PAYMENT POLICY	
Policy Name:	COVID-19 Expanded Telemedicine Policy
Policy Number:	RP-01-COVID
Approved By:	Joanne Landry, Dwayne Parker, Dr. Glenn Hamilton
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Products:	Highmark Health Options Delaware Medicaid
Application:	All participating and non-participating practitioners and facilities unless contractually precluded
Page Number(s):	8

Disclaimer

Highmark Health Options' medical claims payment and prior-authorization policy is a reference resource regarding payment and coverage for the services described. This policy does not constitute medical advice and is not intended to govern and/or otherwise influence medical necessity decisions.

POLICY SCOPE:

This policy applies to claims submitted to Highmark Health Options under the Delaware Medical Assistance product.

The scope of this policy is subject to weekly reviews for expansion and/or modification throughout the COVID-19 designated emergency period.

PURPOSE:

This policy outlines Highmark Health Options reimbursement for telemedicine, telehealth, virtual-care, or eVisit services in specific response to the COVID-19 Pandemic.

DEFINITIONS:

Telehealth: The use of information and communications technologies consisting of telephones, store and forward transfers, remote patient monitoring devices, or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, and health administration services.

Telemedicine: A form of telehealth, which is the delivery of clinical health-care services by means of real time two-way audio, visual, or other telecommunications or electronic communications. This includes the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health-care provider practicing within his or her scope of license as would be practiced in-person with a patient, and legally allowed to practice in the State.

Distant Site: The location where the provider (legally allowed to practice in the state) is rendering the service by means of telemedicine or telehealth. The Plan will not reimburse claims submitted for an access fee by the distant site.

Originating Site: The originating medical site (i.e., provider's office, outpatient facility, etc.) is a site in Delaware at which an eligible member is located at the time the service is performed by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties. The Plan will accept only one claim for the originating site access fee per visit that involves both an originating medical site and a distant site. Only the originating medical site will receive payment for an access fee. Note: An access fee is not applicable for non-medical sites (e.g. member's home).

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.

REIMBURSEMENT GUIDELINES:

Coverage for telehealth & telemedicine are limited to the types of services already considered a covered benefit under Highmark Health Option plans and reimbursement for those services are based on that benefit determination. Coverages and reimbursements for telehealth services are limited to those services performed between a licensed clinician and a member/patient.

When a covered benefit, evaluation and management and consultation services delivered through telehealth may be reimbursed under the following conditions:

1. Professional services rendered via an interactive telecommunication system are only eligible for reimbursement to the provider rendering the telemedicine services. A provider rendering face-to-face care should report the appropriate codes for the in-person services.
2. The patient must be present at the time of all billed services. If state law requires a face-to-face examination PRIOR to the delivery of telemedicine services, the face-to-face services must be concluded and documented in the medical record prior to the initiation of any related telehealth visits.
    a. Note: As part of COVID-19 response, services for telehealth can be provided to both new and established patients as appropriate and allowed by state and federal law.
3. The referring, consulting, or distant provider should obtain written consent from the member agreeing to participate in services delivered via the means of telemedicine. The member has the right to refuse these services at any time and must be made aware of any alternatives, including any delays in service, need to travel, or risks associated with not having services provided via telemedicine.
    a. Note: As part of COVID-19 response, DMMA is waiving this requirement and it is not required to obtain written consent from the member prior to providing telemedicine services.
4. All services provided must be medically appropriate and necessary.
5. Prior authorization for telehealth-delivery is not required, but the Distant Site provider must obtain prior approval for any other covered services which would normally require prior authorization. This applies for participating and non-participating providers.
6. The consultation/evaluation and management service must take place via an interactive audio AND video telecommunications system (unless exceptions are allowed by applicable laws). Interactive telecommunications systems must be multi-media communication which, at minimum, includes audio and video equipment permitting real-time (synchronous) consultation among the patient and practitioner at the Originating Site and the practitioner at

the Distant Site. The technology platform used by the provider must meet technology security requirements, including being both HIPAA and HITECH compliant

   a. **Note:** During the COVID-19 pandemic emergency period, HHO will comply with the Office of Civil Rights under Department of Health and Human Services Enforcement Discretion to expand technologies available to providers to administer telehealth. In this expansion, a covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients.

7. Thorough, appropriate documentation of telemedicine services and other communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.
8. Services billed which indicate telemedicine as the mode of service delivery but are not substantiated by either the claim form or written medical records are subject to disallowances in the course of an audit.

Eligible Providers

Providers performing and billing telemedicine services must be eligible to independently perform and bill the equivalent face-to-face service. Providers must be located in the United States to provide these services.

For services delivered through telehealth, healthcare practitioners must:

- Act within their scope of practice.
- Be licensed for the service for which they are providing to members.
- Be a participating provider with HHO or engaged in the process to become a participating provider.
- Be located within the continental United States.

Originating Site Access Fees

Only the originating medical site will receive payment for an access fee.

Eligible Originating Sites:

- Outpatient Hospitals
- Inpatient Hospitals
- Federally Qualified Health Centers
- Rural Health Centers

- Renal Dialysis Centers
- Skilled Nursing Facilities
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Intermediate Care Facilities/Institutions for Mental Diseases (ICF/IMDs)
- Outpatient Mental Health/Substance Abuse Centers/Clinics
- Community Mental Health Centers/Clinics
- Public Health Clinics
- PACE Centers
- Assisted Living Facilities
- School-Based Wellness Centers
- Patient's Home
- Physicians (or Physicians Assistants under the supervision of a physician)
- Certified Nurse Practitioners
- Medical and Behavioral Health Therapists

Professional service claims (1500/837P) should be billed using CMS Level 2 code Q3014, indicating the telehealth origination site fee, when applicable.

Outpatient facility claims (UB-04/837I) should be billed using CMS Level 2 code Q3014 and revenue code 780, when applicable, and a GT modifier.

Note: An access fee is not applicable for non-medical sites (e.g. member's home).

Real-time Audio (Telephonic only) Visits

Professional services (1500/837P) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968 and submit a 02 place of service.

Facility claims (UB-04/837I) should be billed using CPT codes 99441, 99442, 99443, 98966, 98967, and 98968 with the appropriate revenue code and a GT modifier.

- 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
- Qualified Non-Physician:
  - 98966: 5-10 minutes of medical discussion
  - 98967: 11-20 minutes of medical discussion
  - 98968: 21-30 minutes of medical discussion

For telephonic services over 30 minutes, increase number of units as applicable using the above codes.

Note: Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500/837P form). Facility claims (UB-04/837I form) must also use the GT modifier in addition to other modifiers as appropriate and applicable based on coding guidelines

Real-time Audio & Visual Visits

Professional services claims (1500/837P) should be billed, where appropriate, with appropriate CPT codes applicable to the services provided with a GT or 95 modifier indicating the use of an interactive audio and video telecommunications system.

Outpatient/Inpatient facility claims (UB-04/837I) should be billed with appropriate CPT codes and modifiers applicable to the services provided along with a GT modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code (commonly 780 or 789 for non-behavioral health and 900-919 for behavioral health).

Note: Place of Service "02" (Telehealth) **must** be used when reporting professional telehealth services (1500/837P form). Facility claims (UB-04/837I form) must also use the GT modifier in addition to other modifiers as appropriate and applicable based on coding guidelines

Federally Qualified Health Care Center (FQHC)

FQHC Providers billing for Interactive Telehealth Services or Telephonic Services should continue to bill their appropriate HCPCS (Healthcare Common Procedure Coding System) "G" visit payment code for each payable encounter visit.

In addition, providers should bill the appropriate code for the service provided and use a 02 Modifier as Place of Service for real-time audio and visual telehealth services.

For telephonic services, the same codes listed above should be used as appropriate and a 02 place of service.

Limitations

- HHO will reimburse up to three different consulting providers for separately identifiable telemedicine services provided to a member per date of service and only one facility fee is permitted per date, per member.
- HHO will not reimburse the referring provider at the originating site on the same date of service unless the referring provider is billing for a separate identifiable covered service. Medical records must document that all of the components of the service being billed were provided to the recipient.
- Chart reviews, electronic mail messages, facsimile transmissions or internet services for online medical evaluations are not covered telehealth services.

Codes for Telemedicine:

The Appendix to this policy contains the set of codes which HHO intends to allow for telemedicine based on clinical review of services that can be provided to members effectively and with quality via telemedicine. These codes will be monitored and updated as appropriate as the COVID-19 pandemic continues to evolve.

HHO will maintain and track changes to this document throughout the effective period of this policy.

REFERENCES:

- American Medical Association, *Current Procedure Terminology* CPT® Manual

- CMS Medicare Claims Processing Manual, Chapter 12 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Downloads/covered-telehealth-services.zip

- Delaware Telemedicine Mandate, House Bill 69 (Codified as 18 Del. C. §§ 3770 & 3571R; 18 Del. Admin. Code 1409) http://delcode.delaware.gov/sessionlaws/ga148/chp080.pdf

- Office for Civil Rights, U.S. Department of Health and Human Services - BULLETIN: HIPAA Privacy and Novel Coronavirus https://www.hhs.gov/sites/default/files/february-2020-hipaa-and-novel-coronavirus.pdf

- Division of Medicaid and Medical Assistance - Changes to Telehealth Policies to Respond to COVID-19
  https://www.dhss.delaware.gov/dhss/dmma/files/dmma_telehealth_bulletin_COVI_19.pdf

POLICY UPDATE HISTORY INFORMATION:

03/2020	COVID-19 Policy Implemented