Medical Society of Delaware

LEADING THE WAY TO A HEALTHY DELAWARE

Telemedicine Support Guidelines for COVID-19

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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

Through December 31, 2020, Aetna has extended all member cost-sharing waivers for covered in-network telemedicine visits for outpatient behavioral and mental health counseling services for their Commercial Plans. Self-insured plans offer this waiver at their own discretion.[1] Cost share waivers for any in-network covered medical or behavioral health services telemedicine visit for Aetna Student Health plans are extended until December 31, 2020.

Through December 31, 2020, Aetna is waiving cost shares for all Medicare Advantage plan members for in-network primary care and specialist telehealth visits, including outpatient behavioral and mental health counseling services. 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® general medical care virtual visits. Cost sharing will also be waived for covered real-time virtual visits offered by in-network providers (live videoconferencing or telephone-only telemedicine services). Medicare Advantage members may use telemedicine for any reason, not just COVID-19 diagnosis.[2]

Medicaid providers are encouraged to check with their state Medicaid agency for more information on regulations pertaining to telehealth guidelines.

Aetna reimburses all providers for telemedicine at the same rate as in-person visits including behavioral services, with the exception of some telephone-only services in commercial plans. Telephone only services 99441 – 99443 are now set to equal 99212 – 99214 (e.g. 99441 is set to equate to 99212). This change will remain in effect until further notice.

Please note, for telephone only codes (98966-98968, G2010, G2012) there are reimbursement rates in the fee schedule that are not the same as E&M office visits 99201- 99215.
Given those telephone only codes do not equate to an office visit, they will not result in an office visit reimbursement rate.

Visit https://www.aetna.com/health-care-professionals/covid-faq/telemedicine.html

[1]*Or as specified by state or federal regulation. Available in select states for select conditions. Other restrictions apply. To receive these services, you will be connected to a trusted third-party provider.*
[2]*Disclaimer: Regulations regarding telehealth services and care package availability for Aetna Medicaid members vary by state and, in some cases, are changing in light of the current situation. Aetna Medicaid members with questions about their benefits are encouraged to call the member services phone number on the back of their ID cards.*

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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 that they have extended customer cost-share waivers and other administrative benefits through at least October 31, 2020. They have also extended their interim virtual care and eConsult guidelines through at least December 31, 2020.
Cigna announced that they will:

- Waive customer cost-sharing related to COVID-19 screening, testing and treatment
- Waive customer cost-sharing for telehealth screenings for COVID-19
- Make it easier for customers to be treated virtually for routine medical examinations by providers
- Provide free home delivery of up to 90-day supplies for Rx maintenance medications available through the Express Scripts Pharmacy and 24/7 access to pharmacists
- Make it easier for hospitals to transfer patients to long term acute care hospitals (LTACHs), skilled nursing facilities (SNFs), and acute rehabilitation facilities (AR) to help manage the demands of increasingly high volumes of COVID-19 patients
- Support Cigna doctors and nurse practitioners who wish to support their medical communities
- Support customers with a free, interactive, COVID-19 risk assessment tool

Cigna Reimbursement and Billing Guidance

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.

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**.

Telemedicine Support Guidelines for COVID-19

CMS – Medicare Cont.

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.

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).

Telemedicine Support Guidelines for COVID-19

CMS – Medicare Cont.

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: • 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.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 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 announced on September 2, 2020, that it is extending a waiver of cost-sharing – such as deductibles, coinsurance and copays — for members who require in-network, inpatient hospital care for COVID-19 through Dec. 31. In May, the health insurer announced that the waiver would continue through the end of September. Self-funded employer groups for which Highmark administers benefits may, however, opt-out of this waiver.

Highmark is also extending a waiver of telehealth services through Dec. 31. The waiver for in-network telehealth visit cost-sharing will also be extended through Dec. 31. As with COVID-19 treatment, self-funded employer groups for which Highmark administers benefits may also opt-out of this waiver.

Highmark's Medicare Advantage members will have no cost-sharing for inpatient hospital care for COVID-19 and telehealth visits for both in- and out-of-network care through Dec. 31.
For more information, visit https://hbs.highmarkprc.com/COVID-19/Telemedicine-and-Virtual-Visits

- Access
- Coding / Billing / Reimbursement
- Member Coverage

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

United Healthcare

Effective September 28, 2020, UnitedHealthcare updated a number of temporary provisions that were established as part of the COVID-19 response. Here's a high-level summary of the changes:

Updates to Telehealth Originating Site Requirements

- **Individual and fully insured Group Market health plans:** For Individual and fully insured Group Market health plans, there are changes related to COVID-19 and non-COVID-19 visits, as well as for in- and out-of-network providers. You'll also find state-specific rules, regulations and emergency periods on the State Provision Exception page at UHCprovider.com/covid19. These may vary from federal regulations. If no state-specific exceptions apply, UnitedHealthcare guidelines will apply.
    - **COVID-19 and non-COVID-19 in-network telehealth visits:** The expansion of telehealth access is extended through Dec. 31, 2020. This means health care professionals can temporarily provide telehealth services by a live interactive audio-video or audio-only communications system for members at home or another location. For more details on telehealth billing guidance and provider type eligibility, visit UHCprovider.com/covid19.

Telemedicine Support Guidelines for COVID-19

United Healthcare Cont.

- **COVID-19 out-of-network telehealth visits:** The expansion of telehealth access for out-of-network providers ends Oct. 22, 2020. As of Oct. 23, 2020, out-of-network telehealth services are covered according to the member's benefit plan and UnitedHealthcare's telehealth reimbursement policy.
- **Non-COVID-19 out-of-network telehealth visits:** The expansion of telehealth access for out-of-network providers ended July 24, 2020. As of July 25, 2020, out-of-network telehealth services are covered according to the member's benefit plan and UnitedHealthcare's telehealth reimbursement policy.

- **Medicare Advantage:**
  - **COVID-19 and non-COVID-19 in-network telehealth visits:** The expansion of telehealth access is extended through Dec. 31, 2020. Any originating site requirements that apply under Original Medicare are temporarily waived, so that telehealth services provided through live interactive audio-video can be billed for members at home or another location.
  - **COVID-19 out-of-network telehealth visits:** The expansion of telehealth access is extended through the national public health emergency period, currently scheduled to end Oct. 22, 2020.
  - **Non-COVID-19 out-of-network telehealth visits:** The expansion of telehealth access is extended through the national public health emergency period, currently scheduled to end Oct. 22, 2020.
- **Medicaid:** State regulations apply. Please refer to your state-specific website.

Updates to Temporary Cost Share Waivers
All telehealth non-COVID-19 temporary cost share waivers will end on Sept. 30, 2020 for Medicare Advantage and Individual and fully insured Group Market health plans. After that date, benefits for those services will be adjudicated according to the member's benefit plan. Any payment made to care providers will be based on that benefit determination. Members will be responsible for any copay, coinsurance and deductible.

In addition, cost share waivers for Medicare Advantage primary and specialty care office visits will end as of Sept. 30, 2020. Beginning Oct. 1, 2020, cost sharing will be adjudicated in accordance with the member's benefit plan.

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.

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