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Preliminary Guidance on Telehealth

Telehealth Guidance: Medicaid

- Telehealth allows providers to deliver services to individuals remotely so that providers can monitor and address health conditions. This can be done through "Interactive Telehealth Services," (ITS) which are real time, interactive visual and audio telecommunications; or services conducted telephonically when Interactive Telehealth Services are unavailable.
- Telehealth can be used to satisfy the MaineCare face-to-face requirements when telehealth delivery of the service is of comparable quality to in-person service delivery.
- MaineCare is waiving the requirement for comparable quality on a service by service basis, subject to Department approval (This is done on a case by case basis by contacting MaineCare directly.) In addition, the federal government is allowing for a relaxation of enforcement of HIPAA requirements during the state of emergency, enabling providers to use platforms such as FaceTime, Skype and Zoom, etc., for interactive telehealth services.

- There can be many reasons ITS may not be available, including but not limited to:
  - The member does not have an internet connection.
  - The member does not have a cellular data plan sufficient to support the use of cellular internet.
  - The member does not have an ability to connect to interactive video chat software.
  - The member cannot be transported to an originating site where Interactive Telehealth Services are available and any of the above barriers are present.
- Prior Authorization (PA) is only required for Interactive Telehealth Services if a PA is required for the underlying covered service.
- The same procedure codes and rates apply to telehealth delivery of the underlying covered service as if those services were delivered face-to-face. When billing for Interactive Telehealth Services, health care providers at the Receiving (provider) Site should bill for the underlying covered service using the same process they would if it were delivered face-to-face, with the addition of a GT modifier to the claim**.**
- If a health care provider at an Originating Site is not providing clinical services but is making a room and telecommunications equipment available, that health care provider may bill MaineCare for an originating facility fee using code Q3014 for the service of coordinating the telehealth service. For services occurring in a person's home, there is no originating site and this code should not be billed.
- Telephone Evaluation & Management services are not considered to be "telehealth visits," but instead are intended to be used by providers to conduct a brief medical discussion via telephone (5-30 mins, per codes below) with an existing patient to evaluate new complaints, symptoms, or issues that can be appropriately managed through a phone conversation. Examples might include evaluation of an existing patient's new symptom or complaint and providing recommendations for treatment that do not require an urgent visit. This is what Medicare refers to as a virtual visit is essential equivalent to a triage call. Relevant CPT codes are: 99441: Telephone evaluation and management service; 5-10 minutes of medical discussion; 99442: 11-20 minutes of medical discussion; 99443: 21-30 minutes of medical discussion This should not be billed if the telephone call follows an office visit performed and reported within the past seven (7) days for the same diagnosis, then the telephone services are considered part of the previous office visit or if the clinical decision-making dictates a need to see the member for an office visit within 24 hours or at the next available appointment.
- Co-payments are waived.

https://www.maine.gov/dhhs/oms/pdfs_doc/COVID-19/03232020-Telehealth-Guidance.pdf

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Telehealth Guidance: Medicare

- Medicare pays for specific (Part B) physician or practitioner services furnished through a telecommunications system. Telehealth services substitute for an in-person encounter.
- Submit telehealth services claims, using Place of Service (POS) 02-Telehealth (FFS claims only), to indicate you furnished the billed service as a professional telehealth service from a distant site.
- **HCPCS Code Q3014** describes the Medicare telehealth originating sites facility fee. Bill your MAC for the separately billable Part B originating site facility fee.
- In the 2019 Physician Fee Schedule (PFS) Final Rule, CMS finalized a policy that, effective January 1, 2019, RHCs and FQHCs can receive payment for virtual communication services when at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC or FQHC practitioner to a patient who has had an RHC or FQHC billable visit within the previous year, and both of the following requirements are met:
  - The medical discussion or remote evaluation is for a condition not related to an RHC or FQHC service provided within the previous 7 days, and
  - The medical discussion or remote evaluation does not lead to an RHC or FQHC visit within the next 24 hours or at the soonest available appointment.
- Telehealth services require use of interactive audio and digital telecommunication systems that permit real-time communication between the practitioner at the distant site and the beneficiary at the originating site. The communication technology-based and remote evaluation services are not a substitute for a visit, but are instead brief discussions with the FQHC practitioner to determine if a visit is necessary. If the discussion between the FQHC practitioner and the Medicare beneficiary results in a billable visit, then the usual FQHC billing would occur. The virtual communication G-code would only be separately payable if the discussion between the FQHC practitioner does not result from or lead to an FQHC billable visit. The payment rate for communication technology-based services are valued based on the shorter duration of time and the efficiencies associated with the use of communication technology.
- Virtual communication services would be initiated by the patient contacting the FQHC by a telephone call, integrated audio/video system, or through a store and-forward method such as sending a picture or video to the FQHC practitioner for evaluation and follow up within 24 hours. The FQHC practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.
- An originating site may bill Medicare a facility fee using code Q3014. If the originating site is the home, no facility fee may be billed.
- For synchronous telehealth services in Medicare, a POS 02 must go on the bill. The POS used when the services are not synchronous is where the service took place at the time of the encounter.
- Currently the same co-insurance and deductible rules apply.

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

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Telehealth Guidance
Medicare Coding for Telehealth

Summary of Medicare Telemedicine 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.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

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Telehealth Guidance
Private Insurers

Anthem:

Will Anthem waive member cost shares For COVID-19 testing and visits associated with COVID-19 testing?
Anthem Affiliated health plans will waive cost shares for fully- insured employer, individual, Medicare and Medicaid plan Members—inclusive of copays, coinsurance and deductibles—for COVID-19 test and visits to get the COVID-19 test are waived. Tests samples may be obtained in many settings including a doctor's office, urgent care, ER or even drive-thru testing once available. While a test sample cannot be obtained through a telehealth visit, telehealth providers can help get to a provider who can do so. The waivers apply to members who have individual, employer-sponsored, Medicare and Medicaid plans.

What services are appropriate to provide via telehealth?

- Anthem covers telehealth (i.e., video + audio) services for providers who have access to those platforms/capabilities today.
- Effective March 17, 2020, Anthem's affiliated health plans will waive member cost share for telehealth (video + audio) visits, including visits for mental health or substance abuse disorders, for our fully insured employer plans, Individual plans, Medicare plans and Medicaid plans where permissible for 90 days. Cost sharing will be waived for members using Anthem's telemedicine service, LiveHealth Online, as well as care received from other providers delivering virtual care through internet video + audio services. Self-insured plan sponsors may opt out of this program.

Will Anthem cover telephone- only services in addition to telehealth via video + audio?
Anthem does not cover telephone-only services today (with limited state exceptions) but we are providing this coverage for 90 days effective March 19, 2020, to reflect the concerns we have heard from providers about the need to support continuity of care for members during extended periods of social distancing. Anthem will cover telephone-only medical and behavioral health services from in-network providers and out-of-network providers when required by state law. Anthem will waive associated cost shares for in-network providers only except where a broader waiver is required by law. Exceptions include chiropractic services, physical, occupational, and speech therapies. These services require face-to-face interaction and therefore are not appropriate for telephone-only consultations. Self-insured plan sponsors may opt out of this program.

What codes would be appropriate to consider for a telehealth visit with a patient who wants to receive health guidance related to COVID-19?
Submit Telehealth with the CPT code for the service rendered, Place of Service Code (POS) "02", and append either modifier "95" or "GT."

What member cost-shares will be waived by Anthem affiliated health plans for virtual care through internet video + audio or telephonic-only care?
Effective March 17, 2020, Anthem's affiliated health plans will waive member cost share for telehealth (video + audio) visits, including visits for behavioral health, for our fully insured employer plans, Individual plans, Medicare plans and Medicaid plans where permissible for 90 days. Cost sharing will be waived for members using Anthem's telemedicine service, LiveHealth Online, as well as care received from other providers delivering virtual care through internet video + audio services. Self-insured plan sponsors may opt out of this program.

Effective March 19, 2020, Anthem will cover telephone-only medical and behavioral health services from in-network providers and out-of-network providers when required by state law for 90 days. Anthem will waive associated cost shares for in-network providers only except where a broader waiver is required by law. Exceptions include chiropractic services, physical, occupational, and speech therapies. These services require face-to-face interaction and therefore are not appropriate for telephone-only consultations. Self-insured plan sponsors may opt out of this program.

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Humana:
Humana will waive out-of-pocket costs associated with testing for COVID-19 for patients who meet CDC guidelines at approved laboratory locations. This will apply to Humana's Medicare Advantage, Medicaid and commercial employer-sponsored plans. Self-insured plan sponsors will be able to opt-out of the program at their discretion. The CDC continues to offer free testing for coronavirus.

The company is also announcing the following resources for its members:

- **Telemedicine costs waived for all urgent care needs for next 90 days –** To help reduce the risk of infection and spread of disease, Humana is encouraging members to use telemedicine (e.g., video chat) as a first line of defense for all urgent care needs. The company will waive costs for telemedicine visits for urgent care needs for the next 90 days. This will apply to Humana's Medicare Advantage, Medicaid and commercial employer-sponsored plans and is limited to in-network providers delivering synchronous virtual care (live video-conferencing). Self-insured plan sponsors will be able to opt-out of the program at their discretion. Humana is working closely with federal agencies to understand the impacts of both telemedicine and the coronavirus test on High Deductible Health Plans and Health Savings Accounts.
- **Early prescription refills allowed for next 30 days –** The company is allowing early refills on prescription medicines so members can prepare for extended supply needs—an extra 30- or 90-day supply as appropriate.

Molina:
- Molina will waive co-pays and cost share for the diagnostic laboratory test for COVID-19 until May 1, 2020. (If the outbreak continues please monitor our provider notifications for potential extension of this policy). This policy will cover the test kit for patients who meet CDC guidelines for testing, which can be done in any approved laboratory location. Molina will waive the member costs associated with this diagnostic testing for COVID-19 at any authorized location for all Medicare, Marketplace, and Medicaid lines of business. No Prior Authorization is needed for this testing.
- Molina will offer zero co-pay and cost share for participating (PAR) telemedicine visits (where these are a covered benefit) - for any diagnosis until May 1, 2020. (If the outbreak continues please monitor our provider notifications for potential extension of this policy). Molina members should use telemedicine as their first line of defense in order to limit potential exposure in physician offices. Cost sharing will be waived for all video visits by in-network providers delivering synchronous virtual care (live video-conferencing) for those plans that cover this type of service.
- Molina will waive co-pays and cost share for office visits, urgent care visits, and ED visits where the diagnosis rendered is specifically related to COVID-19 until May 1, 2020. (If the outbreak continues please monitor our provider notifications for potential extension of this policy). Visits for other symptoms or diagnoses will not have co-pay or cost share removed. This includes not removing cost share for other laboratory testing (besides COVID-19 testing), x-rays, or other add-on testing.
- Molina will relax refill timing on all prescriptions until May 1, 2020. (If the outbreak continues please monitor our provider notifications for potential extension of this policy). Under FL Law, once a Declaration of Emergency Order is issued, prescription refill timing is relaxed to allow members refills as necessary up to a 30-Day supply.

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Private Insurers

United HealthCare:

Through June 18, 2020, eligible medical care providers who have the ability and want to connect with their patient through synchronous virtual care (live video-conferencing) can do so. Benefits will be processed in accordance with the member's plan.

UnitedHealthcare will waive the Centers for Medicare and Medicaid's (CMS) originating site restriction for Medicare Advantage, Medicaid and commercial members, so that eligible care providers can bill for telehealth services performed while a patient is at home.

This policy change applies to members whose benefit plans cover telehealth services, and will allow those patients to connect with their doctor through audio/video visits. Member cost sharing will be waived for COVID-19 testing-related visits during this national emergency.

UnitedHealthcare will also reimburse care providers for telephone calls to existing patients, as described within each of the sections below.

- For all UnitedHealthcare commercial plans, any originating site requirements that may apply under UnitedHealthcare reimbursement policies are waived, so that telehealth services provided via a real-time audio and video communication system can be billed for members at home or another location. UnitedHealthcare will reimburse telehealth services that are:
    - Recognized by CMS and appended with modifiers GT or GQ and,
    - Recognized by the American Medical Association (AMA), included in Appendix P of CPT® and appended with modifier 95. Reimbursable codes can be found embedded in the reimbursement policy at **Telehealth and Telemedicine PolicyOpens in a new window**.

- For all UnitedHealthcare Medicare Advantage plans, including Dual Eligible Special Needs Plans, any originating site requirements that may apply under Original Medicare are waived, so that telehealth services provided via a real-time audio and video communication system can be billed for members at home or another location. All CPT/HCPCS codes, payable as telehealth when billed with Place of Service 02 and the GQ or GT modifiers, as appropriate, under Medicare, will be covered on our Medicare Advantage plans for members at home during this time. Standard plan copays, coinsurance and deductibles will apply. Codes that are payable as telehealth under Medicare Advantage can be found here: **cms.govOpens in a new window**

- Our commercial and Medicare Advantage plans currently reimburse for "virtual check-in" patients to connect with their doctors remotely. These services are for established patients, not related to a medical visit within the previous 7 days and not resulting in a medical visit within the next 24 hours (or soonest appointment available). These services can be billed when furnished through several communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

- UnitedHealthcare will reimburse for patients to communicate with their doctors using online patient portals, using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. Our Medicare Advantage, Medicaid and commercial plans currently reimburse for "e-visits" for patients to connect with their doctors remotely. These services are for established patients, not related to a medical visit within the previous 7 days and not resulting in a medical visit within the next 24 hours (or soonest appointment available).

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Telehealth Guidance
Private Insurers

Harvard Pilgrim:

Due to the temporary coronavirus (COVID-19) pandemic, beginning as of dates of service March 6, 2020 Harvard Pilgrim will not impose specific requirements on the type of technology that is used to deliver services (including any limitations on audio-only or live video technologies). This will support the diagnosis and treatment of COVID-19, as well as minimize exposure to members that require clinically appropriate, medically necessary covered services for other conditions during this pandemic. These changes will be in place until further notice. It would not be appropriate to report a telephone only (telehealth) service that requires face-to-face interaction.
Services may be reimbursed when all the following conditions are met:
• Services rendered are clinically appropriate, medically necessary covered services.
• The components of any evaluation and management services (E&M) provided via the telemedicine technologies includes at least a problem focused history and straight forward medical decision making, as defined by the current version of the Current Procedural Terminology (CPT) manual.
• Providers performing and billing telemedicine/telehealth services are eligible to independently perform and bill the equivalent face-to-face service.
• The encounter satisfies the elements of the patient-provider relationship, as determined by the relevant healthcare regulatory board of the state where the patient is physically located.
• The service is conducted and a permanent record of online communications relevant to the ongoing medical care and follow-up of the patient is maintained as part of the patient's medical record.
• Services are filed with the appropriate modifiers and place of service codes. (See Billing Guidelines.)

Harvard Pilgrim Does Not Reimburse
• Separately filed services incidental to an E&M, counseling, or medical services covered by this policy. Examples include ,but are not limited to:
- Reporting of test results
- Provision of educational materials
- Administrative matters, including but not limited to, scheduling, registration, updates to billing information, reminders, and requests for medication refills or referrals or ordering of diagnostic studies.
• A Telemedicine/Telehealth service that occurs the same day as a face-to-face visit when performed by the same provider for the same condition.
• Telemedicine/Telehealth E&M services that are performed on the same day as a surgical procedure, unless it is a significant and separately identifiable service, or it is above and beyond the usual preoperative and postoperative care associated with the procedure.
• Telehealth transmission, per minute.

As telemedicine/telehealth visits aid in limiting the spread of coronavirus, Harvard Pilgrim is waiving member cost-sharing for all telemedicine services (not only COVID-19 services) including copayments, deductibles and coinsurance. This applies for services delivered by both in- and out-of-network providers.
Harvard Pilgrim reimburses services to contracted providers when the service is a covered benefit. Benefits may vary greatly among employer groups. For benefit determination, call the Provider Service Center at 800-708-4414.

During the COVID – 19 pandemic and beginning for dates of service on or after 3/6/2020, Harvard Pilgrim will accept and reimburse for telehealth services when performed via asynchronous or synchronous technology.
• All telemedicine/telehealth must be reported with POS 02 (Telehealth is the location where health services and health related services are provided or received, through a telecommunication system.) Appropriate modifiers will continue to be accepted.
• All telemedicine services may be filed with either modifier GT (via interactive audio and video telecommunications system) or modifier 95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunication system) appended to the appropriate code.

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• All telehealth services may be filed with either modifier GO (Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke) or modifier GQ (Via asynchronous telecommunications system) appended to the appropriate code.

List of codes available in PDF: https://mepca.org/telehealth/

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Telehealth Guidance
Private Insurers

Community Health Options:

Telemedicine and telehealth are used interchangeably within this policy as defining healthcare services provided to the patient by a qualified healthcare professional, both of which are at different locations while using interactive electronic communications systems. Telemedicine services are covered when all the following criteria are met:

- Service is medically appropriate and necessary
- Healthcare provider performing and billing the services is eligible to independently perform and bill the same service face to face. Telehealth is used as a substitute for face to face services at the same location within Health Options scope of coverage
- Telecommunication system complies with standards required under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Claim reports the place of service "02" to identify "distant site"
- Claim includes appropriate telehealth Current Procedure Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code and any applicable modifier. Approved codes are listed on the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- Approved originating site

Originating site is the location of the beneficiary at the time the service is furnished. CMS defines approved originating sites as:

- A county outside of a Metropolitan Statistical Area (MSA)
- A rural Health Professional Shortage Area (HPSA) located in a rural census tract

In addition, sites that participate in a federal telemedicine demonstration program qualify as originating sites in most cases:

  - Physicians or practitioner offices
  - Hospitals
  - Critical access hospitals (CAHs)
  - Rural health clinics
  - Federally qualified health centers (FQHCs)
  - Hospital-based or CAH-based renal dialysis centers (including satellites)
  - Skilled nursing facilities
  - Community mental health centers

Telemedicine/telehealth services that do not utilize real time interactive telecommunications equipment with audio and video capabilities for two-way communication between the member and distant site provider are not covered. Additionally, provider to provider consultation services regarding patient care is not covered.

Coverage exceptions during a National Pandemic/State Emergency situation allows Telehealth services between a provider and a member when real time interactive Telehealth equipment, as described above, is not available and the telehealth service is medically appropriate for the underlying covered service. These exceptions will cover services when members may prefer not to get a health service in-person, or if a member is under restrictions that limit their ability to make an in-person visit. The originating site requirement would be waived under this exception; allowing services to be performed from a member's residence (via telephone, internet capable video/audio system, or patient portal) with a distant site healthcare provider. All Medicare claims billing guidelines continue to apply for appropriate claims reimbursement.