MEDICARE

Published on December 1, 2020, CMS's CY 2021 PFS Final Rule expands coverage of Medicare telehealth services in several ways. The regulation finalizes policy which will result in Medicare covering 251 types of telehealth services as of January 1, 2021. These services fall into three groups, based on when Medicare coverage of these services is due to expire.

- First, CMS added several services permanently to its Medicare telehealth services list (Group A in the table below). This group represents 45 percent of the telehealth services (112 services) that will be covered by CMS on January 1 and includes services such as standard evaluation and management visits, group psychotherapy, neurobehavioral status exams, and short home visits. The majority of Medicare telehealth visit volume that is likely to occur will be in this group.
- Second, CMS will cover many services conducted via telehealth on a temporary basis until December 31, 2021 (Group B). This group represents 23 percent (57 services) of all telehealth services covered on January 1 and includes services such as emergency department visits (all levels), physical therapy, occupational therapy, and speech pathology. CMS's rationale for covering these services on a temporary basis is to gather data to assess if these services should be covered on a permanent basis starting in 2022.
- Third, CMS will cover a large group of telehealth services only until the PHE expires (Group C). This group represents 33 percent (82 services) of all telehealth services covered on January 1 and includes services such as audio-only telehealth visit codes, initial hospital and nursing home visits, and home visits for new patients. Coverage for this group of services will end with the expiration of the PHE (currently set at to January 20, 2021 (HHS)). The extension of the PHE for an additional 90 days beyond January 20, 2021 seems likely given the increase in COVID-19 cases observed in recent weeks.

Medicare telehealth service group	Share of services covered on January 1, 2020	Coverage expiration	Consequence of the expiration of the Public Health Emergency (PHE)
Group A: Permanently covered	45 percent (112 services)	None	Visits originating from the patient's home and urban areas will not be covered. Audio-only visits will not be covered.
Group B: Temporarily covered	23 percent (57 services)	12/31/21 (or later if PHE extends into 2022)	
Group C: PHE covered	33 percent (82 services)	End of PHE (currently 1/20/21)	Not covered

While Medicare telehealth service Group C will cease to be covered after the PHE expires, the expiration of the PHE will have other critical implications for service Groups A and B. For services in Groups A and B the expiration of the

PHE will end the ability of providers and patients to conduct all of these services via audio-only communication, from the patient's residence, and from locations in urban areas. These three Medicare telehealth limitations are written into statute at section 1834(m) of the Social Security Act, and CMS lacks the statutory authority to modify them. It was only through its waiver authority under section 1135 of the Social Security Act that CMS could temporarily remove these limitations during the PHE. Therefore, removing these three limitations to Medicare telehealth coverage requires Congress to pass legislation modifying section 1834(m) of the Social Security Act.

CMS also finalized in its recent regulation coverage enhancements for other Medicare virtual care services, such as remote patient monitoring (RPM) in patients' homes and quick clinical visits described as communications technology-based services (CTBS). While neither of these services are bound by the limitations of section 1834(m) discussed above, CMS's policy changes are expected to remove some of the barriers providers face in offering RPM and CTBSs to their patients. For RPM services, CMS will permit patient consent to be obtained at the time of service delivery and will permit auxiliary clinical personnel to provide RPM services. For CTBSs, CMS created a new billing code (G2252) for longer audio-only visits and will expand the types of clinicians eligible to bill CTBSs (e.g., physical and occupational therapists, and licensed clinical social workers).

Finally, CMS finalized policies which will increase opportunities to use telehealth services in the context of physician incident-to billing and in nursing facilities. For 2021, CMS enabled physicians to provide direct supervision of other clinical staff if they are immediately available to engage via interactive audio-video. In addition, CMS reduced the frequency limit for coverage of subsequent nursing facility care services furnished via telehealth from once every 30 days to once every 14 days.

Collectively, CMS's recent telehealth policy decisions are likely to increase the use of telehealth services within the Medicare program. However, the extent of this increase is heavily dependent upon the date of which the PHE expires. After the PHE ends, some forms of telehealth service use are likely to recede unless Congress acts to modify section 1834(m) of the Social Security Act. Telehealth advocates are likely to be pleased by the potential service use increase, but will also be frustrated by the potential loss of audio-only services, visits from patients' homes, and visits from urban areas when the PHE expires. The instability of Medicare's coverage of telehealth services may create significant barriers to the adoption and use of telehealth services, particularly in urban areas. While CMS will continue to play a central role in future expansion of Medicare telehealth

coverage, the U.S. Congress largely holds the key to expanding Medicare telehealth coverage at this time.

1. Direct Supervision via Telehealth

Until December 31, 2021, or the end of the PHE (whichever is later), "direct supervision" under 42 C.F.R. § 410.21 can be provided using real-time, interactive audio-video technology.

The current definition of direct supervision requires the physician to be physically present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. Under the new definition, direct supervision can be met if the supervising physician is immediately available to engage via interactive audio-video. This change does not require the physician's real-time presence or observation of the service via interactive audio-video technology throughout the performance of the procedure. Audio-only technology is not sufficient to fulfill direct supervision requirements.

The new definition opens opportunities for telehealth and incident-to billing. CMS acknowledged there are no Medicare regulations that explicitly prohibit eligible distant site practitioners from billing for telehealth services provided incident-to their services. But because the current definition of direct supervision required on-site presence of the billing clinician when the service was provided, it was difficult for a billing clinician to fulfill direct supervision of services provided via telehealth incident-to their professional services by auxiliary personnel. Under the new definition, CMS clarified that services that can be provided incident-to may be provided via telehealth incident-to a distant-site physician's service and under the direct supervision of the billing practitioner via virtual presence.

The duration of this change is time-limited because CMS has concerns that widespread direct supervision through virtual presence may not be safe for some clinical situations and overutilization could occur. CMS will study and collect data on whether this change may be appropriate on a permanent basis after the PHE expires.

2. Extended Audio-Only Assessment Services

On an interim basis, for the duration of 2021, CMS created HCPCS code G2252 for extended services delivered via synchronous communications technology, including audio-only (e.g., virtual check-ins). The service is considered to be a communication technology-based service (CTBS) and is subject to all the other requirements of CTBS.

- G2252 (*Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related 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; 11-20 minutes of medical discussion.*)

G2252 is cross-walked to CPT code 99442 for reimbursement purposes, making its reimbursement higher than the current more limited duration virtual check-in code. The code is intended for situations when the acuity of a patient's problem is not necessarily likely to warrant an in-person visit, but when additional time is needed to make this assessment. Because it is a CTBS, the traditional Telehealth Service location restrictions do not apply, which in part means G2252 can be used regardless of the patient's geographic location and regardless of whether the PHE ends prior to the end of CY2021. Thus, while the audio only telehealth codes currently approved subject to Section 1135 PHE waivers may only be used during the PHE, this code would extend beyond the PHE. The communication technology must be synchronous and is subject to the same billing requirements as the other virtual check-in codes. CMS will consider whether this interim policy should be adopted permanently.

3. New Frequency Limitations for Telehealth in Nursing Facilities

CMS is reducing the frequency limitation for coverage of subsequent nursing facility care services furnished via telehealth from once every 30 days to once every 14 days. The original 30-day restriction was due to concerns on the acuity and complexity of nursing facility residents, and to ensure nursing facility residents have frequent encounters with their admitting practitioner. CMS was persuaded that the use of telehealth is crucial to maintaining continuity of care in nursing facilities, and to honor the independent medical judgment of treating clinicians to decide whether telehealth vs in-person care should be used, depending on the needs of each specific resident.

Frequency limitations have already been temporarily waived for the duration of the PHE, but this new rule change is permanent, effective January 1, 2021.

CMS declined to make any changes to the telehealth frequency limitations for hospital inpatient visits and critical care consultations.

4. Policies on Communications Technology Based Services

- CTBS by Therapists. HCPCS codes G2061 through G2063 may be billed by licensed clinical social workers, clinical psychologists, physical therapists (PT), occupational therapists (OT), speech language pathologists (SLP), and other non-physician practitioners who bill Medicare directly for their services, when the service falls within the scope of the practitioner's benefit category. This billing has been temporarily allowed under the PHE waivers, but this new rule change is permanent, effective January 1, 2021. To facilitate billing of CTBS by therapists, CMS designated HCPCS codes G2250, G2251, G2061, G2062, and G2063 as "sometimes therapy" services. When billed by a private practice PT, OT, or SLP, the codes would need to include the corresponding -GO,

-GP, or -GN therapy modifier to signify the CTBS is furnished as therapy services furnished under an OT, PT, or SLP plan of care.

- CTBS by Practitioners Who Do Not Bill E/M. CTBS billing is being extended to other non-physician practitioners through two new "G codes" that can be billed by practitioners who cannot independently bill for E/M services.
    - G2250 *(Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the CMS-1734-P 114 patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.)*

    - G2251 *(Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)*

  Reimbursement for these codes will be equal to the reimbursement for G2010 and G2012 which are billed by physicians and other non-physician practitioners who can bill for E/M services. This change is effective January 1, 2021.
- Consent. Practitioners must continue to obtain patient consent for CTBS (the consent is to notify the patient of copay/cost sharing). CMS stated the timing or manner in which consent is acquired should not interfere with the provision of the service itself. The consent can be verbal or written, and can be documented by the billing practitioner or by auxiliary staff under general supervision.

- Compliance Tip. When a brief CTBS originates from a related E/M service (including one furnished as a telehealth service) provided within the previous 7 days by the same physician or other qualified health care professional, this service is considered bundled into that previous E/M service and is not separately billable to Medicare or to the beneficiary (i.e., it is a provider-liable service).

5. New Telehealth Services For 2021

Starting January 1, 2021, the following codes will be available on a permanent basis as part of the covered Medicare telehealth services list:

Service Type	HCPCS Code	Service Descriptor
Visit Complexity Associated with Certain Office/Outpatient E/Ms	G2211 (formerly GPC1X)	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing

		care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to an evaluation and management visit, new or established)
Prolonged Services	G2212 (formerly 99XXX)	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)
Group Psychotherapy	90853	Group psychotherapy (other than of a multiple-family group)
Neurobehavioral Status Exam	96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)
Care Planning for Patients with Cognitive Impairment	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (e.g., home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of

		caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.
Domiciliary, Rest Home, or Custodial Care services	99334	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. 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 self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.
Home Visits	99347	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. 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 self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
	99348	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low 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 low to moderate severity. Typically, 25 minutes are spent face-to-face with the

		patient and/or family.

CMS classified these services as Category 1 under a streamlined review process based on their determination these services are sufficiently similar to services already on the list of Medicare telehealth services. For codes 99437-99438, the patient's home can serve as a qualifying originating site when the patient is being treated for a substance use disorder or a co-occurring mental health disorder, as permitted by the SUPPORT Act.

CMS also finalized its proposal to allow all Category 3 telehealth services added to the Medicare telehealth list during the public health emergency (PHE) for the COVID-19 pandemic to remain on the list through the calendar year in which the PHE ends. These Category 3 services include the following:

- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99336-99337)
- Home Visits, Established Patient (CPT 99349-99350)
- Emergency Department Visits, Levels 1-5 (CPT 99281-99285)
- Nursing facilities discharge day management (CPT 99315-99316)
- Psychological and Neuropsychological Testing (CPT 96130- 96133; CPT 96136- 96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161- 97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)
- Hospital discharge day management (CPT 99238- 99239)
- Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT 99469, 99472, 99476)
- Continuing Neonatal Intensive Care Services (CPT 99478- 99480)
- Critical Care Services (CPT 99291-99292)
- End-Stage Renal Disease Monthly Capitation Payment codes (CPT 90952, 90953, 90956, 90959, and 90962)
- Subsequent Observation and Observation Discharge Day Management (CPT 99217; CPT 99224- 99226)

Coverage of other codes added to the covered list during the PHE not within Category 3 or that have not been permanently added to the covered list will expire at the end of the PHE.

Conclusion

Continued expansions in Medicare reimbursement mean providers should make enhancements to telehealth programs now, both for the immediate cost savings and growing opportunities for revenue generation, to say nothing of clinical quality and patient satisfaction. However, providers should be mindful of any sunset provisions on these expansions and be prepared to adjust operations in accordance with those timelines. We will continue to monitor CMS for any rule changes or guidance that affect or improve telehealth opportunities.

HUMANA

Telehealth – Expanding access to care

To support providers with caring for their Humana patients while promoting both patient and provider safety, we have updated our existing telehealth policy. At a minimum, we will always follow Centers for Medicare & Medicaid Services (CMS) telehealth that apply to telehealth coverage for our insurance products. This policy will be reviewed periodically for changes based on the evolving COVID-19 public health emergency and updated CMS or state specific rules[1] based on executive orders. Please refer to the applicable CMS or state-specific regulations prior to any claim submissions, and check this page regularly for the latest information.

- **Temporary expansion of telehealth service scope and reimbursement rules**
  - To ease systemic burdens arising from COVID-19 and support shelter-in-place orders, Humana is encouraging the use of telehealth services to care for its members. Please refer to CMS, state and plan coverage guidelines for additional information regarding services that can be delivered via telehealth.

BCBS AZ

Blue Cross® Blue Shield® of Arizona (BCBSAZ) is continuing its waiver of precertification for transitions to post-acute care facilities, as well as all other emergency waivers and adjustments implemented earlier this year. Our care navigators will respond 24/7 to your calls for assistance in caring for our members.

- Support for Medicare Advantage members: **1-888-905-1172**
- All other Blue Cross Blue Shield customers: **602-864-4320**

TYPE OF WAIVER/ADJUSTMENT	LINE OF BUSINESS	CURRENT TIME FRAME
Concurrent review waiver for inpatient acute care hospitalizations ***Penalties for unscheduled admission notification or precertification are also waived.***	BCBSAZ individual and fully insured plans and all BCBSAZ-administered MA plans (*not* those administered by P3)	**Effective July 3 until further notice** (based on ADHS measures for hospital bed capacity)
Preservice review waiver for all transitions from acute care to post-acute care facilities (SNF/EAR/LTAC) ***You must notify BCBSAZ within 72 hours of admission and send medical records within three days for concurrent review.***	BCBSAZ individual and fully insured plans and all BCBSAZ-administered MA plans (*not* those administered by P3)	**Effective July 3 until further notice** (based on ADHS measures for hospital bed capacity)
Preservice review waiver for post-acute care home nursing visits and DME items	BCBSAZ individual and fully insured plans and BCBSAZ-administered MA plans	**Effective July 3 until further notice** (based on ADHS measures for hospital bed capacity)
Preservice review time frame limit adjustment (these were expanded to be valid for 90 days past the approval date); excludes pharmacy authorizations	BCBSAZ individual and fully insured plans and BCBSAZ-administered MA plans	**Reinstated July 3 until further notice** (based on ADHS measures for hospital bed capacity)
Waiver of three-day prior hospitalization requirement for SNF stays	Medicaid and traditional Medicare	Duration of COVID-19 public health emergency
PCP referral waiver for in-network services related to COVID-19 diagnoses (consistent with CDC guidelines for COVID-19 treatment)	PCP Coordinated Care HMO plans	Duration of COVID-19 public health emergency
PCP referral waiver for all services	BCBSAZ-administered MA plans	Duration of COVID-19 public health emergency
Waiver of early refill limits on 30-day prescriptions for maintenance medications	BCBSAZ-administered MA plans	Duration of COVID-19 public health emergency
Preservice review waiver for COVID-19 testing and treatment (consistent with CDC guidelines)	ALL plans—see note below about self-funded plans and those from other BCBS Plans	Duration of COVID-19 public health emergency
Member cost-share waivers		
Member cost-share waiver for in-network tele-everything services for all diagnosis codes	BCBSAZ individual and fully insured plans and BCBSAZ-administered MA plans (Note: MA plans do not cover teledentistry)	Duration of COVID-19 public health emergency
Member cost-share waiver for in-network tele-everything services for COVID-19 diagnosis codes only	Federal Employee Program® (FEP®) plans	March 6 throughout COVID-19 public health emergency
Member cost-share waiver for COVID-19 testing (consistent with CDC guidelines)	ALL plans—see note below about self-funded plans and those from other BCBS Plans	Duration of COVID-19 public health emergency
Member cost-share waiver for COVID-19 treatment (consistent with CDC guidelines)		
Note: Self-funded employer groups and other BCBS Plans determine their own member-benefit coverage and waivers of cost-share and preservice-review requirements.		

P3 Health Partners is an independent company that provides services to BCBSAZ Medicare Advantage providers and members.

BCBSAZ 12/11/2020

AETNA

How is Aetna covering telehealth services for members? (As of 12/14/2020)
Through January 31, 2021, 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**.[6] Self-insured plans offer this waiver at their own discretion.[7] Cost share waivers for any in-network covered medical and behavioral health services telemedicine visit for Aetna Student Health plans are extended until January 31, 2021.

Through January 31, 2021, 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® 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.[8]

For Medicare Advantage plans, effective May 13, 2020 through Janaury 31, 2021, Aetna is waiving member out-of-pocket costs for all in-network primary care visits, whether done in-office and via telehealth, for any reason, and encourages members to continue seeking essential preventive and primary care during the crisis.

[6]*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.*
[7]*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.*
[8]*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.*

CIGNA

Virtual Care

Last Updated October 16th, 2020

Staying connected with your patients through virtual care services

We are committed to helping you to deliver care how, when, and where it best meets the needs of your patients. And as your patients seek more convenient and safe care options, we continue to see growing interest in virtual care (i.e., telehealth) – especially from consumers and their providers who want to ensure they have greater access and connection to each other.

Because we believe virtual care has the potential to help you attract and retain patients, reduce access barriers, and contribute to your ability to provide the right care at the right time, we are pleased to announce our Virtual Care Reimbursement Policy for commercial medical services, effective January 1, 2021.[1] This policy **ensures you can continue to receive ongoing reimbursement for virtual care provided to your patients with Cigna commercial medical coverage**.[2]

1. Please note that our interim COVID-19 virtual care guidelines remain in place until December 31, 2020. If it is necessary to extend that interim coverage without change based on an extended period health emergency period, our new permanent Virtual Care Reimbursement policy may be implemented at a later date. If this happens we will communicate these updates as necessary. Please know that we are committed to ensuring continued access to virtual care for you and your patients.

2. The Virtual Care Reimbursement Policy only applies to services provided to commercial medical customers, including those with Individual & Family Plans (IFP). Cigna Behavioral Health and Cigna Medicare Advantage customers continue to have covered virtual care services through their own separate benefit plans.

- For more information about current Cigna Behavioral Health virtual care guidance, please visit CignaforHCP.com > Resources > Behavioral Resources > Doing Business with Cigna > COVID-19: Interim Guidance.
- For more information about current Cigna Medicare Advantage virtual care guidance, please visit medicareproviders.cigna.com > Billing Guidance and FAQ > Telehealth.

Services reimbursed

Our new policy allows for reimbursement of a variety of services typically performed in an office setting that are appropriate to also perform virtually.

Common services included in the policy

- Routine check-ups
- General wellness visits
- New patient exams
- Behavioral assessments

Common codes included in the policy

- Outpatient E&M codes for new and established patients (99202-99215)
- Physical and occupational therapy E&M codes (97161-97168)
- Telephone-only E&M codes (99441-99443)
- Annual wellness visit codes (G0438 and G0439)

For a complete list of the services that will be covered, please review the Virtual Care Reimbursement Policy.

Commitment to continued updates

Please know that we continue to monitor virtual care health outcomes and claims data – as well as provider, customer, and client feedback – to ensure that our reimbursement and coverage strategy continues to meet the needs of those we serve. To this end, we appreciate the feedback and deep collaboration we've had with provider groups and medical societies regarding virtual care. We are committed to continuing these conversations and will use all feedback we receive to consider updates to our policy, as necessary.

Billing Example

- **Service performed:** Office or other outpatient visit for the evaluation and management of a new patient

- **CPT code billed:** 99202

- **Modifier appended to billed code:** 95, GT, or GQ

- **Place of service billed:** 11

- **Technology used:** Audio and video

- **Reimbursement received (if covered):** 100% of face-to-face rate

- **Customer cost-share:** Applies consistent with face-to-face visit

Billing and reimbursement requirements

For services included in our Virtual Care Reimbursement Policy, a number of general requirements must be met for Cigna to consider reimbursement for a virtual care visit. **When all requirements are met, services will be reimbursed consistent with face-to-face rates (i.e., parity) to ensure providers continue to receive fair reimbursement as we recover from COVID-19.**[3]

3. Please note state and federal mandates, as well as customer benefit plan design, may supersede this guidance.

Reimbursement requirements

- Services must be on the list of eligible codes contained within in our Virtual Care Reimbursement Policy.
- Claims must be submitted on a CMS-1500 form or electronic equivalent.
- Modifier 95, GT, or GQ must be appended to the virtual care code(s).
- Billing POS 02 for virtual services may result in reduced payment or denied claims. Therefore, providers should bill a typical place of service (e.g., POS 11) to ensure they receive the same reimbursement as they typically get for a face-to-face visit.
- Except for the noted phone-only codes, services must be interactive and use both audio and video internet-based technologies (i.e., synchronous communication).[4]
- Store and forward communications (e.g., email or fax communications) are not reimbursable.

For a complete list of billing requirements, please review the Virtual Care Reimbursement Policy.

4. All synchronous technology used must be secure and meet or exceed federal and state privacy requirements.

Additional Information

For additional information about our Virtual Care Reimbursement Policy, please review the policy, contact your provider representative, or call Cigna Customer Service anytime at **800.88Cigna (800.882.6642)**.

Virtual care through our vendor network

One of our key goals is to help your patients connect to affordable, predictable, and convenient care anytime, anywhere. To increase convenient 24/7 access to care if a patient's preferred provider is unavailable in-person or virtually, our virtual care platform also offers solutions that include national virtual care vendors like MDLive.

The role you play

In addition to the in-office care that you deliver today, we encourage you to consider offering virtual care to your patients with Cigna coverage as well – and ensure they're aware that you can continue to offer ongoing covered virtual care as they need it and as it's medically appropriate.

We hope you join us in our journey to offer our customers increased access to virtual care and appreciate your commitment to work with us as our virtual care platform continues to evolve to the meet the needs of our providers, customers, and clients.

UHC

UNITED HEALTHCARE

Effective with dates of service on and after Jan. 1, 2021, UnitedHealthcare will modify the Telehealth and Telemedicine Policy, including the following:

- Eligible telehealth services will only be considered for reimbursement under this policy when reported with place of service (POS) 02. This is consistent with the Centers for Medicare and Medicaid (CMS) billing and reimbursement guidelines. Telehealth claims with any other POS will not be considered eligible for reimbursement.
- Modifiers 95, GT, GQ or G0 may be appended to telehealth claims reported with POS 02, but the modifiers will be considered informational and not necessary to identify telehealth services.
- UnitedHealthcare will consider the member's home as an originating site for eligible services.
- Various codes will be eligible for consideration under the policy including codes listed in the current policy, as well as similar types of services rendered using interactive audio and video technology.
- Certain physical, occupational and speech therapy (PT/OT/ST) telehealth services using interactive audio and video technology will be considered for reimbursement when rendered by qualified health care professionals.
- The policy addresses additional provider-member electronic communication including virtual check-ins, remote patient monitoring and E-visits (non-face-to-face, member-initiated communications with providers using online patient portals).
- Payment will align with applicable state law.

Telehealth services must be rendered using live, interactive audio and video visits and recognized by:

- Centers for Medicare and Medicaid Services (CMS)
- American Medical Association (AMA) included in Appendix P of CPT® as telehealth
- UnitedHealthcare-identified services which can be effectively performed using telehealth.

Medicare Advantage

Effective Jan. 1, 2021 certain UnitedHealthcare Medicare Advantage plans will allow certain Centers for Medicare & Medicaid (CMS)-eligible telehealth services when billed for members at home. For plans with this telehealth benefit, details will be outlined in the member's Evidence of Coverage (EOC) and other plan benefit documents.

Outside of the originating site requirements for plans with the additional benefit, we'll follow the current CMS telehealth code list and billing requirements.

Community Plan

For UnitedHealthcare Community Plans, we'll continue to follow state regulations and guidelines regarding telehealth services and reimbursement. If no state guidance is provided, UnitedHealthcare guidelines will apply, if appropriate.

BlueCross BlueShield of Texas

Telehealth 2021

January 5, 2021

In response to the COVID-19 pandemic, Blue Cross and Blue Shield of Texas (BCBSTX) expanded acces telehealth services to give our members greater access to care. The experience confirmed the importance telehealth in health care delivery. Members can access their medically necessary, covered benefits throug who deliver services through telehealth. Many of our members also have access to various telehealth ven as MDLIVE.

What's covered?

Coverage is **based on the terms of the member's benefit plan** and applicable law. As of Jan. 1, 2021, f regulated **fully insured HMO** and **PPO** members and our **self-funded employer group members**, we co telehealth codes consistent with the **permanent** code lists from:

- The Centers for Medicare and Medicaid Services (CMS), and
- The American Medical Association (AMA)

By, permanent, we mean those codes that are not temporarily available for the duration of the public healt (PHE) or the year of the PHE.

CMS and AMA periodically update their lists. **We will follow their updates**.

We will **not cover** the following codes:

- Codes that are not on the telemedicine code list provided by CMS **or** the AMA
- CMS codes that are temporary for the PHE
- CMS Codes that are active for the year of the PHE only
- AMA codes listed as Private Payer

Our self-funded employer group customers make decisions for their employee benefit plans. **Check eligib benefits** for any variations in member benefit plans.

We **recommend** the following:

- Consider telehealth a mode of care delivery to be used when it can reasonably provide **equivalent** as face-to-face visits.
- Choose telehealth when it **enhances the continuity of care** and care integration if you have an est patient-provider relationship with members.
- **Integrate telehealth records into electronic medical record systems** to enhance continuity of ca maintain robust clinical documentation and improve patient outcomes.

Eligible members

Providers can use telehealth for members with the following types of benefit plans. Care must be consiste terms of the member's benefit plan.

- State-regulated fully insured HMO and PPO plans

- Blue Cross Medicare Advantage (excluding Part D) and Medicare Supplement (see Medicare info b
- Self-funded employer group plans

We will continue to follow applicable state and federal requirements.

Submitting claims

The provider submitting the claim is responsible for accurately coding the service performed. Submit claim medically necessary services delivered via telehealth with the appropriate **modifiers (95, GT, GQ, G0) an Service (POS) 02**.

Acceptable modifiers:

- 95 – synchronous telemedicine (two-way live audio visual)
- GT – interactive audio and video telecommunications
- GQ – asynchronous
- G0 – telehealth services for diagnosis, evaluation or treatment of symptoms of an acute stroke; G0 billed with one of the approved telemedicine modifier (GT, GQ or 95)

Note: If a claim is submitted using a telehealth code, no modifiers are necessary. Only codes that are not telehealth codes require a modifier.

Member cost share

As of Jan. 1, 2021, **copays, deductibles and coinsurance apply** to telehealth visits for most members. share varies according to the member's benefit plans. **Check eligibility and benefits** for each member fo

Our self-funded employer group customers make decisions for their employee benefit plans and may cho telemedicine cost share. **Check eligibility and benefits** for any variations in member benefit plans.

What's covered for Medicare Advantage and Medicare Supplement members

CMS identifies covered services for Medicare members. This means we will cover all the CMS telemedi, including those available only during the PHE for Medicare Advantage and Medicare Supplement mem

For the duration of the PHE, we are waiving cost share for our Medicare Advantage members. This mean members will **not** owe any **copays, deductibles or coinsurance** for telehealth visits. The cost share wai apply to Medicare Supplement members.

Medicaid

We will follow the applicable guidelines of the Texas Department of State and Health Services for Medicai CHIP and STAR Kids members.

Referrals and prior authorizations

Some telehealth care will require **referrals** and **prior authorizations** in accordance with the member's be **Check eligibility and benefits** for each member for details.

Delivery methods

Available telehealth visits with BCBSTX providers include:

- 2-way, live interactive telephone communication (audio only) and digital video consultations

- Asynchronous telecommunication via image and video not provided in real-time (a service is record or captured as an image; the provider evaluates it later)
- Other methods allowed by state and federal laws, which can allow members to connect with physici reducing the risk of exposure to contagious viruses or further illness

Delivery methods for Medicare members

- Providers should use an interactive audio and video telecommunications system that permits real-ti interactive communication to conduct telehealth services. CMS permits audio only in limited circums See the CMS website for designated audio-only codes.

Providers can find the latest guidance on acceptable Health Insurance Portability and Accountability Act (H compliant remote technologies issued by the U.S. Department of Health and Human Services' Office for C Action.

Telehealth Vendors

For state-regulated fully insured members, providers are not required to use a vendor for telehealth servic funded members, providers may be required to use specific vendors as outlined in the member's benefit p

Reimbursement

Currently, covered telehealth claims for eligible members for in-network medically necessary health care s be reimbursed at the same rate as in-person office visits for the same service. We will continue to evaluat reimbursement. Submit claims with appropriate codes and modifiers. For claims using a specific telehealth applicable telehealth reimbursement will apply.

Member benefit and eligibility assistance

Check eligibility and benefits for each member at every visit prior to rendering services. Providers may:

- Verify general coverage by submitting an electronic 270 transaction through Availity® or your preferr
- Connect with a Customer Advocate to check eligibility and telehealth benefits by calling our Provide Service Center at 1-800-451-0287.
- For Medicare Advantage members, call Blue Cross Medicare Advantage Network Management at 1 7100.

By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use policy.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an I Licensee of the Blue Cross and Blue Shield Association

COVID-19 PROVIDER TELEMEDICINE FAQs

Does TRICARE cover COVID-19 testing?

Beneficiaries suspected to have COVID-19 should be tested following CDC guidelines, as TRICARE covers medically necessary and appropriate testing.

What coverage is available for telemedicine?

TRICARE covers the use of interactive audio-visual technology to provide clinical consultations and office visits when appropriate and medically necessary. These services are subject to the same authorization requirements and include, but are not limited to:

- Clinical consultation
- Office visits
- Speech Therapy (ST), Occupational Therapy (OT) and Physical Therapy (PT) can now be provided via telemedicine. ST is approved for new and continuity of care. PT and OP are approved for continuity of care only. The care must meet the requirements set forth in *TPM CH 7 Sec 22.1*. Please watch our website for new guidance.
- Telemental health (individual psychotherapy, psychiatric diagnostic interview examination and medication management)
- Audio-only services are covered

*Please refer to the Telemedicine-Applied Behavior Analysis (ABA) section for more details regarding temporary ABA provisions.

The link to the policy can be found under our provider COVID-19 information page.

Does the beneficiary need to be an existing patient for the provider to be able to conduct a telemedicine appointment?

There is no stipulation in policy that indicates services are for existing patients only. The exception would be for PT and OT providers.

OT/ST/PT were opened up temporarily for telemedicine; is there a projected end date, or how will we notify our providers when there is no longer an exemption?

Information will be posted to provider self-service.

What are the reimbursement rates for telemedicine for PT/OT/ST? Is it by unit or per session?

Please refer the provider to *TRICARE.mil* for reimbursement rates.

I would like to change my patients appointments from an in person appointment to a telemedicine appointment. Is this covered?

Telemedicine visits are covered the same as regular office visits as long as your provider meets TRICARE policy requirements surrounding the delivery of telemedicine. Please refer to the Telemedicine-ABA section for details regarding temporary ABA provisions.

Can a current referral for specialty care be used for telemedicine? Do any codes need to be added to the referral?

As long as the provider meets the criteria in the *TRICARE Policy Manual*, the existing referral will be honored. No additional codes (for telemedicine) need to be added.

Will telephone consults with beneficiaries be paid temporarily during COVID-19?

Yes. TRICARE now covers audio-only telemedicine services.

Is telemedicine for behavioral health only?

No, any provider can provide telemedicine. Please refer to the Telemedicine-ABA section for details regarding temporary ABA provisions.

Is there an application required?

There is no application required.

What are the licensing requirements for telemedicine providers?

Video conferencing platforms used for telemedicine services must have the appropriate verification, confidentiality and security parameters necessary to meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Humana Military | TRICARE®

COVID-19 PROVIDER TELEMEDICINE FAQs

What are the equipment requirements for telemedicine?

Please refer to policy-*TRICARE Policy Manual, Chapter 7, Section 22.1*

Is the beneficiary's home considered an originating site?

Yes

Is there guidance on what platforms are appropriate or how to make Skype usable? Does Humana Military have a list of HIPAA-compliant software/free platforms?

HIPAA-compliant software/platforms used by other providers include: Medici Doxy.me, Chiron, and VSee. The programs are not promoted or endorsed by Humana Military.

Are any other documents/addendums required to ensure proper coverage and payment of claims?

There is no addendum required.

Is there a need for additional credentialing to bill Place of Service (POS) 02-physicians or practitioners furnishing telemedicine services from distant site ID?

There is no additional credentialing required.

How do I bill for telemedicine services?

Please refer provider to policy for applicable CPT codes.

Synchronous* telemedicine services will use CPT or HCPCS codes with a GT modifier for distant site and Q3014 for an applicable originating site to distinguish telemedicine services. Also, Place of Service "POS 02" is to be reported in conjunction with the GT modifier.

Asynchronous* telemedicine services will use CPT or HCPCS codes with a GQ modifier.

**Synchronous telemedicine services involve an interactive, electronic information exchange in at least two directions in the same time period. Asynchronous telemedicine services involve storing, forwarding, and transmitting medical information on telemedicine encounters in one direction at a time.*

When submitting claims for telemedicine services, the provider may indicate "Signature not required-distance telemedicine site" in the required patient signature field.

For more details, please refer to *TPM15 Chapter 7, Section 22.1* and *TPM15 Chapter 7, Section 3.8*.

Is Partial Hospitalization Program (PHP) covered under telemedicine?

Yes, as long as services are less than six hours.
Learn more →

In regards to location-specific plans, will providers be tied to additional locations as needed?

If the provider files a claim from a network location that they are not affiliated to, Wisconsin Physicians Service (WPS) will affiliate the provider to that location.

Telemedicine ABA

Can Applied Behavior Analysis (ABA) services be provided via telemedicine?

TRICARE is temporarily permitting the unlimited use of CPT code 97156 ("Patient/Caregiver Guidance") via synchronous (real- time HIPAA compliant audio and video) TH services only to beneficiaries with an existing, active authorization from the contractors.

Note: This change is in effect from March 31, 2020 through the end of the COVID-19 public health emergency

Who can render "Patient/Caregiver guidance"?

CPT code 97156 (either in-person or via telehealth) may only be rendered by Board Certified Behavior Analysts (BCBA) and assistant behavior analysts.

What codes are included in this exception?

This exception is limited to CPT code 97156. CPT codes 97151, 97153, and 97155 are still excluded from TRICARE coverage under the ACD for delivery via telemedicine.

Humana Military | TRICARE®

COVID-19 PROVIDER TELEMEDICINE FAQs

Will documentation requirements change due to this exception?

Every session rendered as 97156 via telehealth shall adhere to the same documentation standards set forth in *TOM Chapter 18, Section 4, Paragraph 17.2* to include documenting Place of Service 02.

What do I need to know about filing claims for ABA telemedicine?

The claims filed must include the GT modifier and Place of Service (POS) code 02 or the claim shall be denied.

On any date of service, if the GT modifier is used for CPT code 97156, only 97151 and T1023 shall be payable in addition to 97156/GT for the same date of service. All other CPT codes filed on the same date of service as CPT code 97156/GT shall be denied reimbursement.

On any date of service where CPT code 97156 is filed without the GT modifier, all CPT codes in the existing ABA authorization for that beneficiary shall be payable.

How will claims be processed for ABA telemedicine services?

Our claims processor has made coding changes to allow for the temporary provision of rendering unlimited CPT code 97156 via telemedicine.

Note: Due to required claims system changes for this temporary provision, providers should anticipate longer processing and payment times.

Do current ABA authorizations need to be updated for telemedicine?

No. An additional authorization is not required, nor are changes to the existing authorization. An expiration date extension will not be required or allowed. (Maintaining the current authorization ensures that all submitted claims are tied to an existing authorization, therefore preventing any non-authorized ACD claims from being paid.)

Can I use telemedicine for ABA for all of my authorized TRICARE beneficiaries?

Telemedicine is not appropriate for all beneficiaries diagnosed with Autism Spectrum Disorder (ASD). Clinical judgment should be used when determining who is appropriate to receive ABA services virtually.

What are the equipment requirements for telemedicine?

Please refer to policy *TRICARE Policy Manual, Chapter 7, Section 22.1*.

How does this exception affect the authorization timeline?

No extensions to the authorization timeline will be granted. For authorizations expiring during this period, and subsequent authorization requests, all relevant requirements (i.e., the PDDBI) are expected to be completed on time.

No retro-authorizations will be approved. Do not let an authorization lapse.

What happens if the authorization is expiring during this window?

For authorizations that expire during this specified window, the ABA provider may complete the treatment plan update through an indirect assessment and submit the claim using CPT code 97151. All requirements of CPT code 97151 still apply.

If my patient needs authorization to begin ABA services, has the process changed?

For new authorizations resulting from new referrals during this timeframe, CPT code 97151 will be issued to complete an indirect assessment, review of records, and development of a treatment plan.

The treatment plan should be developed with the full recommendation of all CPT codes for the 6-month authorization period. Any program modifications may be completed under in-person CPT code 97155 once the social distancing provision is lifted.

No other ACD program requirements will be exempt.

Humana Military | TRICARE®

COVID-19 PROVIDER TELEMEDICINE FAQs

Where can I find more information about this provision?

Additional information can be found here →

Note: The "Policy" link under the COVID-19 Guidance section contains the notification being sent to ABA providers regarding this provision.

An important note about TRICARE program information

At the time of publication, this information is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. Military hospital and clinic guidelines and policies may be different than those outlined in this publication. For the most recent information, contact your TRICARE regional contractor or local military hospital or clinic.

Telemedicine platforms

I received an email from Humana Military about platforms I could use for telemedicine. Can you explain what this is?

Humana Military has identified four vendors that have agreed to assist our providers with their telemedicine needs at a potentially lower cost. You should review each vendor by going to HumanaMilitary.com/platforms to determine which vendor offers you the best options.

Are these vendors contracted with Humana Military?

No, you will need to work directly with these vendors for your needs.

Can Humana Military help me set up an agreement with these vendors?

No, since we are not contracted with these vendors, you will need to work directly with them on all agreements, costs and support.

I already provide telemedicine for my patients. Do I need to change what I am doing?

No, if you are already using a platform that meets the requirements and your needs, there is no need to change.

How will I know which one is the best for me? Could you recommend one?

Each provider office will have different telemedicine needs. Review each vendor's information to determine which one best meets your office demands. Each vendor offers customer service to answer your specific questions. Please visit HumanaMilitary.com/platforms to view all options and details.

Am I required to use one of these vendors?

No, these vendors are options to review if you are looking for a method of delivering telemedicine.

Humana Military | TRICARE®