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.

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Aetna

How long are Aetna's liberalized coverage of telemedicine services and cost share waivers in effect? (As of 2/3/2021)
Aetna's liberalized coverage of Commercial telemedicine services, as described in its telemedicine policy, will continue until further notice.[5]

All member cost-sharing waivers for covered in-network telemedicine visits for outpatient behavioral and mental health counseling services for Commercial plans are active until January 31, 2021.[6] Aetna self-insured plan sponsors offer this waiver at their discretion.

Cost share waivers for any in-network covered medical and behavioral health services telemedicine visit for Aetna Student Health plans are active until January 31, 2021.

For Individual Aetna Medicare Advantage members, copays are waived for in-network telehealth visits for primary care and behavioral health through March 31, 2021. Cost share waivers for specialist telehealth visits expired on January 31, 2021 for all Medicare Advantage members. A telehealth visit with a specialist provider will now result in the same cost share as an in-person office visit.

Please refer to the Telemedicine policy for services covered.
[5,6]Or as specified by state or federal regulation.

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

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.
Visit **https://www.amerihealthcaritasde.com/assets/pdf/covid-19/covid-19-telehealth-faq.pdf**

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Cigna

Current interim coverage accommodations for commercial Cigna medical services:

- The cost-share waiver for COVID-19 diagnostic testing and related office visits is in place until the end of Public Health Emergency (PHE) period, currently through April 20, 2021.
- The cost-share waiver for COVID-19 related treatment was in place through February 15, 2021 dates of service. As of February 16, 2021 dates of service, cost-share applies for any COVID-19 related treatment. Inpatient COVID-19 care that began on or before February 15, 2021, and continued after February 16, 2021, will have cost-share waived for the entire course of the facility stay. Certain client exceptions may apply to this guidance.
- All commercial Cigna plans (e.g., employer-sponsored plans) have customer cost-share for non-COVID-19 services.
- Most other interim accommodations (e.g., for credentialing and authorizations) are in place through March 31, 2021, as outlined on this page.
- The interim COVID-19 virtual care guidelines as outlined on this page were in place for dates of service through December 31, 2020. As of January 1, 2021, Cigna implemented a new Virtual Care Reimbursement Policy to ensure continued reimbursement of virtual care services at face-to-face rates. Please visit **CignaforHCP.com/virtualcare** for additional information about this new policy. We also continue to make several additional accommodations related to virtual care through the PHE period. Please review the "Virtual care services" frequently asked questions section on this page for more information.
- Please note that state mandates and customer benefit plans may supersede our guidelines.

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.
See additional information in CMS Toolkit at **https://tinyurl.com/cmstelehealthtoolkit**.

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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).

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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.

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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 March 5, 2021, that members who require in-network, inpatient hospital care for COVID-19 will not have to worry about paying cost-sharing such as deductibles, coinsurance and copays through June 30, 2021. The health insurer had previously made the decision to waive cost-sharing for in-network, inpatient COVID-19 related hospital care through March 31, 2021. Self-funded employer groups for which Highmark administers benefits may, however, opt-out of this waiver.

Highmark is also extending the waiver of cost-sharing for in-network telehealth visits through June 30. 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 also have no cost-sharing for telehealth visits in or out-of-network through June 30, 2021. Additionally, Medicare Advantage members will see no copays for COVID related hospital admissions for the duration of the public health emergency. For more information, visit:

- 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

UnitedHealthcare Exchange, Individual and Fully Insured Employer-sponsored health plans:

- **Cost-share for COVID-19 testing-related telehealth visits**: For COVID-19 testing-related telehealth visits, you will have $0 cost-share with in-network and out-of-network providers through the national public health emergency period, currently scheduled to end April 20, 2021.
- **Cost-share for COVID-19 treatment via telehealth visits:** Coverage for in-network and out-of-network telehealth services related to COVID-19 treatment will be determined by your benefit plan. You will be responsible for any copay, coinsurance or deductible.
- **Coverage for telehealth visits not related to COVID-19:** Members may have telehealth visits from their home with their network providers. Coverage for in-network and out-of-network telehealth visits not related to COVID-19 will be determined by your benefit plan. You will be responsible for any copay, coinsurance or deductible.

UnitedHealthcare Medicare Advantage plans:

- **Cost-share for COVID-19 testing-related telehealth visits:** For COVID-19 testing-related telehealth, you will have $0 cost-share for in-network and out-of-network visits through the national public health emergency period, currently scheduled to end April 20, 2021.
- **Cost-share for COVID-19 treatment via telehealth visits:** For COVID-19 treatment via telehealth, you will have $0 cost-share for in-network and out-of-network visits through Mar. 31, 2021.
- **Expanded access for telehealth visits not related to COVID-19:** For in-network and out-of-network providers, you will have expanded access to telehealth through the national public health emergency period, currently scheduled to end April 20, 2021.
  Cost-share for telehealth visits not related to COVID-19 will be determined by your benefit plan. Most UnitedHealthcare Medicare Advantage plans have $0 copays for covered telehealth services. Check your plan materials for details on any copayment, coinsurance or deductible.

Medicaid health plans: For individuals enrolled in UnitedHealthcare Community Plans, state variations and regulations may apply during this time. Please review the **UnitedHealthcare Community Plan website** and your state's site for the latest applicable information. If no state-specific exceptions apply, traditional UnitedHealthcare plan guidelines will apply.

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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Revised 3-4-21