HIGHMARK® Delaware HEALTH OPTIONS

CORONAVIRUS (COVID-19) TELEHEALTH SERVICES FAQS

Last Updated: April 1, 2020

Overview

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

Frequently Asked Questions

What changes has Highmark Health Options made to its telehealth reimbursement policies as a result of COVID-19?

To broaden access to telehealth services during the COVID-19 public health emergency, Highmark Health Options is temporarily waiving the CMS and state-based originating site restrictions for all members.
This change will apply immediately and be effective until the COVID-19 public health emergency ends. Telehealth services will be reimbursed based on national reimbursement determinations, policies and contracted rates as outlined in your participation agreement.

Why is Highmark Health Options changing its reimbursement policy requirements to allow members to receive telehealth services in their homes, or in any setting of care?

This change is to help reduce potential exposure to COVID-19 and to make it easier for members to connect with providers during this time.

Will the established relationship requirement still be enforced under the policy change?

No. The established relationship requirement will not be enforced at this time. In response to COVID-19, effective 3/18/2020 and until further notice as stipulated by Governor John Carney, Title 24 requirements that patients present in-person before telemedicine services be provided are suspended. Members are urged to avoid travel to physician's offices, clinics, hospitals, or any health care facility where they could risk their own or others' exposure to illness.

Which types of providers does the policy change apply to?

There is no change to the type of provider who may submit claims for telehealth services. Qualifying services include any covered service that would typically be provided to an eligible individual in a face-to-face setting by a licensed provider. Telehealth is not limited based on the diagnosed medical condition of the eligible recipient or geographical location. All telehealth services must be furnished within the limits of provider program policies and within the scope and practice of the provider's professional standards.

If a service is not covered in a face-to-face setting, it is not covered through telehealth. A service provided through telehealth is subject to the same program restrictions, limitations and coverage that exist for the service when provided in a face-to-face setting.

How can Telehealth be delivered?

Interactive Communication – Provider and patient interact in "real-time" using an interactive telecommunications system that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient, at the originating site, and the physician or practitioner at the distant site; or

Telephonic Services – In addition to Interactive telehealth services, telephones are an acceptable mode to deliver telehealth if the following conditions are met: It is determined that interactive telehealth services are unavailable, and telephonic services are medically appropriate for the underlying covered service.

Chart reviews, electronic mail messages, facsimile transmissions or internet services for online medical evaluations are not coverable telehealth services.

Effective immediately, the HHS Office for Civil Rights will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through every day communications technologies, such as FaceTime, Skype, Facebook Messenger video chat, or Google Hangouts video during the COVID-19 public health emergency. *For more information visit: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

Telephonic Services

If video and audio services are not available, Highmark Health Options will reimburse participating providers for telephonic screenings billed using CPT codes including but not limited to 99441-99443 and 98966–98968.

Please note that providers may only bill for one telephonic and/or video and audio service if the member is seen in the office on the same date of service. If billing for a separate and distinct service provided on the same date of service, please ensure appropriate modifiers are applied to the claim.

Are telehealth services only limited to members with COVID-19?

No. Telehealth services are available to all Highmark Health Options members.

Do the reimbursement policy changes require providers to bill differently?

Providers should follow standard Highmark Health Options billing, coding, and editing procedures for telehealth billing. The claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site.

- Place of Service "02": The location where health services and health related services are provided or received, through a telecommunication system.
- Modifier GQ: Via asynchronous telecommunications system.
- Modifier GT: Via Interactive Audio and Video Telecommunications systems.
- Modifier 95: Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System.

CPT codes are available on HHO site as Appendix to complete COVID-19 Expanded Telemedicine Policy.

Are specific modifiers required to be applied to the existing codes?

Additional or different modifiers associated with telehealth services are not required under this waiver.

Are there any excluded services?

Yes, the Program will not reimburse telehealth providers for the following:

- Incomplete delivery of services via telemedicine, including technical interruptions that result in partial service delivery
- When a provider is only assisting the beneficiary with technology and not delivering a clinical service
- For a telemedicine transaction fee and/or facility fee defined as a fee associated with the cost incurred through a third party
- For store and forward as defined by a telecommunication technique in which information is sent to an intermediate station where it is kept and sent at a later time.

How much will I be reimbursed for telehealth services?

Providers will be reimbursed according to the applicable fee schedule.

Can hospitals, nursing homes, home health agencies or other healthcare facilities bill for telehealth services?

If a member is in a health care facility and receives a service via telehealth, the health care facility will only be eligible to bill for the originating site facility fee.

Is prior authorization required for telehealth services?

Highmark Health Options will not require prior authorization for telehealth services.

Is member consent required to perform telehealth services?

Providers are not required to obtain written consent from the member agreeing to participate in telehealth services.

Am I required to retain medical records?

Yes, the originating and distant site providers shall maintain documentation in the same manner as during an in-person visit or consultation, using either electronic or paper medical records, which shall be retained for a period of no less than ten (10) years after the last payment was made for services.

Where can I get more information?

For more information on the latest Highmark Health Options COVID-19 related resources, visit www.highmarkhealthoptions.com