkinson Cnty. Senior Care, LLC v. Miss. Div. of Medicaid*, 341 So. 3d 932, 939 (Miss. 2002) (a representation or omission requires "intent or culpable negligence" for estoppel to apply). Further, to the extent the March 23 email was a "mistake," agencies are granted wide-ranging authority to correct mistakes of law. *Miss. Methodist Hosp. & Rehab. Ctr., Inc. v. Miss. Div. of Medicaid*, 319 So. 3d 1049, 1059 (Miss. 2021). Finally, BCBSMS has shown no detriment or change of position because of the March 23, 2020 email *Miss. Div. of Medicaid v. Yalobusha Cnty. Nursing Home*, 346 So. 3d 414, 426 (Miss. 2022) (estoppel requires detriment or prejudice caused by change of position). BCBSMS adopted its telemedicine policy without CPT Code 99214 before the March 23, 2020 email. Moreover, BCBSMS was given the ability to revise its telemedicine policy to correct its omission of CPT Code 99214 and reprocess claims appropriately, but it declined to do so. The omission of CPT Code 99214 from BCBSMS'

telemedicine policy was a violation of Bulletin 2020-1, which had the force of law, and with which BCBSMS was legally obligated to comply. The March 23, 2020 email in no way altered the provisions of Bulletin 2020-1. BCBSMS was aware of the law, and the remedies below merely require BCBSMS to correct its failure to follow the law. Given the foregoing, the Commissioner finds that BCBSMS's estoppel argument is without merit.

**XII.**

BCBSMS also asserts that "safe, high quality" telemedicine visits could not be provided for CPT Code 99214 services. The Commissioner finds this argument is without merit for the reasons set forth in the Examination Report.

**XIII.**

BCBSMS raises several other issues in its rebuttal related to exam process and procedures, but the Commissioner finds that these issues lack merit.[3]

**XIV.**

Under Miss. Code Ann. § 83-5-209(3) (Rev. 2022), the Commissioner must consider and review the Examination Report along with any submissions or rebuttals and all relevant portions of examiner work papers and enter an Order: (1) adopting the Report of Examination as final or with modifications or corrections; (2) rejecting the Report of Examination with directions to reopen; or (3) calling for an investigatory hearing. The Commissioner hereby orders in compliance with Miss. Code Ann. § 83-5-209(3) that the Affidavit and the Examination Report attached hereto jointly as Exhibit "A" be, and hereby are, adopted as final.

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3 One of the procedural issues raised by BCBSMS is the assertion that the Examination Report was not verified under oath. This assertion ignores the Affidavit of the Chief Examiner that the Examination Report was consistent with the NAIC guidelines, and the fact that this Affidavit is the type that has been used on other BCBSMS examinations without objection of BCBSMS. That said, the Examiner in Charge has executed another Affidavit which cures any defect in the original Affidavit. The revised Affidavit is part of attachment "A" hereto.

## XV.

Miss. Code Ann. § 83-5-209(3) also provides that "if the examination report reveals that the company [BCBSMS here] is operating in violation of any law, regulation, or prior order of the Commissioner, the Commissioner may order the company to take any action the Commissioner considers necessary and appropriate to cure such violation; . . ." Miss. Code Ann. § 83-5-209(3). As Commissioner, I have reviewed all of the foregoing and hereby find, and order as follows:

1. BCBSMS violated Bulletin 2020-1 and Miss. Code Ann. § 83-9-351 (Rev. 2019).

2. For any CPT Code 99214 claim for services between March 16, 2020 and November 20, 2021 where BCBSMS downcoded the claim to CPT Code 99213, BCBSMS will reprocess the claims and pay the provider the difference between the allowable amount for the CPT Code 99213 previously reimbursed claim and the allowable amount for a CPT 99214 submitted claim provided the documentation initially submitted by the provider supports a CPT Code 99214 claim. If the documentation initially submitted for a CPT code 99214 does not support CPT Code 99214 reimbursement, then BCBSMS shall contact the provider and allow for additional documentation to be provided within thirty (30) days of such communication. This process shall be completed within sixty (60) days of the date of this Order.

3. BCBSMS will allow Providers who filed CPT 99213 claims for Fully-Insured BCBSMS Members for dates of service between March 16, 2020 and November 20, 2021 an opportunity to request a review of such claims at a CPT 99214 level, if the medical records for that visit support that level. Within thirty (30) days of this Order, BCBSMS will inform the Providers that should they desire to have a previously reimbursed CPT 99213 claim reviewed, supporting medical records along with a transmittal form are to be submitted within 30 days of notice. The medical records will be reviewed and if found to be supportive of a CPT 99214 claim, the difference between the Allowable for a CPT 99213 and the allowable for a CPT 99214 will be paid to the Providers. The notification to providers shall state a claim evaluation should be requested only if the provider in good faith contends the submitted medical records support a CPT 99214 visit.

4. BCBSMS shall provide MID a written update, acceptable to MID, as to its compliance with Nos. 1 & 2 above thirty (30) days after the date of this Order and then sixty (60) days after the date of this Order, and then as may be reasonably requested by MID. Further, MID or the Examiners shall be entitled to request any additional documents for review if MID finds the thirty (30) day/sixty (60) day update or any other update to not be reasonably sufficient.

5. Failure of BCBSMS to comply with Nos. 2, 3, and 4 above may result in further corrective action by MID.

**XVI.**

**IT IS FURTHER ORDERED** that a copy of the adopted Report, accompanied by this Order, shall be served upon the BCBSMS by certified mail, postage pre-paid, return receipt requested.

**XVII.**

**IT IS FURTHER ORDERED t**hat the MID shall continue to hold the content of the Examination Report as private and confidential for a period of ten (10) days from the date of this Order, pursuant to Miss. Code Ann. § 83-5-209(6)(a) (Rev. 2011).

**XVIII.**

**IT IS FURTHER ORDERED,** pursuant to Miss. Code Ann. § 83-5-209(4) (Rev. 2022), that within thirty (30) days of the issuance of the adopted Examination Report, BCBSMS shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted Report and related orders.

**SO ORDERED,** this the 30th day of November, 2022.

MIKE CHANEY
COMMISSIONER OF INSURANCE

## CERTIFICATE OF MAILING

I hereby certify that a true and correct copy of the above and foregoing Order and a copy of the final Report of Examination, as adopted by the Mississippi Department of Insurance, was sent by certified mail, postage pre-paid, return receipt requested, on this the 30th day of November, 2022, to:

**Ms. Carol Pigott, President & CEO**
**Blue Cross Blue Shield of Mississippi, A Mutual Insurance Company**
**3545 Lakeland Drive**
**Flowood, MS 39232**

Christina J. Kelsey
Senior Attorney

Christina J. Kelsey
Senior Attorney
Counsel for the Mississippi Department of Insurance
Post Office Box 79
Jackson, MS 39205-0079
(601) 359-3577
Miss. Bar No. 9853

Exhibit "A"

# MISSISSIPPI INSURANCE DEPARTMENT

## Report of Examination

## of

## Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company

## as of

## July 12, 2022

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# EXAMINER'S AFFIDAVIT AS TO STANDARDS AND PROCEDURES USED IN AN EXAMINATION

State of Massachusetts,

County of Norfolk,

Marc Springer, being duly sworn, states as follows:

1. I have authority to represent the Mississippi Insurance Department in the examination of Blue Cross & Blue Shield of Mississippi.

2. The Mississippi Insurance Department is accredited under the National Association of Insurance Commissioners Financial Regulation Standards and Accreditation.

3. I have reviewed the examination work papers and examination report, and the examination of Blue Cross & Blue Shield of Mississppi was performed in a manner consistent with the standards and procedures required by the National Association of Insurance Commissioners and the Mississippi Insurance Department.

4. The examination report accompaning this affidavit is a final written verified report of examination under oath pursuant to and in accordance with Miss. Code. Ann. § 83-5-209(2).

The affiant says nothing further.

Marc Springer, CIE, MBA, MCM
Examiner-in-Charge

Subscribed and sworn before me by Marc Springer on this 28 day of November, 20 22

Notary Public

MOHAMED ABESSE
MY COMMISSION EXPIRES
MAY 27, 2027
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS

My commission expires May 27, 2027

**MIKE CHANEY**
Commissioner of Insurance
State Fire Marshal

**MARK HAIRE**
Deputy Commissioner of Insurance

# MISSISSIPPI INSURANCE DEPARTMENT

501 N. WEST STREET, SUITE 1001
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July 12, 2022

Hon. Mike Chaney
Commissioner of Insurance
Mississippi Insurance Department
1001 Woolfolk Building
501 North West Street
Jackson, Mississippi 39201

Dear Commissioner Chaney:

Pursuant to your instructions and authorization, a targeted examination has been conducted, as of July 12, 2022, regarding compliance with telemedicine requirements stated under § 83-9-351 (Supp. 2019) and Mississippi Insurance Department ("MID") Bulletin 2020-1 and all subsequent bulletins ("MS requirements") of:

**BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, A MUTUAL INSURANCE COMPANY**
3545 Lakeland Drive
Flowood, MS 39232

| License # | NAIC Group # | NAIC # | FEETS# | MATS |
|---|---|---|---|---|
| 7700147 | 1126 | 60111 | N/A | MS-MS099-38 |

This examination was commenced in accordance with Miss. Code Ann. § 83-5-201 *et seq*. and was performed remotely. The report of examination is herewith submitted.

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# SCOPE OF EXAMINATION

As requested by the Commissioner, Risk & Regulatory Consulting, LLC ("RRC" or "examiners") conducted a targeted market conduct examination of Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company (the "Company" or "BCBSMS").

While the NAIC Market Regulation Handbook ("MRHB") does not include standards that pertain to the scope of the targeted review, the underlying principles that govern a policies and procedures review were referenced while conducting the examination. The examiners also considered insurance industry best practices while reviewing the Company's telemedicine and provider communications policies and procedures.

The main objective of this targeted market conduct examination ("MCE" or "Examination") was to determine the Company's compliance with Miss. Code Ann. § 83-9-351 (Supp. 2019) and MID Bulletin 2020-1 and all subsequent bulletins related thereto ("subsequent bulletins"). In doing so, the examiners evaluated the Company's stated reasons why its Novel Coronavirus (COVID-19) Pandemic Telemedicine Policy ("TM Policy") excluded coverage for certain procedures when performed via telemedicine such as CPT 99214. Also, the Examination evaluated whether the Company's exclusion of CPT 99214 from its TM Policy was appropriate based on the documentation and analysis provided by the Company. The examiners performed the following tasks to obtain an understanding of the services and procedures included and excluded under the Company's TM Policy:

1. Information requests ("IR") were issued to the Company requesting the analysis BCBSMS performed in designing the TM Policy.

2. The examiners conducted meetings with Mississippi providers, including Mississippi State Medical Association ("MSMA") members, to obtain information regarding services and procedures that can be performed via telemedicine such as CPT 99214. In addition, the examiners met with the Executive Director of the Mississippi Board of Medical Licensure ("MBML").

3. The examiners conducted meetings with several of the Company's business units to understand the initiatives taken by the Company in designing the TM Policy.

4. The examiners reviewed Approved and Denied claims data to determine how the Company adjudicated claims that included CPT 99214.

Other areas under review included whether providers were reimbursed at the same rate for telemedicine services as for in-person office visits; and timeliness and transparency of communications with providers and members.

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## BACKGROUND

Shortly after receiving MID Bulletin 2020-1, the Company drafted and implemented its TM Policy. Subsequently, the MID received numerous complaints from medical providers regarding the Company's exclusion of CPT Code 99214 under the TM Policy. The providers informed the MID that this was an important issue because this Code is widely used to provide telemedicine services to patients and other insurance carriers in Mississippi included this code in their Telemedicine Policies. On October 28, 2020, the Commissioner informed the Company that, given the volume of complaints received from providers regarding the exclusion of CPT Code 99214 from the Company's TM Policy, a targeted market conduct examination would be conducted to determine whether claims impacted by the 99214 Codes were being properly administered and paid in accordance with Miss. Code Ann. § 83-9-351(Supp. 2019) and MID Bulletin 2020-1 and all subsequent bulletins.[1]

## EXECUTIVE SUMMARY

1. The Company's TM Policy was mainly created by their employees (including their Chief Financial Officer) who are not medical professionals. The Company did reach out to certain providers to discuss the TM Policy, but most of the individuals the Company contacted were not medical professionals. Further, in its discussions with providers, the Company never discussed reimbursement of CPT 99214.[1]

[1] *The Examination of 99214 claims also involved CPT 99213, for reasons set forth herein.*

2. The Company provided no documentation to support its decision to include or exclude specific CPT codes from the TM Policy, including CPT 99214.

3. The Company applied a universal approach to their evaluation of CPT 99214 and decided to exclude this code from the TM Policy due to its stated opinions on clinical appropriateness and patient safety concerns. However, several providers interviewed by the examiners stated that CPT 99214 services they provided through telemedicine were both clinically appropriate and safely delivered.

4. It is the provider's responsibility to determine what services are clinically appropriate and can be safely provided through telemedicine. State law specifically allows providers to deliver services via telemedicine if the provider determines the delivery meets the standard of care. *See* Miss. Code Ann. § 41-127-1.[2] As such, this scenario alone signifies the Company's non-compliance with Miss. Code Ann. § 83-9-351 (Supp. 2019) and MID Bulletin 2020-1 and all subsequent bulletins because the Company did not allow providers to perform the same services via telemedicine as they would if the services were provided in-person.

[2] *Miss. Code § 83-9-351(5) does allow the Company to exclude from coverage treatments that are not "medically necessary." However, the Company stipulated that it did not review or evaluate CPT 99214 claims for medical necessity. Thus, the Company essentially stipulated the treatments for which the claims were made were medically necessary. Whether a service is medically necessary is a separate issue from the question of whether a service can be delivered via a particular medium (e.g., via telemedicine).*

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5. Every medical professional affiliated with the MSBML and the Mississippi State Medical Association (MSMA) with whom the examiners consulted opined that many services associated with CPT 99214 are clinically appropriate and can safely be provided through telemedicine. These medical professionals uniformly disputed that all (or even many) CPT 99214 services are inappropriate or unsafe for delivery via telemedicine. In fact, several providers interviewed revealed that they regularly provide CPT Code 99214 services via telemedicine and that other insurers cover such services (CPT Code 99214) under their Telemedicine Policies.[3]

[3] *As previously noted, the Company's position (as set forth in its responses to the IRs) regarding the exclusion of CPT Code 99214 from its TM Policy claims to focus on clinical appropriateness and patient safety. However, the provider that performs the services is in the best position to determine whether a clinical service can be delivered safely and with quality through telemedicine. Also, in terms of patient safety, the Company's position ignores the severity of the COVID-19 pandemic and its impact on the ability to deliver in person clinical services. A June 1, 2021 article from Becker's Hospital Review notes that the COVID-19 death rate as of May 21, 2021 was 245 per 100,000 Mississippi residents, the fifth-highest death rate in the nation.*

6. When faced with claims appropriately submitted under CPT 99214, the Company primarily auto adjudicated them using CPT 99213, which is reimbursed at a lower rate than CPT 99214 (known as down coding). The paid claims population data included 8,078 claims that were submitted with CPT 99214 but that were inappropriately down coded to CPT 99213 and reimbursed at the lower rate for CPT code 99213. Significantly, the Company did not take the position that the service should not be delivered via telemedicine, but instead the Company's position was that the service be downcoded to a lower reimbursement CPT code. The allowable reimbursement rate as stated in the population data for these CPT 99214 claims as submitted by providers was $1,400,791.00 and after down coding, the total allowable reimbursement amount was $786,297. Please see Exhibit I located at the end of this document regarding definitions for CPT Codes 99213 and 99214.

7. The TM Policy reveals that only services included in the policy will be covered, and a claim submission that includes a service not included under the policy will be processed by using allowable reimbursement amount for the most closely related code in the policy. As a result, based on the claim population data provided, it is impossible to identify claims submitted by providers using a CPT Code 99213 where services provided matched CPT Code 99214.

8. Under the Company's BlueCard Program, Mississippi insureds can obtain telemedicine services from providers located outside of Mississippi that are contracted with another Blue Cross Blue Shield Association Plan. A review of the paid claims population data revealed that Blue Cross Blue Shield Association Plans in other states such as Arkansas, Florida, Tennessee, and Texas included CPT Code 99214 under their TM Policy. The paid claims population data included 3,389 claims that were submitted with CPT 99214 and were adjudicated using a CPT 99214 reimbursement rate. The allowable reimbursement rate as stated in the population data for these claims as submitted by providers was $724,000 and the total allowable reimbursement amount was $394,824. Although a Blue Cross Blue Shield Plan located outside of Mississippi adjudicated such claims, the Company funded

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the payment of the claims since they entailed a Mississippi insured. As a result, an insured under the Blue Cross & Blue Shield of Mississippi Plan would need to obtain the services from an out of state provider in order to receive CPT Code 99214 telemedicine services.

9. As for communications with providers, the examiners concluded the Company did not timely and transparently communicate to providers significant changes that impacted provider operations.

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## MARKET CONDUCT ACTIVITIES

This Examination was a targeted review of the Company's TM Policy and its provider and member communications to determine if violations of Mississippi law occurred.

### Designing the TM Policy

The Company explained that, given the short time span for the creation and implementation of the TM Policy, the Company acted swiftly to create such a policy using its judgment as to clinical appropriateness and patient safety. In order to gain an in-depth understanding of the initiatives taken by the Company in designing the TM Policy, the examiners issued IRs requesting the Company's documentation supporting its development of its TM Policy, which included meeting notes, decision rationale, evidentiary standards documentation, and any other professional medical documentation considered during the development process. In summary, the Company stated that it performed the following steps:

1. Reviewed MID Bulletin 2020-1;

2. Identified standard telemedicine codes that were available;

3. The Medicare coverage and coverage provided by the Federal Employee Health Plan were compared against the standard telemedicine codes available;

4. Contacted network providers to determine their ability to perform a telemedicine service and obtain their opinions on what services are clinically appropriate to be provided via telemedicine;

5. Reviewed the TM Policies of other BCBS Association Plans and other health insurance carriers; and

6. Drafted the TM Policy and discussed it with the MSMA, the Mississippi Academy of Family Practice ("MSAFP") and the Company's Provider Leadership Committees.

The Company also provided the following documents with their response:

1. A listing of CPT Codes that included a description for each CPT and the Company's allowable amount;

2. A memo that included high level information about calls made to seven network providers;

3. Several emails that documented a discussion with a behavioral health provider regarding the inclusion of Applied Behavior Analysis Therapy within the TM Policy;

4. A listing that included the 2019 and 2020 Centers for Medicare and Medicaid Services (CMS) telemedicine services by CPT Code;

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5. A chart that outlined the Medicare telemedicine services CPT Codes included under traditional and COVID – 19 Telemedicine Policies; and

6. A memo that included high level information about a meeting held with network hospitals regarding the applicable CPT Codes covered under the TM Policy.

The Company's TM Policy was mostly designed by Company employees in the Provider Partnerships Unit. These employees are not clinicians or physicians. However, the Company explained that the Company's Medical Director was available to discuss any questions that the employees had while designing the TM Policy.

The examiners conducted interviews with the Chief Financial Officer, Medical Director, General Counsel, and key employees in the Provider Partnerships, Claims, and Communications Units. In summary, the interviews reiterated the information that was included in the Company's IR responses but did not provide more information. However, during the interview with the Medical Director, several references to medical periodicals were made regarding the use of telemedicine during the pandemic. In response to a follow-up IR, the Company provided the following articles:

1. "Early Impact of CMS Expansion of Medicare Telehealth During COVID-19", published by HealthAffairs on June 15, 2020;

2. "Ensuring Quality in the Era of Virtual Care", published by the American Medical Association on February 2, 2021;

3. "Use and Content of Primary Care Office-Based vs. Telemedicine Care Visits During the COVID-19 Pandemic in the US", published by American Medical Association on October 2, 2020;

4. "Optimal Use of Telehealth to Deliver Safe Patient Care" published by The Joint Commission, Division of Healthcare Improvement on October 7, 2020; and

5. "Telemedicine is a Tool – not a Replacement for Your Doctor's Touch", publisher and date is unknown.

Although the information in each of the five articles applies to telemedicine, the articles did not address specific information about the services and treatments that could be included in a TM Policy. Instead, the articles address the quality of care provided in either an office-based or telemedicine setting, the general use of telemedicine during the COVID-19 Pandemic, and the use of telemedicine in the future. The articles did not include information regarding specific evaluation and management of CPT Codes such as 99214.

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**Designing the Telemedicine Policy – Examiner Comments**

The Company failed to provide documentation supporting its decision to include or exclude a CPT Code within the TM Policy. When it was asked why the Company did not provide analysis and documentation supporting its TM Policy, the Company provided the following response:

> The analysis was conducted mainly through meetings and discussions with persons working remotely. No additional documentation is available.

Within its responses to IRs and interview questions, the Company also stated that it was operating under a tight deadline to meet the Mississippi requirements and the TM Policy was designed in the matter of days. But because the Mississippi requirements remained in effect through November 20, 2021, the Company had ample time to perform a formally documented analysis of CPT Codes to be covered or excluded from the TM Policy. This is evidenced by the fact that, as time progressed throughout the pandemic, the Company added more CPT Codes to its TM Policy. But again, the Company did not provide documentation supporting this analysis of CPT codes.

The Company's analysis of CPT Codes it included and excluded from its TM Policy should have considered various medical and behavioral health conditions to be covered under specific CPT codes. Instead, the Company applied a universal standard that all services provided under a CPT code, such as 99214, are not clinically appropriate for delivery by telemedicine. It based its rationale on the idea that some patients have more complex care needs and require diagnostic testing or information (lab tests, accurate vital sign measurements, etc.). While the examiners agree with the Company's statement that telemedicine services are not clinically appropriate for all patients (depending on the patient and the complexity of the specific treatment at issue), every provider the examiners interviewed concluded that many CPT 99214 services can be safely delivered via telemedicine in a safe and effective manner. The examiners will illustrate how a 99214 service can easily be provided via telemedicine in a later section of this report. The information discussed in this section illustrates how the Company's TM Policy could have been strengthened with documented analysis to ensure the delivery of telemedicine services to all those in need during the pandemic and to comply with MS requirements.

**Discussions with Providers Regarding the Telemedicine Policy – Examiner Comments**

As discussed above, the Company reached out to network providers to discuss their ability to perform telemedicine services and to obtain their opinions on what services are clinically appropriate to be provided via telemedicine. This provider outreach was only performed in March 2020 during the early phase of the pandemic. The Company's outreach included discussions with mostly non-clinicians. For example, the Company reached out to a local clinic and spoke to its Chief Financial Officer (CFO). If the purpose of the outreach was to discuss the ability to perform telemedicine services, a clinician that performs such services would have been the most knowledgeable individual to provide valuable input rather than a CFO. Here is a summary of the outreach calls the Company says it made:

1. Neurologist, St. Dominic Medical Associates (Family Practice);

2. Chief Executive Officer (CEO), Jackson Heart (Cardiology Practice);

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3. CEO, MS Sports Medicine (Orthopedics Practice);

4. Director of Managed Care, Hattiesburg Clinic (Family Practice);

5. Chief Administrative Officer (CAO), Baptist Memorial Healthcare (Family Practice);

6. CEO, Capital Orthopedics (Orthopedics Practice);

7. CFO, Rush Health System (Family Practice); and

8. RN, Canopy Children's Solutions (Mental Health Provider).

The Company provided a two-page memo that documented calls with the individuals noted above. This memo was presented at a high level of detail. Based on the comments noted for each provider contact, the Company did not seek the providers' opinions on what services are clinically appropriate to be provided via telemedicine as stated by the Company. The memo contained notes for each provider outreach that only addressed the provider's ability to conduct telemedicine services and the reimbursements for such services.

In summary, a significant policy such as the TM Policy was only discussed during the early stage of the pandemic with eight providers as noted above. Furthermore, only two of the eight discussions were held with a clinician of the provider entity. Six discussions were held with non-clinicians such as a CEO or CFO. It is also important to note that the Company's provider outreach was limited to family practitioners, cardiologists, psychologists, and orthopedists. The Company did not contact other specialists such as allergists, dermatologists, gastroenterologists, gynecologists, pulmonologists, or urologists to discuss their ability to perform telemedicine services. The information discussed in this section illustrates how the Company's TM Policy could have been strengthened with documented analysis to ensure the delivery of telemedicine services to all those in need during the pandemic and to comply with MS requirements.

**Discussions with MS Medical Associations and Boards Regarding the TM Policy – Examiner Comments**

The Company stated that during the early phase of the pandemic, it met with the MSMA and MSAFP to discuss the TM Policy. Although the examiners requested meeting notes about these discussions, the Company stated that all information had been provided. The only information the Company provided was its statement that it had met with the MSMA and MSAFP and that the TM Policy was discussed generally including the limitations and exclusions under the Policy. The notes contained no further specifics. The Company further stated that the MSMA participated in reviewing CPT Codes and in particular, the exclusion of CPT Code 99214 under the TM Policy.

The examiners conducted a meeting with the MSMA to confirm the Company's comments noted above. The Company's recollection of the discussion varied from the MSMA's recollection. Within the Company's responses to IRs and interview questions, the Company provided the following response on how it addressed provider concerns about service limitations and exclusions in the TM Policy:

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> BCBSMS listened and engaged in discussions with Providers concerning the TM Policies explaining the reasons for the exclusion of certain CPT Codes. Providers expressed understanding and support.

Based on this statement and similar statements the Company made to MID, the examiners were left with the impression that the MSMA endorsed the TM Policy. Yet the MSMA representatives informed the examiners that the MSMA did not endorse the policy since clinically appropriate CPT Code 99214 level services were being performed by providers via telemedicine but excluded under the Company's TM Policy. The MSMA representatives said that they explained to the Company that not only can a CPT Code 99214 be performed via telemedicine, but it is being done now and other insurers include CPT Code 99214 in their Telemedicine Policies. The MSMA continuously expressed its concern about the Company's decision to exclude CPT Code 99214 from the TM Policy during meetings with the Company and through other communications with the Company.

It is important to note that one of the providers that serves on the MSMA board submitted a complaint to the MID in May 2020 on the Company's decision to exclude CPT Code 99214 from the TM Policy. Despite this complaint, and complaints received from other providers, the Company did not update the TM Policy to include CPT Code 99214.

The examiners met with individuals from the MSBML, including the Executive Director (who is a physician), to discuss the Company's TM Policy. In particular, the examiners discussed the Company's decision to exclude CPT Code 99214 from its TM Policy. The Executive Director conveyed that it is the provider and not the insurer that determines which services can be provided safely to a patient for any type of service, whether delivered through telemedicine or otherwise, and that telemedicine is a tool that providers may use if the service can be delivered consistent with the standard of care. The Executive Director further noted that the MSBML has a regulation that addresses how a provider can safely deliver services to patients via telemedicine. In particular, directives regarding the patient/provider relationship including the diagnosis and treatment of a medical condition through the utilization of telemedicine is located under Miss. Code Ann. §73-25-33, §73-25-34 (1972, as amended) Rule 5.4 and §73-25-34 (1972, as amended) Rule 5.5

Finally, the Executive Director stated that, in his opinion, a CPT 99214 service can be safely delivered through telemedicine. The Executive Director further noted his opinion that, in terms of the definition of CPT 99214, its requirements 1 (a detailed history) and 3 (medical decision making of moderate complexity) can easily be achieved through telemedicine and since only two of three requirements must be met, such services should have been covered under the TM Policy. Also, per the Executive Director, a 99214 service for depression provided through telemedicine should have been covered under the TM Policy since all three requirements for this code are met (*i.e.*, 1. A detailed history; 2. A detailed examination (very easily achieved via telemedicine); and 3. Medical decision making of moderate complexity).

The information discussed in this section illustrates how the Company's TM Policy should have been strengthened with documented analysis to provide delivery of telemedicine services to all those in need during the pandemic to comply with MS requirements. The information discussed also demonstrates that the Company's decision to automatically down code all CPT 99214 claims to CPT
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99213 was not justified.

**Medical Journal Articles Regarding Telemedicine – Examiner Comments**

As discussed above, the Company provided five articles from medical journals it reviewed when designing its TM Policy. In general, these articles address the quality of care provided in either an office-based or telemedicine setting.

The examiners reviewed the following articles and letters while researching telemedicine guidance provided by medical associations:

1. A letter submitted to the NAIC by the American Academy of Family Physicians (AAFP), July 9, 2020 that supports the on-going use of telemedicine;

2. A letter submitted to CMS by AAFP on July 13, 2020 that supports the extension of the pandemic telemedicine policy;

3. A joint letter submitted to Congress by numerous medical associations including the AAFP on June 29, 2020 requesting the advancement of telehealth reform;

4. "CMS Heeds AAFP's call to dramatically expand telehealth" published by AAFP on April 1, 2020;

5. "A toolkit for building and growing a sustainable telehealth program in your practice" AAFP in September 2020;

6. "Telemedicine advances outpace common sense regulations" published by AAFP on September 19, 2017;

7. "Telemedicine II: What we've learned so far" published by AAFP on December 3, 2020; and

8. "Telemedicine is worthy of payer's long term investment", published by AAFP on July 9, 2020.

The articles and letters listed above support the continued and enhanced use of telemedicine. Specific information about the services and treatments (such as evaluation and management codes such as CPT Code 99214) that could be included in a TM Policy is included in some articles. In summary, these articles and letters strive to enhance, not restrict, the use of telemedicine services. These articles and letters, along with the articles provided by the Company, support the use of telemedicine prior to, during, and after the pandemic.

**The Exclusion of CPT Code 99214 from the TM Policy**

The Company's IR responses state that it designed its TM Policy with a primary focus on clinical appropriateness and patient safety. The Company applied a universal rationale regarding its

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decision not to include CPT Code 99214 in the TM Policy. While there are hundreds of medical and behavioral health conditions that can be provided under a CPT Code 99214 service through telemedicine, the Company's undocumented analysis only contemplated highly complex patients, such as those with medical conditions such as hypertension, diabetes, and hyperlipidemia.

When asked how the Company's decision to limit telemedicine services to a level 3 (CPT Code 99213) complied with MS requirements, the Company provided the following response:

> Miss Code Ann. §83-9-351(2) requires that "[a]ll [sic] health insurance and employee benefit plans in the state must provide coverage for telemedicine services to the same extent that the services would be covered if they were provided through in-person consultation." Miss Code Ann. §83-9-351(5) provides that "[n]othing [sic] in this section shall be construed to prohibit a health insurance or employee benefit plan from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered person's policy." This Code Section requires BCBSMS to cover services in the same way it would cover services for an in-person consultation. BCBSMS, like all insurers, has limitations related to medical necessity and appropriateness of care for in-person consultations, and similar limitations apply to telemedicine consultations. Miss. Code Ann. §83-9-351(5) contemplates the need for such limitations. BCBSMS limited telemedicine visits to low complexity, routine or ongoing evaluation and management visits. These limits were established with a primary focus on clinical appropriateness and patient safety.

It is important to note that the Company's interpretation of MS requirements found in Miss. Code Ann. § 83-9-351 and Mississippi Bulletin 2020-1 (and all subsequent bulletins) conflicts with key tenets of the statute and bulletin. In particular, the requirements state that coverage for telemedicine shall be provided for services that are medically necessary and that such coverage must be provided to the same extent that the services would be covered if they were provided through in-person consultation and billed using the appropriate procedure code for the covered services. The Company told examiners that the Company did not evaluate the telemedicine claims for medical necessity. Therefore, § 83-9-351(5) was not a basis for excluding CPT 99214. The examiners found through interviews with providers and a review of MID complaints, providers regularly performed telemedicine services through a CPT Code 99214. Based upon the opinion of medical professionals, providers are in the best position to determine whether a medically necessary service can be delivered safely and with quality through telemedicine to their existing patients in accordance with the standard of care pursuant to Miss. Code Ann. § 41-127-1. In fact, the Company allows providers to perform a CPT Code 99214 service for an in-person visit without applying any limitations. Thus, the process for telemedicine services should not be treated differently per MS requirements.

As for the Company's statement about limiting telemedicine visits to low complexity, routine, or ongoing evaluation and management visits, the Company's position does not comply with MS requirements found in Miss. Code Ann. § 83-9-351 and Mississippi Bulletin 2020-1 (and all subsequent bulletins). In particular, the law does not mention the complexity of a telemedicine visit. The law instead is based on the medical necessity of the service provided as stated under § 83-9-351(5). As noted, regarding telemedicine claims, the Company decided not to conduct medical necessity reviews for such claims. Again, the provider that performs the services is in the best position to determine the appropriateness of the mode of delivery of a service that can be

delivered safely and with quality through telemedicine.

Finally, it is also important to note that the Company's TM Policy includes coverage for evaluation and management services that are not routine or on-going. For example, the Company's TM Policy includes coverage for new patient evaluation and management services such as CPT Codes 99201, 99202, and 99203. These services entail the performance of a problem focused (99201 and 99202) or detailed (99203) examination. Again, such services performed on a new patient are not considered to be routine or ongoing. This is an obvious inconsistency in the Company's rationale for deriving its TM Policy.

The Company further stated the following:

> Telemedicine visits typically are not clinically appropriate for patients with more complex care needs and who require diagnostic testing or information (lab tests, accurate vital sign measurements, etc.). For example, a patient with uncontrolled hypertension, diabetes and hyperlipidemia would require an accurate blood pressure measurement, laboratory testing, potential physical exam of extremities to assess for diabetic wounds and discussion about their healthcare needs. An office visit with a complex patient such as this can include complicated instructions regarding medication adjustments. Such medication adjustments can be difficult to comprehend even through in-person office visits. To assist with comprehension of instructions, a discharge summary with medication adjustment is frequently provided at the clinic visits. Unfortunately, in many telemedicine visits, the technology to deliver written instruction is not available and complex instructions are delivered verbally, with limited ability to document for patient reference. The need for in-person discussion or a discharge summary is even more important in our state given the low health care literacy rates. Failure to appropriately follow instruction can lead to dire consequences for a complex patient. It is not possible to safely conduct such a complex office visit through telemedicine without proper resources and equipment. Even in these challenging times, the issue of quality of care must be the paramount consideration in patient care. This limitation is permissible under Miss Code Ann. 83-9-351(5) because coverage is being provided by BCBSMS to the same extent that services would be covered if they were provided through in-person consultation. In the Pandemic Telemedicine Policies, non-coverage for 99214 is appropriate because the Policies consider medical appropriateness for telemedicine visits just as BCBSMS would for an in-person visit. For a telemedicine claim, no further review is needed to make the medical appropriateness determination because the appropriate level of examination that consistently delivers safe, high quality visits cannot be provided to meet the requirements of a 99214 visit and meet the needs of the patient. The analysis is the same for Bulletin 2020-1. Coverage for telemedicine services is required "to the same extent that the services would be covered if they were provided through in-person consultation." As provided above, BCBSMS covers telemedicine office visits to the same extent they would be covered if provided in-person. The Policies were established through careful consideration of telemedicine visits and through discussions with Provider stakeholders in the State of Mississippi. The purpose of these Policies is to ensure appropriate, quality patient care is provided via telemedicine visits and to prevent fraud, waste and abuse associated with telemedicine visits.

The Company's statement above does not accurately present a true telemedicine visit since the diagnostic testing it notes are impossible through telemedicine. In summary, a 99214 telemedicine service does not necessarily entail complex care needs (the term complex care is not defined by

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the Company), nor does it necessarily require diagnostic testing or information (lab tests, accurate vital sign measurements, etc.). Within its IR responses and statements made during interviews, the Company references a patient with uncontrolled hypertension, diabetes, and hyperlipidemia that would require an accurate blood pressure measurement, laboratory testing, potential physical exam of extremities to assess for diabetic wounds, and discussion about his or her healthcare needs as its position for excluding 99214 services under its TM Policy. Notably, within its position, the Company ignores the fact that 99214 services can be provided via telemedicine, such as treatment for an ear infection, a sinus infection, or a mental health visit. In the following section of this report, the examiners illustrate how 99214 services can be provided via telemedicine.

Finally, it is important to note that 99214 telemedicine services can in fact be provided for patients with uncontrolled hypertension, diabetes, and hyperlipidemia and in the following section of this report, the examiners will illustrate this type of service. It is also important to note that any type of diagnostic testing needed can be performed via a separate in-office visit (curbside, isolated rooms near entrances, etc.). In doing so, this limits the patient's potential exposure to the virus in the office setting. This approach signifies the MS providers' commitment to providing clinically appropriate telemedicine services that can be delivered safely and with quality.

Within its response, the Company also notes the following (repeated here for ease of reference):

> An office visit with a complex patient such as this can include complicated instructions regarding medication adjustments. Such medication adjustments can be difficult to comprehend even through in-person office visits. To assist with comprehension of instructions, a discharge summary with medication adjustment is frequently provided at the clinic visits. Unfortunately, in many telemedicine visits, the technology to deliver written instruction is not available and complex instructions are delivered verbally, with limited ability to document for patient reference. The need for in-person discussion or a discharge summary is even more important in our state given the low health care literacy rates. Failure to appropriately follow instruction can lead to dire consequences for a complex patient. It is not possible to safely conduct such a complex office visit through telemedicine without proper resources and equipment.

The Company said it has tremendous concern over the delivery of complicated instructions regarding medication adjustments and notes that a discharge summary includes such instructions. It claims a discharge summary is unavailable for a telemedicine visit. The examiners disagree with the Company's assertions about a discharge plan. Through a 99214 telemedicine service, a provider can discuss a discharge plan, including medication change instructions with the member verbally, and the same information can also be emailed or texted to the patient. Access to email should not usually be an issue since patients often use computers or other approved electronic devices for telemedicine service, and if the service is via telephone, cell use is common. In this regard, the telemedicine service is performed in a safe manner.

Since the Company's undocumented analysis of the exclusion of CPT Code 99214 in the TM Policy only focused on patients with more complex care needs, such as individuals with uncontrolled hypertension, diabetes, and hyperlipidemia, the examiners asked the Company if it considered other medical and behavioral health conditions. The Company provided the following response:

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> BCBSMS did consider other medical and mental health conditions, however, the overall risk associated with complex patients weighed in favor of in-person visits for complex patients. To reach this conclusion, BCBSMS focused on safety, quality, effectiveness and equality of potential clinical scenarios using the modalities of telemedicine that were in place in the TM Policies. The thought process was applied to all complex patients regardless of diagnosis. There was an emphasis on hypertension, diabetes and atherosclerotic cardiovascular disease due to the high prevalence of the disease – almost 1 in 3 patients in BCBSMS' Primary Care Network have a diagnosis of hypertension – and the significant health burden it places on the State of Mississippi. Even faced with a COVID-19 pandemic, an effort to provide safe, evidence-based, effective care was felt to be important. This focus was further heightened as data emerged on the impact of these diseases on overall risk to morbidity and mortality if a patient acquired COVID-19. To aid in ensuring complex patients were receiving necessary services for COVID-19 comorbidities, BCBSMS provided reporting to Blue Primary Care Providers informing them of their patients with comorbidities and encouraging those providers to reach out to these identified patients.

The examiners could not assess the Company's response, as noted above, since it did not maintain documentation on the other medical and behavioral health conditions and the Company informed the examiners that such analysis was performed via meetings. Nonetheless, as previously noted, based upon the opinion of medical professionals it is the provider's responsibility to determine what services are clinically appropriate for safe and quality delivery through telemedicine. The Company did not allow providers to perform the same services via telemedicine as they would if the service was provided in-person, which violates Miss. Code Ann. § 83-9-351 (Supp. 2019) and MID Bulletin 2020-1 (and all subsequent bulletins).

The information discussed in this section illustrates how the Company's TM Policy could have been strengthened with documented analysis to ensure the delivery of telemedicine services to all those in need during the pandemic and to comply with MS requirements. It is important to note that in the opinion of the Examiners, the Company's decision not to cover CPT Code 99214 in its TM Policy is neither reasonable nor logical. In the following section the Examiners will discuss how a CPT Code 99214 level of service can be provided through telemedicine.

**The Exclusion of CPT Code 99214 from the TM Policy – Examiner Comments**

As illustrated above, the Company provided minimal documented information about its decision to exclude CPT Code 99214 from its TM Policy. Thus, the information presented in this section discusses how a CPT Code 99214 can be performed through telemedicine. Initially, it is important to first discuss the following information about CPT 99214:

1. CMS oversees programs including Medicare, Medicaid, the Children's Health Insurance Program, and the state and federal health insurance marketplaces. As part of its oversight responsibility, CMS creates policies, procedures, and guidance documents that health insurers must follow to comply with federal requirements. CMS does not have oversight responsibilities for commercial health insurance policies offered by health insurers, but many commercial health carriers defer to CMS guidance when designing policies and procedures. In response to the COVID-19 Pandemic, CMS created a Medicare Telemedicine Policy (CMS Policy) effective March 1, 2020. This CMS Policy includes

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297 CPT Codes such as 99214. During the pandemic, most state insurance departments did not issue any guidance documents on the CPT Codes to be covered under TM Policies. In fact, as noted by the Company, it reviewed the CMS Policy while designing the TM Policy.

2. CMS designs its policies, procedures, and guidance documents, such as the CMS Policy, with a focus on the delivery of safe and quality healthcare. This focus is paramount in the delivery of healthcare to individuals covered by Medicare Health Plans. This is especially true since, with few exceptions, Medicare is only available for individuals that are 65 and older, which is one of the Country's most vulnerable populations (in terms of healthcare needs).

3. Since the Company did not provide a documented analysis of its decision on the exclusion of CPT Code 99214 from its TM Policy, the examiners created a documented analysis of their review of CPT 99214, which is addressed below. As a result, based upon a review of available information and interviews with clinical experts, the examiners believe that CPT Code 99214 is a service that can safely be delivered through telemedicine.

4. The examiners next step was to review the current procedural terminology (known as CPT) definition of CPT Code 99214 as follows:

> Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

5. Along with their review of the definition for CPT Code 99214, the examiners also considered patient safety and the quality of care provided through telemedicine while performing their analysis. As noted above, although the CMS Policy contemplates delivery of safe and quality healthcare, the Examiner's analysis of CPT Code 99214 also considered such factors.

The Coding Specialist Examiner used the 1995 CMS coding guidelines to determine whether certain conditions could be treated through telemedicine by using CPT Code 99214. In summary, these coding guidelines specify the requirements that must be met for a service to meet the level of care provided under a specified CPT Code. Although the 1995 CMS coding guidelines were used for this analysis, these guidelines apply to all types of health insurance plans (such as commercial health plans). This is true because the tool is based on CPT Codes which are used and applicable to all types of health insurance plans. Finally, these coding guidelines are widely used by many individuals (such as providers and their billing employees, healthcare auditors, and quality reviewers) and CMS Examiners to ensure that services provided are accurately coded and billed. For these reasons, the Coding Specialist Examiner used the 1995 CMS coding guidelines to illustrate how services, such as those provided under CPT Code 99214, can be achieved through

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telemedicine.

The CMS coding requirements for evaluation and management office visit CPT Code 99214 consists of these three components that are explained in more detail below:

1. history;
2. exam; and
3. medical decision making.

1. History consists of these three elements:
   a. History of present illness (HPI) is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. And in order to be considered a 99214 a detailed history is required. Thus, at least four of the following items must be identified:
      - Location – for example: left leg,
      - Quality - for example: aching, burning, radiating pain
      - Severity – for example: 10 on a scale of 1 to 10
      - Duration – for example: started 3 days ago
      - Timing - for example: constant or comes and goes
      - Context – for example: lifted large object while at work
      - Modifying factors – for example: better when heat is applied
      - Associated signs and symptoms – for example: numbness in toes

   b. Review of Systems (ROS) – an inventory of body systems is obtained by asking a series of questions to identify signs and/or symptoms the patient may be experiencing or has experienced. 99214 requires at least two ROS. These systems are recognized for ROS purposes:
      - Constitutional Symptoms (for example, fever, weight loss)
      - Eyes
      - Ears, nose, mouth, throat
      - Cardiovascular
      - Respiratory
      - Gastrointestinal
      - Genitourinary
      - Musculoskeletal
      - Integumentary (skin and/or breast)
      - Neurological
      - Psychiatric
      - Endocrine
      - Hematologic/lymphatic
      - Allergic/immunologic

   c. Past/Family/Social History (PFSH) – 99214 requires only one of the following:
      - Past history- includes experiences with illnesses, operations, injuries, and treatments

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- Family history – includes a review of medical events, diseases, and hereditary conditions that may place the patient at risk and must be pertinent to the presenting problem
- Social history – includes an age appropriate review of past and current activities such as smoking, drug use, exercise, etc.

2. Exam – there are four types of exams as follows and 99214 requires a detailed examination:
   - Problem Focused – A limited examination of the affected body area or organ system
   - Expanded Problem Focused – A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s)
   - Detailed – An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s)
   - Comprehensive – A general multi-system examination or complete examination of a single organ system

3. Medical decision making (MDM) consists of the following three elements and 99214 requires moderate MDM:
   - Number of diagnosis and management options
   - Amount or Complexity of data reviewed
   - Risk of complications, morbidity and/or mortality

**Please see Exhibit II for coding examples.**

**Other Considerations**

The examiners asked the Company if it was aware of differences in the handling of telemedicine claims by other BCBS plans. The Company provided the following response: "BCBSMS has not conducted an analysis of the differences in the handling of telemedicine claims by other Blue Plans." Yet the Examiner's review of IR responses revealed that the Company had reviewed TM Policies for other BCBS plans in the creation of its TM Policy. While addressing this matter with the Company, examiners noted that the intent of the Company's review was to obtain a basic understanding of TM claims and 99214 was not included in their review. But, as explained below, the Company knew its insureds were receiving 99214 TM services as provided through the BlueCard Program.

Under the Company's BlueCard Program, members insured under the MS health plans can obtain services from BCBS network providers in any state where BCBS has a presence. Although the Company's Plan would be responsible for reimbursing the provider located outside of Mississippi, the claims would be processed in accordance with the TM Policy of the other state (host state). Several other BCBS health plan TM Policies included CPT Code 99214. Through a review of the approved claims data, the examiners identified other BCBS health plans such as Alabama, Arkansas, Florida, Georgia, Louisiana, Texas, and Tennessee that allowed 99214 TM visits. The Company's 2020 TM approved claims data includes 3,390 approved BlueCard CPT Code 99214 claims.

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Based on this information, the Company was, or should have been, aware of how many 99214 TM claims were being approved by the Company and should have revisited its TM Policy analysis to determine whether changes were needed. The Company did not do so, which represents another example of a flawed TM Policy. Further, the fact that BCBS plans of other states cover CPT Code 99214 shows the arbitrary nature of the Company universally not including CPT 99214 in its TM policy.

**Telemedicine Policy – Covered Services**

The Company provided the examiners with the following version dates of the TM Policy that were communicated to providers during 2020: March 23, 2020; March 26, 2020; April 2, 2020; April 24, 2020; April 27, 2020, and June 29, 2020. Although the TM Policy included 24 outpatient and 52 inpatient CPT Codes (76 CPT Codes), the examiners' review of the claim population data submitted by the Company identified 508 CPT Codes. The Company informed the examiners that although many CPT Codes in the claims data are not included in their TM Policy, they were included in the data for the following reasons:

1) Several claim forms submitted by providers included both services provided through telemedicine and others provided through in-person office visits. As a result, the claim was identified as telemedicine. For example, a member may have received an evaluation and management service through telemedicine and later arrived at the provider's office for lab procedures;

2) Several claims involved another payer (such as Medicare or a child covered under both parent's health insurance policy) and the Company was the secondary payor. In that context, the Company will adjust the claim in accordance with the primary payor's instructions and

3) Several claims were BlueCard (a Mississippi member receives services from a provider located outside the state that is a network provider for another BCBS Association Plan, known as the host state) and were processed according to Telemedicine Policy of the host state.

Despite the explanations provided by the Company as stated above, the examiners identified many claim lines in the paid claims population for CPT Codes not included in the TM Policy that met the following criteria:

1) The claim line was deemed as a telemedicine service;
2) The Company was not a secondary payor; and
3) The claim was not BlueCard.

To address this matter, the examiners issued an IR asking the Company to provide a comprehensive listing of all telemedicine CPT Codes (including temporary codes, COVID-19 specific codes and those for which the allowable amount is zero) in an Excel spreadsheet. The Company provided a listing that included only the 76 CPT Codes as discussed above. While discussing these observations with the Company in interviews, the Company again stated that it only covered CPT Codes as stated in its TM Policy. That said, the Company agreed to research this matter further upon receiving an IR. Thus, the examiners submitted the following information request:

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> After reviewing the Company's response to IR 1 and IR 7 regarding covered telemedicine codes, the Examiners compared the information to the paid claims data and found a significant number of procedure codes that were approved and covered as telemedicine services but not listed in the covered telemedicine procedure codes provided by the Company. For example, as discussed during the interview, CPT code 92507 was found on many lines in the approved claims data and is also stated as a code recommended for inclusion in the Telemedicine Policy as stated in document 5 provided in response to IR 7. To aid in the review and examination of the Company's data and to better understand the Company's processes, Examiners are requesting a complete and cohesive list of covered telemedicine procedure codes programmed into the Company's claims system or addressed otherwise such as a manual process as approved for payment. For each of those covered telemedicine procedure codes, also provide the date that the procedure code was added as an approved telemedicine service. NOTE: The Company is encouraged to review all IR responses (such 1, 2 and 7) and the claims data to ensure that the requested information is provided for all procedure codes that are included in the Telemedicine Policy.

The Company provided a spreadsheet that included the requested information. The spreadsheet included 170 CPT Codes and only 76 of the listed CPT Codes are included in the Company's TM Policy.

The examiners also asked the Company if the complete listing (*i.e.*, 170 CPT Codes included in the spreadsheet) of all CPT Codes included under the TM Policy was available to providers through the provider portal. The Company provided the following response:

> A complete list of codes covered under the TM Policies was not available. Most codes covered under the TM Policies were available for review via myBlue Provider (provider portal) article postings beginning March 19, 2020; however, there were some codes subsequently covered under the TM Policies after interaction and discussion with Providers (e.g., CPT 92507, etc.). BCBSMS endeavored to provide a comprehensive listing and provided regular updates via myBlue Provider to encompass as many Providers as possible.

As illustrated above, the Company was unaware of all the CPT Codes covered under their TM Policy until the examiners shared their observations regarding their review of claims population data. This matter represents another example of how the TM Policy was flawed and not properly communicated to providers. As a result, most providers were only aware of the 76 CPT Codes stated under the TM Policy although 94 other CPT Codes were available through telemedicine.

The Company's failure to provide a complete listing of CPT Codes covered under the TM Policy detrimentally affected Mississippi insureds and providers. In particular, for services covered by the Company through telemedicine but not included in the TM Policy, insureds might have needlessly exposed themselves to the possibility of contracting COVID-19 through an in-person office visit or they might have postponed receiving a needed service. In terms of the provider's impact under this scenario, the opportunity to provide needed telemedicine services to patients was missed.

The Company's TM Policy is the only information available to providers regarding the CPT Codes covered under the TM Policy. Although the TM Policy includes 24 outpatient and 52 inpatient

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CPT Codes, the Company provided the examiners with an internal listing that included an additional 94 CPT Codes that are covered under the Policy. However, those CPT Codes are not included in the TM Policy. Thus, providers were unaware that they could be reimbursed for such services under the TM Policy. Therefore, in the opinion of the examiners, the Company did not comply with the requirements noted under Title 19, Part 3, Rule 14.06, Miss Code Ann. § 83-9-351(Supp. 2019) and MID Bulletin 2020-1 (and all subsequent bulletins).

**Provider Communications**

The examiners requested the Company's policies and procedures for communications with providers regarding the following:

**A.** Changes in covered benefits,
**B.** Changes in utilization review requirements,
**C.** Changes in provider reimbursements /maximum allowable contract rate, and
**D.** All other changes that impact providers

The Company provided the following response:

> BCBSMS does not maintain a written policy and procedure for provider communications.

However, the Company did provide a verbal explanation of the general process for each type of communication noted above. In summary, most information is communicated to providers through the Company's online portal known as the "*my*Blue Provider Portal" and, in some cases, a direct mailing is also used. The Company also revealed that network hospitals receive an annual renewal letter that typically includes revisions or updates related to covered benefits, utilization review requirements, and provider reimbursement rates/methodologies. The renewal letters are mailed 60 days before the contract renewal effective date of January 1. In terms of maintaining a transparent communication process that allows ample time for providers to understand the communication and ask questions before any applicable effective date associated with the communication, the Company stated that advance notice of a change is always provided, and providers can contact the Company with any questions. In terms of reimbursement rate changes, the Company stated again that 60 days' notice is provided which allows ample time to ask questions. In particular, the Company noted the following:

> Network Providers are afforded various avenues to contact the Company, including but not limited to, phone calls to the Provider Services Call Center or Provider Administration teams, direct electronic communication via *my*Blue Provider, email directly to a dedicated Provider Networks monitored mailbox, and direct phone call or email with Provider Partnerships personnel.

The examiners also interviewed the Company's employees responsible for provider communications and they provided the same information about the provider communication policies and procedures obtained through written responses to IRs. The Company did not provide the examiners with any documents that indicated that the Company maintains a transparent communication process with their providers.

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The examiners reviewed a representative sample of 10 of the 19 provider communication population items submitted by the Company (pertaining to the Examination scope). The examiners reviewed the 10 communications sent to providers, related correspondence received from providers regarding questions or comments on the communication, and the Company's responses to such questions or comments. In summary, the Company's communications are not always timely and transparent as discussed below.

*Comprehensive Quality Model*

The Comprehensive Quality Model (CQM or Model) was a new initiative rolled out by the Company on January 1, 2021. From August – October 2020, the Company sent providers slides regarding the CQM and the information was also discussed with each hospital. But the CQM was only discussed in general terms and the factors that applied to each hospital were unavailable when the CQM slides were provided and discussed with providers or when the annual renewal letter was mailed to each provider.

This initiative is mentioned at a high level in the 2021 in-network hospital renewal letter and the purpose of this Model as stated in the renewal letter is as follows:

> The Model is essential to elevating the quality of healthcare services rendered to Members, and ensures reimbursement more appropriately aligns with the value of services delivered rather than the volume of services rendered.

The 2021 in-network hospital renewal letter also notes the following:

> Additional details regarding the performance measures and technical specifications, and evaluation and monitoring criteria of the Model, will be available on *my*Blue Provider no later than November 15, 2020, via Appendix C – Comprehensive Quality Model, which has been incorporated by reference into Attachment A – Network Hospital Policies and Procedures.

Finally, the renewal letter states that the provider must review, sign, and return the renewal contract by December 15, 2020. As discussed above, the Company's procedures purportedly allow for 60 days' notice regarding changes discussed in the annual renewal letter. However, assuming that providers received their renewal letters on November 1, 2020, the CQM data needed to make a decision was not available until November 15, 2020. As a result, the provider had only 30 days to review the information and respond to the Company. Further, there are some situations where the dates as outlined above were not met. For example, an email communication with North Mississippi Health Services (NMHS) provided by the Company stated that the NMHS 2021 renewal letter was not delivered until November 10, 2020. Thus, this provider had only 20 days to review and agree to the renewal notice and all associated information. To allow for a timely and transparent annual renewal process, it is recommended that the Company mail renewal information before November 1 of each year to ensure that the information is delivered by November 1. Also, to allow for adequate time for providers to review the contract renewal terms, the renewal documents received by providers on November 1 should be completely transparent and include all contract terms (such as CQM data) that must be agreed to before the effective date.

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*Ambulatory Payment Classification Outpatient Reimbursement Site Neutral Reimbursement 2020 In-network Hospital Annual Renewal Letter*

The 2020 in network hospital renewal letter (2020 letter) included a section labeled Inpatient/Outpatient that included information about ambulatory payment classification (APC) outpatient reimbursement site neutral reimbursement, which discusses certain surgical procedures that can be performed in an ambulatory surgery setting to ensure cost consistency across various places of treatment. The 2020 letter notes that the APC Manual and Appendices will be available on *my*BlueProvider no later than December 1, 2019. The Company also provided the following high-level information in the 2020 letter:

> Site neutral payment will be implemented effective April 1, 2020, for the following surgical procedures, which can be performed in an ambulatory surgery setting, subject to medical policy: Tympanostomy; Tonsillectomy and Adenoidectomy; Nerve Injections; esophagogastroduodenoscopy (EGD); Cataract; Carpal Tunnel and Colonoscopy.

The 2020 letter did not allow for adequate time for providers to review and evaluate the information since the APC information was not available until December 1, 2019 with additional information provided in 2020 before the April 1, 2020 effective date. Thus, the Company did not provide a fully transparent 2020 letter since the providers had to sign the agreement before January 1, 2020 without knowing all the details of the site neutral payments as stated above. It is also important to note that the limited information was only made available to providers on December 1, 2019, (although the Company states that 60 days' notice is provided for all changes for the renewal process). For this change, providers received only 30 days' notice.

*2021 In-network Hospital Annual Renewal Letter*

Similar to the 2020 letter, the 2021 in network hospital renewal letter (2021 letter) included a section labeled Inpatient/Outpatient that included the following statement:

> BCBSMS continues to evaluate and implement reimbursement and medical policies to reduce discrepancies in cost by place of treatment for non-Specialty Services. To further those efforts, BCBSMS is implementing, effective January 1, 2021, site neutral payment for the following surgical procedures which can be performed in an ambulatory surgery setting, subject to medical policy: Injections; Orthopedic Knee and Shoulder Surgeries and Nasal/Sinus Surgeries.

The Company further notes that the APC Manual and Appendices will be available on *my*Blue Provider Portal no later than December 1, 2020. Finally, the Company also notes that a new outpatient reimbursement model is under evaluation and will be introduced in 2021. The examiners once again note that the Company did not provide a fully transparent 2021 letter since the providers had to sign the agreement prior to January 1, 2021 without knowing all of the details on the new outpatient reimbursement model as stated above. It is also important to note that the limited information was only made available to providers on December 1, 2020 although the Company states that 60 days' notice is provided for all changes for the renewal process. For this change, providers received only 30 days' advance notice.

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*Total Hip and Total Knee Arthroplasty Medical Policy Implementation*

In a letter dated September 1, 2020, the Company communicated the following significant change to in-network providers:

> Effective October 1, 2020, Blue Cross & Blue Shield of Mississippi (BCBSMS) will implement the Total Hip and Total Knee Arthroplasty Medical Policies for the North East Service area of the state. These Medical Policies specify clinical criteria that must be met in order to determine the clinically appropriate place of treatment (inpatient versus ambulatory). Depending on the Member's coverage and Benefit Plans, if the Member's clinical circumstances do not meet the inpatient clinical criteria as set forth in the Total Hip and Total Knee Arthroplasty Medical Policies, the total joint replacement must be performed in an ambulatory setting by a Blue Specialty Care Network Provider.

Only a few of the many in-network hospitals were selected as entities that will perform the total hip and total knee procedures. As a result, this major change had a tremendous financial effect on providers that were already facing financial hardships during the COVID-19 pandemic. This change also impacted members that were scheduled for such procedures and would need to reschedule with one of the few remaining in-network providers. Finally, through a complaint submitted to the MID, it was revealed that an in-network facility that performed such procedures was not notified that it would no longer be an in-network provider performing such services until they reached out to the Company to discuss the letter it received during the first week in September 2020. To date, this in-network hospital provider is unaware of the reasons why its facility was not selected as an in-network facility to perform hip and knee replacement procedures. Thus, the Company was not transparent in providing information on this major change. Also, providing only 30 days' notice to providers is inadequate and seriously affected providers and members.

*Telemedicine Policy*

As discussed above, the Company's TM Policy includes 24 outpatient CPT Codes and 52 inpatient CPT Codes. The TM Policy is available to providers on the *my*BlueProvider Portal. As previously noted, during the Examination the Company provided the examiners with an internal spreadsheet that included 170 CPT Codes included in the TM Policy. The examiners also asked the Company if the complete listing of the 170 CPT Codes included under the TM Policy was available to providers through the provider portal. The Company provided the following response:

> A complete list of codes covered under the TM Policies was not available. Most codes covered under the TM Policies were available for review via myBlue Provider (provider portal) article postings beginning March 19, 2020; however, there were some codes subsequently covered under the TM Policies after interaction and discussion with Providers (e.g., CPT 92507, etc.). BCBSMS endeavored to provide a comprehensive listing and provided regular updates via myBlue Provider to encompass as many Providers as possible.

This is another example of how the Company was not transparent to providers regarding the communication of all CPT Codes covered under the TM Policy. In summary, it is the opinion of the examiners that the items discussed above potentially represent violations of Title 19, Part 3, Rule 14.06.

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## COMMENTS AND RECOMMENDATIONS

**Telemedicine Policy – Exclusion of CPT Code 99214**

Although some Mississippi providers submitted claims reflecting a CPT Code 99214, the Company informed them that telemedicine services are limited to level 3 (99213). As a result, claims submitted with a level 4 (99214) were downcoded to a level 3. Based on this information, multiple providers followed instructions and did not submit claims with a CPT code 99214 although a level 4 service was provided to the patient. We recommend the Company be instructed to draft a letter to be sent to all Mississippi providers that submitted a CPT code 99214 claim between March 2020 through the date of this report explaining the results of the Examination and asking such providers to review their patient records and resubmit all claims using a CPT code 99214 in situations where such services provided were only reimbursed by the Company at a level 3 (CPT Code 99213). It is further recommended that the letter be reviewed and approved by the examiners and MID. While reprocessing such claims, the Company should apply late payment interest by using the receipt date of the initial claim submission (start date) and the payment date of the resubmitted claim (end date). In summary, the Company's TM Policy should have included CPT Code 99214 since it is the provider's responsibility to determine what services are clinically appropriate and can be safely provided through telemedicine. State law specifically allows providers to deliver services via telemedicine if the provider determines the delivery meets the standard of care. *See* Miss. Code Ann. § 41-127-1.

**Telemedicine Policy – Covered Services**

We recommend the Company be directed to submit the spreadsheet of all CPT Codes included in the TM Policy inclusive of the effective date for each Code. The Company should be instructed to draft a letter to be sent to all its in-network Mississippi providers explaining the results of the Examination and asking such providers to review their patient records and to submit or resubmit claims reflecting the services performed on patients based on the CPT Codes included in the TM Policy (internal only listing of Codes). It is recommended that the letter be reviewed and approved by the examiners and MID. While reprocessing such claims, the Company should apply late payment interest by using the receipt date of the initial claim submission (start date) and the payment date of the resubmitted claim (end date). In summary, the Company's TM Policy should have included CPT Code 99214 since it is the provider's responsibility to determine what services are clinically appropriate and can be safely provided through telemedicine. State law specifically allows providers to deliver services via telemedicine if the provider determines the delivery meets the standard of care. *See* Miss. Code Ann. § 41-127-1.

**Provider Communications**

It is recommended that the Company design written provider communication procedures that ensure that information is transparent and provided in a timely manner. Regarding the annual renewal process, the Company should not require that providers sign a renewal notice until all contractual terms include the detailed information necessary for providers to understand and plan for such terms. A corrective action plan should be presented to the examiners and MID for review.

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# ACKNOWLEDGMENT

The examiners representing the Mississippi Insurance Department and participating in this examination were:

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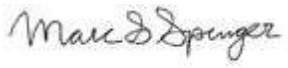
|---|---|
| Examiner-in-charge: | Marc Springer, CIE, MBA, MCM |
| Supervising Examiner: | John Humphries |
| Examiner: | Jo-Anne Arrowood, AMCM, CIE, FLMI, AIRC, ACS |

The courteous cooperation of the officers and employees responsible for assisting in the examination is hereby acknowledged and appreciated.

Respectfully submitted,



Marc Springer, CIE, MBA, MCM
Examiner-in-Charge

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# Exhibit I

**Current Procedural Terminology Definitions**

**CPT 99213** – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family

**CPT 99214** – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

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# Exhibit II

**Coding Examples**

Here are two examples of how CPT Code 99214 services can be performed through telemedicine according to CMS coding guidelines:

**Example 1: Acute uncomplicated medical condition – Patient has an earache. The coding template as discussed above is included again below and the red font signifies the criteria that was met in order to allow for a 99214 service through telemedicine. Although only two of the following three components are required to be treated as a 99214 level of service, this visit met all three components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Please note that the red font below represents the attributes of the medical condition being illustrated.**

1. History is comprised of the following three elements:
   a. HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present and in order to be considered a 99214 a detailed history is required. Thus, at least four of the next items must be identified:
      - Location – left ear
      - Quality - dull ache
      - Severity – for example: 10 on a scale of 1 to 10
      - Duration – past 24 hours
      - Timing - for example: constant or comes and goes
      - Context – for example: lifted large object while at work
      - Modifying factors – feels better when warm compress is applied
      - Associated signs and symptoms – for example: numbness in toes

   b. ROS – an inventory of body systems is obtained by asking a series of questions to identify signs and/or symptoms the patient may be experiencing or has experienced. 99214 requires at least two ROS. These systems are recognized for ROS purposes:
      - Constitutional Symptoms – Patient denies fever, headache or neck pain
      - Eyes
      - Ears, nose, mouth, throat – Patient states pain in left ear and denies any issues with nose, mouth and throat
      - Cardiovascular
      - Respiratory
      - Gastrointestinal
      - Genitourinary
      - Musculoskeletal – Patient denies neck pain
      - Integumentary (skin and/or breast)
      - Neurological – Patient denies headache
      - Psychiatric
      - Endocrine

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- Hematologic/lymphatic
- Allergic/immunologic

c. PFSH – 99214 requires only one of the following:
   - Past history- Patient gets swimmers ear every summer and symptoms are the same as previous presentations.
   - Family history – includes a review of medical events, diseases, and hereditary conditions that may place the patient at risk and must be pertinent to the presenting problem
   - Social history – includes an age appropriate review of past and current activities such as smoking, drug use, exercise, etc.

2. Exam – there are four types of exams as follows and 99214 requires a detailed examination:
   - Problem Focused – A limited examination of the affected body area or organ system
   - Expanded Problem Focused – A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s)
   - Detailed – An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s). Here are the details:
     Constitutional: Patient is in no distress, general appearance is well groomed; Skin: No rashes in visible areas; Neck: No masses visible, symmetrical and trachea midline. Normal ROM; Respiratory: In no respiratory distress; and Psychological: Alert and Oriented x3
   - Comprehensive – A general multi-system examination or complete examination of a single organ system

3. MDM consists of the following three elements and 99214 requires moderate MDM:
   - Number of diagnosis and management options
   - Amount or Complexity of data reviewed
   - Risk of complications, morbidity and/or mortality

Assessment – Patient has swimmer's ear, and the provider prescribed ciprofloxacin (a prescription is moderate on the level of risk table).

**Example 2 – Chronic conditions – Patient has diabetes II, hypertension, and hyperlipidemia. The coding template as discussed above is included again below and the red font signifies the criteria that was met in order to allow for a 99214 service through telemedicine. This visit met the following two components: A detailed history and medical decision making of moderate complexity. Although the detailed examination component was not met, please be reminded that only two of the three components must be met to be considered a 99214 level of service. Please note that the red font below represents the attributes of the medical condition being illustrated.**

1. History consists of the following three elements:
   a. HPI* is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. And in order

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to be considered a 99214 a detailed history is required. Thus, at least four of the following items must be identified:

- Location – for example: left leg,
- Quality - for example: aching, burning, radiating pain
- Severity – for example: 10 on a scale of 1 to 10
- Duration – for example: started 3 days ago
- Timing - for example: constant or comes and goes
- Context – for example: lifted large object while at work
- Modifying factors – for example: better when heat is applied
- Associated signs and symptoms – for example: numbness in toes

* For this example, the three chronic conditions (diabetes II, hypertension, and hyperlipidemia) represent the HPI. Patient is presenting via a telehealth visit for her 6-month follow up of diabetes II, hypertension, and hyperlipidemia. States she has been compliant with her medication regime. Patient states her sugars are well controlled, running between 87 and 108. Diet controlled. Last A1c 6.6.

b. ROS – an inventory of body systems is obtained by asking a series of questions to identify signs and/or symptoms the patient may be experiencing or has experienced. 99214 requires at least two ROS. These systems are recognized for ROS purposes:
   - Constitutional Symptoms (for example, fever, weight loss)
   - Eyes
   - Ears, nose, mouth, throat
   - Cardiovascular
   - Respiratory – no cough or shortness of breath
   - Gastrointestinal – no nausea
   - Genitourinary
   - Musculoskeletal – no myalgia
   - Integumentary (skin and/or breast) – no rash
   - Neurological – no dizziness
   - Psychiatric
   - Endocrine
   - Hematologic/lymphatic
   - Allergic/immunologic

c. PFSH – 99214 requires only one of the following:
   - Past history- includes experiences with illnesses, operations, injuries, and treatments
   - Family history – includes a review of medical events, diseases, and hereditary conditions that may place the patient at risk and must be pertinent to the presenting problem
   - Social history – includes an age appropriate review of past and current activities such as smoking, drug use, exercise, etc. – Patient indicates she quit smoking 3 months ago utilizing the patch.

2. Exam – there are four types of exams as follows and 99214 requires a detailed examination:

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- Problem Focused – A limited examination of the affected body area or organ system
- Expanded Problem Focused – A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s) Constitutional, Skin, Respiratory, Psychological. Patient has been monitoring her blood pressure and I reviewed her log via the video camera. It's been running a little high. Last 3 readings: 138/97, 145/93, 142/90. Hypertension is not well controlled.
- Detailed – An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s)
- Comprehensive – A general multi-system examination or complete examination of a single organ system

3. MDM consists of the following three elements and 99214 requires moderate MDM:

- Number of diagnosis and management options 2 established problems stable- 2pts, 1 established problem not at goal- 2pts
- Amount or Complexity of data reviewed
- Risk of complications, morbidity and/or mortality – prescriptions

Assessment – Diabetes II well controlled. Will check A1c in July. Hyperlipidemia well controlled. Refill Lipitor 20mg qd. Hypertension is uncontrolled. Will increase Lisinopril to 20mg and keep hydrochlorothiazide 12.5 qd. Patient will come into the office in 5 days after starting new dose and get a blood pressure reading. Patient expressed understanding. Patient is due for another lab draw in July and will come in at her convenience at that time.

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