



Medical Society of Delaware
LEADING THE WAY TO A HEALTHY DELAWARE

Telemedicine Support Guidelines for COVID-19



Table of Contents

Department of Insurance Guidance..... Page 3

Guidance from Insurance Payers..... Pages 3 - 9

Aetna..... Page 3

AmeriHealth Caritas..... Page 4

Cigna..... Page 4

CMS – Medicare..... Pages 4 - 7

DMMA – Medicaid..... Page 8

Highmark BCBS..... Page 9

Highmark Health Options..... Page 9

United Healthcare..... Page 10

Delaware Telehealth Coalition..... Page 10

ERISA Plans..... Page 10

Telemedicine Support Guidelines for COVID-19

The Delaware Department of Insurance issued guidance in a bulletin dated March 20, 2020 which included telemedicine, see bulletin at <https://tinyurl.com/doibulletin>.

With respect to health insurance carriers, the Governor's Updated Emergency Declaration reinforce that:

- Patients do not have to present in-person or before relevant services may be provided
- Delaware residents do not need to be in Delaware at the time relevant services are provided; and
- Out-of-state providers who would be permitted to provide these services in Delaware if they were licensed under Title 24 may provide telemedicine services to a Delaware resident if they hold an active license in another jurisdiction.

Accordingly, the Department expects carriers who are covering claims under insurance policies to which the telemedicine provision applies to fully reimburse providers who are providing telemedicine services through telehealth in accordance with the law. Since COVID19 is a communicable disease, some insureds may choose to seek medical advice through these services instead of in-person health care services for any care, including but not limited to symptoms that relate to COVID-19. Accordingly, this provision applies to all telehealth and telemedicine services, not just those provided in connection with the testing and treatment of COVID-19.

Guidance from Delaware Insurance Payers

Aetna

Until **June 4, 2020**, Aetna will waive member cost sharing for any in-network covered telemedicine visit – regardless of diagnosis – for their commercial plans. For Aetna Commercial plans offering Teladoc®. MinuteClinic Video Visit coverage or a different virtual care option, cost sharing will be waived for those virtual visits. Cost sharing will also be waived for covered real-time virtual visits offered by in-network providers (live videoconferencing and telephone-only telemedicine services) for all Commercial plan designs. Commercial members may use telemedicine services for any reason, not just COVID-19 diagnosis.

Through **September 30, 2020**, Aetna is extending all member cost-sharing waivers for covered in-network telemedicine visits for outpatient and mental health counseling services for their Commercial plans. Self-insured plans offer this waiver at their own discretion.

Through **September 30, 2020**, Aetna is extending all member cost-sharing waivers for in-network telehealth visits for outpatient behavioral and mental health counseling services for all Medicare Advantage plan members. Aetna Medicare Advantage members should continue to use telemedicine as their first line of defense for appropriate symptoms or conditions to limit potential exposure in physician offices. Cost sharing will be waived for all Teladoc® virtual visits. Cost sharing will also be waived for real-time virtual visits offered by in-network providers (live video conferencing or telephone-only telemedicine services). Medicare Advantage members may use telemedicine for any reason, not just COVID-19 diagnosis.

<https://tinyurl.com/aetnacovidext>

Telemedicine Support Guidelines for COVID-19

AmeriHealth Caritas

In response to the COVID-19 public health emergency, AmeriHealth Caritas Delaware is expanding its telehealth policies effective immediately. We're closely monitoring updates from the Division of Medicaid and Medical Assistance (DMMA), the Centers for Disease Control and Prevention (CDC), and Centers for Medicare & Medicaid Services (CMS) to adjust our policies as needed.

<https://www.amerihealthcaritasde.com/assets/pdf/covid-19/covid-19-telehealth-faq.pdf>

Cigna

Cigna announced the following changes:

- Waive customer cost-sharing for telehealth screenings for COVID-19 through May 31, 2020
- Make it easier for customers to be treated virtually for routine medical examinations by providers
- Cigna will allow providers to bill a standard face-to-face visit for all virtual care services, including those not related to COVID-19.
- This means that providers can perform services for commercial Cigna customers in a virtual setting and bill as though the services were performed face-to-face.
- Providers should bill using a face-to-face evaluation and management code, append the GQ modifier, and use the POS that would be typically billed if the service was delivered face to face.¹
- Providers will be reimbursed consistent with their typical face-to-face rates.
- Providers can also bill code G2012 for a 5-10 minute phone conversation, and Cigna will waive cost-share for the customer. This will allow for quick telephonic consultations related to COVID-19 screening or other necessary consults, and will offer appropriate reimbursement to providers for this amount of time.²
- Customer cost-share will apply as outlined below.²

Cigna claims processing systems will be able to accurately and timely administer claims when health care providers follow the below coding guidance. Claims will be processed consistent with these rules beginning April 6, 2020 for dates of service on or after March 2, 2020 and until at least May 31, 2020.³

1. QualCare Workers' Compensation providers should not use a GQ modifier.
2. Not applicable to QualCare Workers' Compensation.
3. Effective dates for QualCare Workers' Compensation are being determined. We will provide updates as the information becomes available.

<https://tinyurl.com/cignatele>

CMS - Medicare

The Centers for Medicare & Medicaid Services (CMS) **announced** several waivers and policy changes to broaden access to telehealth services for Medicare beneficiaries during the COVID-19 public health emergency. On June 2, 2020 CMS released a **Frequently Asked Questions** document.

Telemedicine Support Guidelines for COVID-19

CMS – Medicare Cont.

On May 1, 2020 CMS announced that they are increasing payments for Telehealth telephone visits to match payments for similar office and outpatient visits. This would increase payments for these services from a range of about \$14-\$41 to about \$46-\$110. **The payments are retroactive to March 1, 2020.**

On March 30, CMS announced a number of new policies to help physicians and hospitals during the COVID-19 pandemic, **including coverage for audio-only telephone visits**. See additional information in CMS Toolkit at <https://tinyurl.com/cmstelehealthtoolkit>.

Payment for Medicare Telehealth Services

CMS granted an expanded Section 1135 waiver, under which Medicare will pay for office, hospital, and other visits furnished via telehealth across all areas of the country and in all settings, including in patients' homes, starting March 6, 2020 and for the duration of the COVID-19 public health emergency. This operationalizes the waiver of the originating and geographic site restrictions on telehealth services that are codified in Section 1834(m) of the Social Security Act (the Act). Medicare considers these telehealth services the same as in-person visits and will pay for them at the same rate as regular, in-person visits.

Cost-sharing

Medicare coinsurance and deductible would generally still apply to the Section 1834(m) Medicare telehealth services, but the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) is providing flexibility for health care providers to reduce or waive cost-sharing for telehealth visits paid by federal health care programs. More information is available in a [policy statement](#) and [fact sheet from OIG](#).

Requirement for Established Patient Relationship

The COVID-19 spending package signed by President Trump last week included "qualified provider" language that limited the delivery of telehealth services to patients with an established relationship with a provider or a member of the provider's practice. **In this announcement, CMS confirms that HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.**

Virtual Check-ins

In the calendar year 2019 physician fee schedule final rule, CMS established payment for brief, communication technology-based "check-ins" between providers and established patients to determine whether an office visit is necessary. The originating and geographic site restrictions from Section 1834(m) of the Act do not apply to these check-ins and they therefore can be provided in all locations. **CMS reminds providers of the availability of these check-ins in this announcement and highlights that providers can use telephones, audio/video devices, secure text messaging, email or use of a patient portal for the purpose of these check-ins.** CMS also underscores that patients must agree to individual services but that providers may educate beneficiaries on the availability of the check-in service prior to patient agreement.

Telemedicine Support Guidelines for COVID-19

CMS – Medicare Cont.

E-visits

CMS explains that in all locations and all areas of the country, established Medicare patients may have non-face-to-face patient-initiated communications with their doctors via online patient portals. For these e-visits, the patient must generate the initial inquiry and communications can occur over a 7-day period. Medicare Part B also pays for e-visits or patient-initiated online evaluation and management (E/M) conducted via a patient portal, both with providers who may independently bill Medicare for E/M visits and those who may not (such as physical therapists, occupational therapists, speech language pathologists, and clinical psychologists).

Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency. [More information is available from HHS.](#)

Condition-agnostic Care

CMS clarifies that the expanded telehealth authority is not limited to patients with or suspected of having COVID-19. Providers may treat patients through telehealth regardless of their diagnosis or symptoms, as long as services are reasonable and necessary.

KEY TAKEAWAYS

Telehealth flexibilities include:

- Waivers of originating and geographic site restrictions on Medicare telehealth services, permitting the delivery of these services in all areas of the country and all locations, including patients' homes.
- The ability of providers to use expanded telehealth authority for new and established patients for diagnosis and treatment of COVID19, as well as for conditions unrelated to the pandemic.
- Permission for providers to use everyday communications technologies, such as FaceTime or Skype, during the COVID-19 public health emergency, without running afoul of HIPAA penalties.
- Coverage provided for audio-only telephone visits.

Summary of Medicare Telehealth Services

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: <ul style="list-style-type: none"> • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	<ul style="list-style-type: none"> • HCPCS code G2012 • HCPCS code G2010 	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	<ul style="list-style-type: none"> • 99431 • 99422 • 99423 • G2061 • G2062 • G2063 	For established patients.

Telemedicine Support Guidelines for COVID-19

DMMA - Medicaid

Telehealth Provider Eligibility In response to COVID-19, effective 3/18/2020 until further notice, DMMA relaxed eligibility requirements for providers providing Telehealth Services. For services delivered through telehealth technology from DMAP or MCOs to be covered, healthcare practitioners must:

Act within their scope of practice;

- Be licensed for the service for which they bill DMAP;
- Any out of state healthcare provider who would be permitted to provide telemedicine services in Delaware if they were licensed under Title 24 may provide telemedicine services to a Delaware resident if they hold an active license in another jurisdiction;
- Be enrolled with, or have engaged in the process to become enrolled with, DMAP/MCOs; and
- Be located within the continental United States. Additionally, Title 24 requirements that patients present in person before telemedicine services may be provided are suspended.

Billing for Telehealth

In general, services must be billed in accordance with applicable sections of DMAP Provider manuals. For Interactive Telehealth Services, the same procedure codes and rates apply to the underlying covered service as if those services were delivered face-to-face.

In response to COVID-19, effective 3/18/2020 until further notice, Telephonic Services can be provided to any member for any visit not related to an E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment. Billable Telephonic Services must be between the patient and the Physician or other qualified health professional.

Originating Site Providers

If the Health Care Provider at the Originating Site is making a room and telecommunications equipment available the provider may bill for an Originating Facility Fee using code Q3014.

Non-Federally Qualified Health Care Center (FQHC) Distant Site/Rendering Providers

- Distant Site/Rendering Providers billing for Interactive Telehealth Services should continue to bill their appropriate Usual & Customary charge for the service provided and use Place of Service value **02** for all Telehealth charges.
- Distant Site/Rendering Providers billing for Telephonic Services should use the following codes as appropriate, and should use Place of Service value **02** for all Telehealth charges:
 - Physician or other qualified health professional:
 - 99441: 5-10 minutes of medical discussion
 - 99442: 11-20 minutes of medical discussion
 - 99443: 21-30 minutes of medical discussion

https://dhss.delaware.gov/dhss/dmma/files/dmma_telehealth_bulletin_COVI_19.pdf

<https://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?EntryId=1080>

Telemedicine Support Guidelines for COVID-19

Highmark BCBS

Highmark has extended its Coronavirus Testing and Care Coverage until September 30th. Highmark is continuing to waive all in-network virtual medicine and telehealth visit costs. Plus, Coronavirus testing, as long as it's recommended by a medical professional, and in-network hospital treatment of Coronavirus are covered at no charge.

Highmark telemedicine options:

Virtual Visits: Virtual Retail Clinic Visits, Virtual PCP Visits, Specialist Virtual Visits, Virtual Behavioral Health and TeleDermatology, Telemedicine/Telehealth visits with any provider whose scope of practice includes telehealth/telemedicine.

In line with the OCR's decision, Highmark Delaware will temporarily relax its current telemedicine policy requirements as they relate to the specific communication applications used. Also, though we do currently utilize specific vendors for the provision of telehealth services, providers are not required to use those vendors and can arrange to provide services on their own. A listing of specific CPT codes is currently available on our Provider Resource Center with reimbursement consistent with rates paid for identical in-person services for Delaware providers. As with all services, participating providers that bill for telehealth and telemedicine services must bill codes appropriate to the servicing being performed and provide any required supporting documentation for such services.

Which providers can offer telemedicine?

All providers are eligible to provide telehealth visits for covered services within the scope of their license, deemed appropriate using their medical judgment, and delivered within the definition of the code billed.

Note... Medicare Advantage plans continue to follow CMS guidelines.

FAQ Sheet: <https://hdebcbshighmarkprc.com/COVID-19/Telemedicine-and-Virtual-Visits-DE>

Telemedicine Billing Code List: <https://tinyurl.com/highmarktelebill>

Highmark Health Options

Telehealth: Highmark Health Options covers telehealth services and to the extent possible, we encourage the use of telehealth to screen and provide COVID-19 related services to Medicaid population. If there are any questions related to telehealth service and HHO policy, please contact us at 1-844-325-6251 or reach out to your provider relations representative.

<https://tinyurl.com/healthoptionstele>

Telemedicine Support Guidelines for COVID-19

United Healthcare

UHC Extending Temporary Telehealth Expansion and Reimbursement Through Sept. 30, 2020

To help you deliver care and be reimbursed for telehealth services, for certain markets and plans UHC is temporarily continuing to waive the Centers for Medicare & Medicaid Services (CMS) originating site requirement for members through Sept. 30, 2020.*

And, UHC will temporarily reimburse providers for telehealth visits at parity with the rate they would receive for an in-person visit.

Depending on whether a claim is for a Medicare Advantage, Medicaid, Individual and fully insured Group Market health plan members, those policies may require slightly different modifiers, date of service limitations or place of service indicators for a telehealth claim to be reimbursed. For more details, please visit [UHCprovider.com/covid19](https://uhcprovider.com/covid19).

Extending Telehealth Cost Share Waivers

UHC is also continuing its expansion of telehealth including temporarily waiving member cost share for telehealth visits for medical, outpatient behavioral, physical, occupational and speech therapy, chiropractic therapy, home health, hospice and remote patient monitoring services, with opt-in available for self-funded employers.

- For COVID-19 in- and out-of-network telehealth services, UnitedHealthcare is waiving cost share through the national public health emergency period.
- For COVID-19 in-network only telehealth services, UnitedHealthcare will extend the cost share waiver from July 25, 2020 through Sept. 30, 2020.*
- For non-COVID-19 in-network only telehealth services, UnitedHealthcare will extend the cost share waiver through Sept. 30, 2020.*

* This date is subject to change based on direction from CMS.

<https://tinyurl.com/uhsummary>

Delaware Telehealth Coalition

<https://detelehealth.wixsite.com/detelehealth/covid-19-resources>

IMPORTANT - ERISA plans are still exempt and therefore may not be subject to the same guidelines as CMS, DMMA and commercial insurers.

Please note... Information may have been updated by the health plan due to changing conditions. MSD will revise as updates are received.

[Back to Top](#)

Revised 6-18-20