SANTÉ COMMUNITY PHYSICIANS

MEMORANDUM

DATE: **March 27, 2020**

TO: **Santé Community Physicians**

FROM: **Kelly Lilles, Director, Physician Services and Education**

RE: **Compiled Resources regarding COVID-19**

Santé is working diligently to provide our providers compiled and up-to-date information regarding COVID-19. From telehealth services to billing guidelines, we are here to support you and your practice. Below are materials compiled from different resources.

Health Plan Resources:

- Aetna (*please see attachment below*)
- Anthem
  https://providernews.anthem.com/california/article/information-from-anthem-for-care-providers-about-covid-19-5
- Blue Shield (*please see attachment below*)
- Cigna (*please see attachment below*)
- UnitedHealthcare
  - FAQ Updates - This is where all FAQS and updated policies can be found.
    https://providernews.anthem.com/california/article/information-from-anthem-for-care-providers-about-covid-19-

5https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19.html

- Diagnosis, Coding and Reimbursement Updates - This section was recently added and will continue to be enhanced based on questions received. https://www.uhcprovider.com/en/resource-library/news/diagnosis-coding-update-covid-19.html

- Telehealth FAQ - This is where you can find the latest updates and answers to FAQs regarding the Telehealth policy. https://www.uhcprovider.com/en/resource-library/news/provider-telehealth-faqs.html

- Telehealth Reimbursement Policy https://www.uhcprovider.com/content/provider/en/viewer.html?file=https%3A%2F%2Fwww.uhcprovider.com%2Fcontent%2Fdam%2Fprovider%2Fdocs%2Fpublic%2Fpolicies%2Fcomm-reimbursement%2FCOMM-Telehealth-and-Telemedicine-Policy.pdf

Other Resources:

- ❖ Centers for Medicare & Medicaid Services Telehealth FAQ

- ❖ U.S. Department of Health and Human Services (HHS) Medical Learning Network Telehealth Services Booklet

If you have any questions, please feel free to contact Santé Physician Services Department at (559) 228-4308.

Telemedicine and Direct Patient Contact

Policy Type:	Revised
Applies to:	• All Medical Products (including Commercial & Medicare) • All participating and nonparticipating physicians, facilities, and other qualified health care professionals
Policy Implementation:	Date of Service
Policy Revision Date:	Click Here
Last Review:	December, 2019
Next Review	December, 2020

Our payment policies ensure that we pay providers based on the code that most accurately describes the procedure performed. We include CPT/HCPCS, CMS or other coding methodologies in our payment policies when appropriate. Unless noted otherwise, payment policies apply to all professionals who deliver health care services. When developing payment policies, we consider coding methodology, industry-standard payment logic, regulatory requirements, benefits design and other factors.

Table of Contents

Overview

This policy addresses our guidelines regarding payment for telehealth, telemedicine, direct patient contact, care plan oversight, concierge medicine, and missed appointments.

Refer to Expanded Claim Edits for additional coding and reimbursement policies that may apply separately from the policy detailed below.

Definitions/Glossary

Term	Definition
Asynchronous Telecommunication	Telecommunication systems that store medical information such as diagnostic images or video and forward it from one site to another for the physician or health care practitioner to view in the future at a site different from the patient. This is a non-interactive telecommunication because the physician or health care practitioner views the medical information without the patient being present.
Synchronous Interactive Audio and Video Telecommunication, Interactive Audio and Visual Transmissions and Audio-Visual Communication Technology	Real-time interactive video teleconferencing that involves communication between the patient and a distant physician or health care practitioner who is performing the medical service. The physician or health care practitioner sees the patient throughout the communication, so that two-way communication (sight and sound) can take place.

Telehealth	Telehealth is broader than telemedicine and takes in all health care services that are provided via live, interactive audio and visual transmissions of a physician-patient encounter. These health care services include non-clinical services, such as provider training, administrative meetings and continuing medical education; in addition to clinical services. Telehealth may be provided via real-time telecommunications or transmitted by store-and-forward technology.
Telemedicine	Telemedicine services involve the delivery of clinical medicine via real-time telecommunications such as telephone, the internet, or other communications networks or devices that do not involve in person direct patient contact.

Payment Guidelines

Telemedicine for Commercial Plans	
Two-way, Synchronous (i.e. real-time) Audiovisual Interactive Medical Service **Modifiers GT, 95**	We pay for two-way, synchronous (i.e. real-time) audiovisual interactive medical services between the patient and the provider. We consider services recognized by The Centers for Medicare and Medicaid Services (CMS) and appended with modifier GT, as well as services recognized by the AMA included in Appendix P of the CPT® Codebook and appended with modifier 95. A list of eligible CPT/HCPCS codes is available here. When a provider reports modifier GT or 95, it certifies the patient received services via an audiovisual telecommunications system. • GT: Telehealth service rendered via interactive audio and video telecommunications system • 95: Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system Click here for more information about our telemedicine visit co-pay liberalization in response to the Coronavirus COVID-19 outbreak.

Asynchronous Telecommunication **Modifier GQ**	We don't pay for asynchronous telemedicine services. • These services are considered incidental to the overall episode of care for the member. • When providers report modifier GQ it certifies the patient received services via an asynchronous method. Click here for more information about our telemedicine visit co-pay liberalization in response to the Coronavirus COVID-19 outbreak.
Tele-Stroke Services **Modifier G0**	We pay for tele-stroke services when appended with modifier G0. • G0: Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke

Telemedicine for Medicare Advantage Plans	
Telemedicine for Medicare Members/Plans	Medicare Advantage members may be eligible for telemedicine services in accordance with CMS regulations. We follow CMS policy. www.cms.gov

Direct Patient Contact	
Direct Patient Contact	Other than two-way synchronous (i.e. real time) audio visual interactive medical services, and tele-stroke services, as above, we don't pay for medical services that don't include direct in-person patient contact. Payment for these services is considered incidental to the overall episode of care for the member. One example of time spent without direct patient contact is physician standby services. We consider services payable only when provided in-person face-to-face.

Telehealth Transmission Fees	
Telehealth Transmission Fees **HCPCs codes Q3014 and T1014**	Charges for telehealth services or transmission fees aren't eligible for payment. These services are incidental to the charges associated with the evaluation and management of the patient.

Care Plan Oversight	
Care Plan Oversight	Care plan oversight is not eligible for payment. Care plan oversight is billed for physician supervision of patients under the care of home health agencies, hospice or nursing facilities. It includes the time spent

	reviewing reports on patient status and care conferences. We do not pay for time without direct patient contact. *Note:* Care plan oversight is eligible for payment on case management exceptions authorized by Patient Management.

Concierge Medicine or Boutique Medicine	
Concierge Medicine or Boutique Medicine	Concierge medicine, also called boutique medicine is a fee charged for services a patient receives outside of direct patient contact. These services are considered above and beyond the usual, such as scheduling preference or return phone calls from the provider. These services do not represent treatment of disease or injury. They are standard administrative services that are included in the evaluation & management service, we don't allow separate payment. No specific code exists for these services. Services may be billed with a written description, such as "Concierge Services" or "Administrative Services."

Missed Appointments	
Missed Appointments	We don't cover missed appointments because no direct or indirect medical care was rendered to the patient. Charges due to a missed appointment are the responsibility of the member.

List of Eligible CPT/HCPCs for two-way, synchronous

Eligible Code Description	Eligible CPT/HCPCS
Psychiatric diagnostic interview examination	90791, 90792
Individual psychotherapy	90832, 90833, 90834, 90836, 90837, 90838
Psychotherapy for crisis; first 60 minutes; or each additional 30 minutes	90839, 90840
Psychoanalysis	90845
Family or group psychotherapy	90846, 90847, 90853
Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	90863
End-Stage renal disease (ESRD) related services	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964,

	90965, 90966, 90967, 90968, 90969, 90970
Remote imaging for detection of retinal disease	92227
External mobile cardiovascular telemetry with ECG recording	93228, 93229
External patient and when performed auto activated ECG rhythm derived event recording	93268, 93270, 93271, 93272
Medical genetics and genetic counseling services	96040
Neurobehavioral status examination	96116
Administration of patient-focused health risk assessment instrument with scoring and documentation or for the benefit of the patient, per standardized instrument	96160, 96161
Individual and group medical nutrition therapy	97802, 97803, 97804; G0270
Education and training for patient self-management by a qualified, non-physician health care professional	98960, 98961, 98962
Office or other outpatient visits or consults	99201 – 99205, 99211 – 99215, 99241 – 99245
Subsequent hospital care services, with the limitation of 1 Telehealth visit every 3 days	99231, 99232, 99233
Inpatient consultation for a new or established patient	99251 - 99255
Subsequent nursing facility care services, with the limitation of 1 Telehealth visit every 30 days	99307, 99308, 99309, 99310
Prolonged service, inpatient or office	99354, 99355, 99356, 99357
Smoking and tobacco use cessation counseling visit	99406, 99407, G0436, G0437
Alcohol and substance screen and intervention	99408, 99409
Transitional care management services	99495, 99496
Advanced care planning	99497, 99498
Interactive complexity	90785
Individual and group diabetes self-management training services	G0108, G0109
Counseling visit to discuss need for lung cancer screening using low dose CT scan	G0296
Alcohol and/or substance abuse structured assessment	G0396, G0397
Follow-up inpatient Telehealth consultations furnished to beneficiaries in hospitals or SNFs	G0406*, G0407*, G0408*
Telehealth consultations, emergency department or initial inpatient	G0425*, G0426*, G0427*
Annual Wellness Visit, includes a personalized prevention plan of service	G0438, G0439
Alcohol misuse screening, counseling	G0442, G0443
Annual depression screening	G0444

High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior	G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease	G0446
Face-to-face behavioral counseling for obesity	G0447
Telehealth Pharmacologic Management	G0459
Comprehensive assessment of and care planning for patients requiring chronic care management services	G0506
Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient via telehealth; subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	G0508*, G0509*
Prolonged preventive service	G0513, G0514
Opioid treatment	G2086, G2087, G2088

*Modifier GT, 95 not required

Questions and Answers

Beginning **March 6, 2020**, Aetna will offer zero co-pay for covered telemedicine visits for any reason for **90 days**. We will waive the cost share for all video and telephone visits through the Aetna-covered Teladoc offerings and in-network providers delivering synchronous virtual care (live video-conferencing) for all Commercial plan designs*. Self-insured plan sponsors can opt-out of this program at their discretion.

*We will also cover and waive cost share for below codes during the 90-day period.

The following codes require an audiovisual connection:

Eligible Code Description	Eligible CPT/HCPCS
Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes; 11 – 20 minutes; or 21 or more minutes	G2061, G2062, G2063
Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	H0015 GT or 95
Mental health partial hospitalization, treatment, less than 24 hours.	H0035 GT or 95
Behavioral health day treatment, per hour.	H2012 GT or 95
Alcohol and/or other drug treatment program, per diem	H2036 GT or 95
Intensive outpatient psychiatric services, per diem	S9480 GT or 95
Behavior identification assessment, administered by a QHP, face to face with patient and/or guardians administering assessments and discussing findings and recommendations. Includes non-face-to-face analyzing of past data, scoring/interpreting the assessment, and preparing the report/treatment plan.	97151 GT or 95

Adaptive behavior treatment with protocol modification, administered by QHP, which may include simultaneous direction of a technician working face to face with a patient.	97155 GT or 95
Family adaptive behavior treatment guidance administered by QHP, with parent/guardian	97156 GT or 95
Multiple-family group adaptive behavior treatment guidance, administered by QHP, with multiple sets of parents/guardians	97157 GT or 95
Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10; 11-20; or 21 or more minutes.	98970, 98971, 98972
Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10; 11-20; or 21 or more minutes.	99421, 99422, 99423

The following codes require an audiovisual connection or telephone:

Eligible Code Description	Eligible CPT/HCPCS
Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, 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.	G2010
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; 5-10 minutes of medical discussion.	G2012
Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10; 11-20; or 21-30 minutes of medical discussion.	98966, 98967, 98968
Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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; 5-10; 11-20; or 20-30 minutes of medical discussion.	99441, 99442, 99443
Psychiatric diagnostic interview examination	90791, 90792 GT or 95
Individual psychotherapy	90832, 90833, 90834, 90836, 90837, 90838 GT or 95
Psychotherapy for crisis; first 60 minutes; or each additional 30 minutes	90839, 90840 GT or 95
Psychoanalysis	90845 GT or 95

Family or group psychotherapy	90846, 90847, 90853 GT or 95
Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	90863 GT or 95
Neurobehavioral status examination	96116 GT or 95

For more information, see our press release.

Additional References

N/A

Policy Revision Date

- Effective 01/01/20: Added coverage details for Commercial Plans and Medicare Advantage Plans
- 08/30/18 Update: Removed "Telemedicine for Consumer Business/Aetna Leap℠ Plans" section. Plans are no longer active as of 01/01/2018.
- 07/05/18 Update: Removed Medicare from the "Applies to" section. Medicare Advantage follows CMS guidelines for telemedicine as of January, 2012.
- Effective 03/08/17: Existing stand-alone policy "Concierge Medicine or Boutique Medicine" added to Telemedicine and Direct Patient Contact Policy. No change in policy.
- Effective 01/26/17: Added Modifier 95.
- Effective 01/01/17: Added Telemedicine Policy for Consumer Business/Aetna Leap℠ Plans.
- Effective 05/01/12: Exception removed from Direct Patient Contact Policy to allow payment when precertified.
- Effective 07/23/09: Charges for coordination of care under the "Patient-Centered Medical Home" model are eligible for payment.
- Effective 05/22/07: Charges for an online medical evaluation (e.g. eHealth visit) may be eligible for payment.

March 16, 2020

To: Network Hospital Administrators Distributed via: email

Subject: Blue Shield of California's Processes to Address COVID-19

Dear Hospital Administrator,

At Blue Shield of California, our top priority is to ensure our members have access to quality, affordable care and that our shared communities are safe as we work together to confront the COVID-19 virus. We are taking immediate steps to support COVID-19 screening and testing to promote the health, safety and well-being of our members.

Blue Shield is waiving all member cost-sharing and any prior approval for COVID-19 testing prescribed by a physician. This includes cost-sharing for hospital, urgent care, emergency room, and office visits where the purpose of the visit is to screen or test for the virus.

We will continue to inform you of business decisions made by Blue Shield that affect processes for addressing COVID-19 as you provide care for our members. We ask that you keep us informed of your capacity to provide care as patient influx grows, so we can efficiently plan for member needs. We will be monitoring the situation to determine whether we need to proactively reach out to some of our providers who serve larger member populations. We also want to know if you are setting up "drive-through testing" stations for your patients. To report any concerns about capacity issues, please contact your Blue Shield Provider Relations Representative.

Please be aware that callers to our Provider Customer Service phone lines are experiencing longer than usual waiting times, due to higher call volumes resulting from the COVID-19 pandemic. If you are looking for information regarding eligibility, benefits and claims, we strongly urge you to use online resources at our Provider Connection website at blueshieldca.com/provider. If your request is not urgent and you would rather call, we ask for your cooperation in waiting until next week to call our Provider Customer Service Department to obtain such information.

Please review the attached *Questions and Answers for Blue Shield of California Network Providers* for additional information on topics related to providing screening, testing and care to address the COVID-19 pandemic. If you have additional questions that are not addressed in the *Q&A*, please contact your Blue Shield Provider Relations Representative or Blue Shield Provider Contracting Director.

Sincerely,

Aliza Arjoyan
Senior Vice President,
Network Management and Provider Partnerships

Attachment: *Questions and Answers for Blue Shield of California Network Providers*

T10916 (3/20)
Y0118_20_146C_C 03162020

COVID-19 (Coronavirus)
Questions and Answers for Blue Shield of California Network Providers

Commercial and Medicare Business-related questions

March 16, 2020

Blue Shield of California (Blue Shield) is taking immediate steps to address COVID-19 and promote the health, safety and well-being of our members.

Please carefully review the information below related to providing care for Blue Shield members during this challenging time. If you have questions about eligibility or benefits, we strongly encourage you to visit Provider Connection at blueshieldca.com/provider to use our online services for finding such information. Due to higher than usual call volumes, providers have experienced long waiting periods when calling our Provider Customer Service Department. There is also general information available at our **member website** at blueshieldca.com/coronavirus.

Cost-sharing Responsibilities for Blue Shield Members

1. **Are cost-sharing responsibilities waived for Blue Shield members for screening and testing for COVID-19?**

   Blue Shield is waiving all member cost-sharing and any prior authorization for COVID-19 **screening and testing** for all fully-insured commercial plan HMO and PPO members and Medicare Advantage HMO and PPO members. This includes cost-sharing for screening and testing at hospitals, urgent care, emergency room, or physician offices and other appropriately designated locations.

2. **What about Blue Shield members whose coverage is under a self-funded employer plan? Do the same cost-sharing waivers apply to them?**

   Not all "self-funded" employer plans are waiving cost-sharing for their Blue Shield plan members for COVID-19 screening and testing. Please verify with Blue Shield whether a member whose coverage is through a self-funded client whether their self-funded plan is waiving cost-sharing.

   How do I recognize a member's plan as being under a "self-funded" client?
   If a member's plan ID card indicates "**Administrative Services Only,"** the member's plan is under a self-funded client. Self-funded plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA), which is federal law. Self-funded plans may opt out of compliance with the state mandate to waive cost-sharing for COVID-19 screening and testing.

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3. **For those members who qualify for cost-sharing waivers, does the waiver apply to treatment and care resulting from a positive result of testing for COVID-19?**

   No. Waivers for cost-sharing responsibility DO NOT apply to members receiving treatment and care resulting from their diagnosis of COVID-19.

   Consistent with our policy, if a member is admitted to the hospital, the hospital should follow its normal process of notifying Blue Shield that they have admitted one of our members.

4. **Will Blue Shield waive copays for calls to Teladoc for COVID-19 screening?**

   - To support effective access to Teladoc, Blue Shield is waiving copayments for ALL calls to Teladoc for Blue Shield fully-insured members, until further notice. The member will be informed of this decision when they contact Teladoc.

     Please note that copayments for Teladoc access are made up-front; since it is not possible to determine whether the Teladoc call is related to COVID-19 up-front, Teladoc copayments will be waived "across the board" until further notice.

5. **Will Blue Shield assume risk for the waived copayments administered by capitated providers for COVID-19 screening and testing provided to Blue Shield Members?**

   For our fee-for-service business, Blue Shield will absorb the costs for waived copayments for COVID-19 screening and testing in order to support network providers. Providers may submit claims through the normal process.

   For our capitated commercial business, Blue Shield will also absorb the costs for waived copayments for COVID-19 screening and testing in order to support network providers. We will send out a follow-up communication to explain the process for this remediation.

   For our capitated Medicare business, Blue Shield also will absorb the costs for waived copayments for COVID-19 screening and testing in order to support network providers. We will send out a follow-up communication to explain the process for this remediation.

Prior Authorization

There is no prior authorization required for COVID-19 treatment.

Billing/Coding for testing for COVID-19

- **Which billing codes should be used to bill for testing for COVID-19?**
  There are two new HCPCS codes for healthcare providers who need to **test** patients for COVID-19.

  - **HCPCS code U0001:** Providers using the Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel may bill for that test using this newly created HCPCS code (U0001).

  - **HCPCS code U0002**: The second new HCPCS code (U0002) can be used by laboratories and healthcare facilities to bill Medicare as well as by other health insurers that choose to adopt this new code for such tests. HCPCS code U0002 generally describes 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) using any technique, multiple types or subtypes (includes all targets).

  Guidelines provided by Centers for Medicare and Medicaid Services (CMS) are also recognized for commercial coverage, as well. The guidelines are available at **www.cms.gov/files**.

  Blue Shield is offering coverage for these testing codes effective for dates of service on and after **February 4, 2020** for Blue Shield and Blue Shield Promise members. This is a business decision made by Blue Shield for Blue Shield and Blue Shield Promise plan members.

Billing/Coding for screening via office visits, emergency room, and urgent care for COVID-19

- **Which billing codes should be used for screening provided for COVID-19?**

  - As stated on the Centers for Disease Control website at www.cdc.gov, there are currently no diagnosis codes as of yet that are specific to COVID-19.

  - There are interim ICD-10-CM official coding guidelines, effective February 20, 2020 (see below and at https://www.cdc.gov/nchs).

    - Because of the public health emergency, the World Health Organization (WHO) developed a new ICD-10 Diagnosis code U07.1 2019-nCoV acute respiratory disease, which will be part of the ICD-10 October 1, 2020 updates.

      Please note: Blue Shield has made a business decision to adopt the diagnosis code U07.1 in our claims system with an effective date of February 4, 2020 (meaning for dates of service on and after February 4, 2020).

      This decision applies ONLY to those plans for which Blue Shield is the primary payor.

      This means that Blue Shield will be accepting (for diagnoses) EITHER the CDC diagnosis coding spelled out below OR the new ICD-10 Code U07.1 described above.

The interim coding advice states to use existing codes and assign the following ICD-10-CM codes for *confirmed* cases related to COVID-19:

- Pneumonia due to COVID-19: J12.89 (Other viral pneumonia) and B97.29 (Other coronavirus as the cause of diseases classified elsewhere)
- Acute bronchitis due to COVID-19: J20.8 (Acute bronchitis due to other specified organisms) and B97.29 (Other coronavirus as the cause of diseases classified elsewhere)
- Bronchitis not otherwise specified (NOS) due to COVID-19: J40 (Bronchitis, not specified as acute or chronic) and B97.29 (Other coronavirus as the cause of diseases classified elsewhere)
- Lower respiratory infection NOS or acute respiratory infection NOS due to COVID-19: J22 (Unspecified acute lower respiratory infection) and B97.29 (Other coronavirus as the cause of diseases classified elsewhere)
- Respiratory infection NOS due to COVID-19: J98.8 (Other specified respiratory disorders) and B97.29 (Other coronavirus as the cause of diseases classified elsewhere)
    - Acute respiratory distress syndrome (ARDS) due to COVID-19: J80 (Acute respiratory distress syndrome) and B97.29 (Other coronavirus as the cause of diseases classified elsewhere)

- For possible exposure to COVID-19 that is ruled out after evaluation, assign code Z03.818 (Encounter for observation for suspected exposure to other biological agents ruled out). If a patient was exposed to someone with a confirmed case of COVID-19, assign code Z20.828 (Contact with and (suspected) exposure to other viral communicable diseases).

- If a patient presents with signs or symptoms without an established definitive diagnosis, assign codes for each of the presenting signs and symptoms such as:
    - Cough (R05)
    - Shortness of breath (R06.02)
    - Fever, unspecified (R50.9)

  Of special note, it typically would ***not*** be appropriate to assign code B34.2, Coronavirus infection, unspecified, for COVID-19 since this code is for unspecified sites and COVID-19 cases have usually been respiratory in nature.

  Do not assign code B97.29 for cases documented as "possible," "probable" or "suspected." Instead, assign codes for the signs or symptoms present or exposure to the virus.

  These guidelines may be updated if new clinical information becomes available. Visit the **NCHS website** to find information related to the coding of COVID-19.

Claims

- **Has Blue Shield received any claims related to COVID-19?**
  Due to federal privacy laws, we will not comment on whether any of our plan members have the virus or are receiving treatment.

Access to Supplies/Care

- **Is Blue Shield using telehealth to increase access to care while decreasing infection risks?** Teladoc service is available with waived co-payments for **all** calls for our fully insured members, as well as our Medicare Advantage HMO and PPO members. Only our self-funded clients have Teladoc as an optional buy-up. Teladoc service representatives and doctors are prepared to address questions around Coronavirus as they would any other illness, natural disaster, etc. This is a good first step to take for members who have Teladoc or NurseHelp 24/7 hotline benefits in order to learn more about their condition and treatment options.

- **Do all members with access to Teladoc have this service listed on their member ID cards?** All standard ID cards include the Teladoc copay and the Teladoc phone number. Only customized ID cards may not have this information.

- **How much do tests and test kits cost? How many are available for our network of providers?**

  We are not commenting on the cost or availability of the test kits. This is a question for either state or federal agencies.

- **With the interrupted supply chain between the US and China, there are general concerns about a pending shortage of prescription drugs. Will Blue Shield allow members to obtain early refills on their regular medications to ensure they have no disruption?**

  If a member cannot access their current supply of medication or requires an additional supply, a member or their provider/prescriber can call in and request an early refill of their prescription. Blue Shield is also closely monitoring the impact to the prescription drug supply and will take immediate steps to ensure members have access to medications.

  In the event of a drug shortage, Blue Shield has a standard process to ensure members have access to available medications to treat their condition.

Blue Shield's messages to members

Blue Shield is actively encouraging members to stay home from work (or school) if they are feeling ill. We are reminding our members of their benefits for using the **Teladoc** service, and encouraging them to report their conditions to their family doctor or urgent care clinic so that they can be appropriately referred for screening and lab tests, if necessary. **Heal** is available to many of our members for in-home visits, and NurseHelp 24/7 is available to our members to help them navigate healthcare decisions. This approach will help ensure they go to the right location to be tested and may help them avoid unnecessary visits to service locations where they may infect others.

Whom should I contact with questions?

If you are looking for eligibility, benefits and claims information, or to submit an authorization, please visit blueshieldca.com/provider. Providers calling Provider Customer Service phone lines are experiencing long wait times due to a higher volume of calls resulting from the COVID-19 pandemic.

We will continue to update and periodically distribute *Questions and Answers for Blue Shield of California Network Providers*. We also invite you to subscribe to Blue Shield's News Center for general, periodic announcements from Blue Shield.

Blue Shield of California Network Provider Update

To: Network Facility Administrators

March 25, 2020

From: Aliza Arjoyan, Senior Vice President
Network Management and Provider Partnerships

Distributed via: email

Subject: Blue Shield of California's COVID-19 Website for Providers Now Live

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At Blue Shield of California (Blue Shield), we continue to do all we can to support the health, safety and well-being of our members, as well as our network providers, during this COVID-19 public health emergency.

This week, we launched a provider website you can visit at any time: COVID-19: What our network providers need to know. Information on topics such as member cost-sharing, coding, billing, telehealth, and pharmacy services are available and will be updated frequently at the website.

We will also continue to proactively inform you of business decisions made by Blue Shield that may affect processes for addressing COVID-19 as you provide care for our members. We ask that you keep us informed of your capacity to provide care as patient influx grows, so we can efficiently plan for member needs and support you in any way we can. For example, please tell us if you are setting up a "drive-through" screening and/or testing site, or other emergent solutions. To report process developments or concerns about capacity issues, please contact your Blue Shield Provider Relations Representative.

Due to the COVID-19 public health emergency, callers to our Provider Customer Care Department at **(800) 541-6652** are experiencing longer wait times to speak directly with a representative. **Our automated information is available at (800) 541-6652 via our interactive voice response/voice response unit (IVR/VRU) system.** We also encourage you to visit Provider Connection, at blueshieldca.com, to get updates on eligibility, benefits, and claims status.

If your provider organization is contracted with both Blue Shield of California and Blue Shield of California Promise Health plan, you can also use Provider Connection at blueshieldca.com/provider to view **authorization status** there, via AuthAccel, for Blue Shield Promise members, in addition to Blue Shield members. The attached document tells you how to use this feature if it applies to you.

Thank you for the ongoing, dedicated care you provide for our members. We will continue to keep you informed as quickly and effectively as possible.

Attachment: *How to get authorization status for Blue Shield of California and Blue Shield of California Promise Health Plan members.*

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CIGNA CORONAVIRUS (COVID-19) INTERIM BILLING GUIDANCE FOR PROVIDERS

Updated as of March 17, 2020

As the COVID-19 pandemic continues to spread throughout the United States, we appreciate that providers across the country are on the front line to offer dedicated care to our customers and help protect local communities.

We also know it's more important than ever for Cigna to be committed to our customers' health and to remove the barriers you face in delivering safe, efficient, and quality care.

To honor this commitment, Cigna recently announced that we will:

- Waive customer cost-sharing for office visits related to COVID-19 screening and testing through May 31, 2020
- Waive customer cost-sharing for telehealth screenings for COVID-19 through May 31, 2020
- Make it easier for customers to be treated virtually for routine medical examinations by in-network physicians
- Provide free home delivery of up to 90-day supplies for Rx maintenance medications available through the Express Scripts Pharmacy and 24/7 access to pharmacists

To further this commitment, we are providing this COVID-19 Billing and Reimbursement Guidance to help ensure you can keep delivering the care you need to – in the office, at a facility, or virtually – all while getting properly reimbursed for the services you provide our customers.

To allow accurate and timely reimbursement for COVID-19 related services, Cigna is requesting that health care professionals submit claims using specific codes that our claim systems will recognize. If these recommended codes are used it will facilitate proper payment and help avoid errors and reimbursement delays.

Please note that this billing guidance document will continually be updated. Please check this document daily for updates, clarifications, and additional frequently asked questions.

Table of Contents

Interim Billing Guidelines for Coronavirus (COVID-19)

Updated March 17, 2020

- Please note that state and federal mandates may supersede these guidelines.
- These guidelines apply to fully insured clients and those self-funded clients who have chosen to follow these guidelines
- Cigna claims processing systems will be able to accept this coding guidance on April 6, 2020 for dates of service on or after March 2, 2020.
- Cigna will reimburse in person visits, phone calls, real-time synchronous virtual visits, and testing for COVID-19 without copay or cost share for all individuals covered under a fully-insured Cigna medical benefit plan and when billed according to the following guidelines:

Testing for COVID-19

a. Cigna will reimburse COVID-19 testing without customer copay or cost-share.
b. Kits approved through the CDC and/or the FDA approval process are eligible for reimbursement and should be billed with one of the following codes: HCPCS code U0001 (CDC kit), HCPCS codes U0002, or CPT code 87635 (FDA).
c. This billing requirement and associated reimbursement applies to services submitted on CMS1500 or UB04 claim forms and all electronic equivalents

Phone calls for COVID-19 (e.g.: 5-10 min virtual visit with or without video with the licensed health care provider)

a. HCPCS code G2012 will be reimbursed without customer copay or cost-share
b. In agreement with CDC recommendations one of the following ICD10 diagnosis codes should be billed:

    - For cases where there is a concern about a possible exposure to COVID-19, <u>but this is ruled out after evaluation</u>, it would be appropriate to assign the code Z03.818: Encounter for observation for suspected exposure to other biological agents ruled out.
    - For cases where there is an <u>actual exposure to someone who is confirmed to have COVID-19</u>, it would be appropriate to assign the code Z20.828: Contact with and (suspected) exposure to other viral communicable diseases.
    - This billing requirement and associated reimbursement applies to claims submitted on CMS 1500 claim forms or its electronic equivalent only.

All other virtual visits

a. CPT® code 99241 will be reimbursed for all other synchronous real-time virtual visits when billed with Place of Service 11.
b. If the visit is related to COVID-19, the above-mentioned ICD10 diagnosis codes (Z03.818 or Z20.828) are required to be billed and reimbursement will be without customer copay/cost-share.
c. If the virtual visit is not related to COVID-19, the ICD10 code for the visit should be billed and reimbursement will be made according to applicable benefits and related cost share.
d. No virtual care modifier should be billed
e. This billing requirement and associated reimbursement applies to services submitted on CMS1500 claim forms or its electronic equivalent only.

COVID-19 in person office visits, urgent care and emergency room visits

a. Cigna will reimburse in person office visits, urgent care and other outpatient visits for COVID-19 without customer cost share when one of the following appropriate ICD10 diagnosis code is billed:

- For cases where there is a concern about a possible exposure to COVID-19, it would be appropriate to assign the code Z03.818: Encounter for observation for suspected exposure to other biological agents ruled out.
- For cases where there is an actual exposure to someone who is confirmed to have COVID-19, it would be appropriate to assign the code Z20.828: Contact with and (suspected) exposure to other viral communicable diseases.
- This billing requirement and associated reimbursement applies to claims submitted on CMS1500 or UB04 claim forms and all electronic equivalents

Reimbursement for treatment of confirmed cases of COVID-19

Should be billed with ICD10 code B97.29: Other coronavirus as the cause of diseases classified elsewhere. Customer cost share applies to these claims.

Testing	
Code	**Description**
U0001	2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel
U0002	2019-nCoV Coronavirus, SARS COV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets)
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
Virtual Visits	
Code	**Description**
99241	Office consultation for a new or established patient, which requires these 3 key components: a problem focused history; a problem focused examination; and 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
G2012	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; 5-10 minutes of medical discussion

PROVIDER FREQUENTLY ASKED QUESTIONS FOR CORONAVIRUS (COVID-19)

Updated as of March 17, 2020

Key information

- In December 2019, a new kind of coronavirus, COVID-19, was identified as the cause of various cases of pneumonia in Wuhan City, Hubei Province of China. The virus is present in many locations around the world, including in the United States.

- On March 5, 2020, Cigna posted a press release announcing we will waive all co-pays and customer cost-share for COVID-19 testing.

- On March 13, 2020, Cigna posted a new press release announcing we will waive customers' out-of-pocket costs for COVID-19 testing-related visits with in-network providers, whether at a doctor's office, urgent care clinic, emergency room or via telehealth, through May 31, 2020.

- Due to the speed at which information related to COVID-19 is being released, this document will continually be updated as appropriate.

Key policy guidance at-a-glance

The following information applies when providers correctly bill using the guidance on the previous pages.

- Customers can receive in-network COVID-19 screening (office visit or virtual), testing (i.e., specimen collection by clinician), and laboratory testing (i.e., performed by state, hospital, or commercial laboratory) at no cost-share through May 31, 2020.

- Customers can receive COVID-19 related virtual care at no cost-share through May 31, 2020 (e.g., telephonic screening) when seeing their usual provider through our own contracted provider network or through our vendor network (e.g., Amwell or MDLive).

- Customers can receive non-COVID-19 related virtual care from their provider through May 31, 2020 (e.g., oncology follow-up visit), covered and reimbursed at standard office visit rates and customer cost-share.

- Non COVID-19 related in-office and virtual care remains at standard cost share, billing, and reimbursement requirements.

Questions and Answers

COVID-19 LABORATORY TESTING

Q. Will Cigna cover the laboratory test for COVID-19?

Yes. To help remove any barriers to receive testing, Cigna is committed to covering the laboratory test for COVID-19 similar to a preventive benefit for fully-insured plans – thereby waiving co-pays, coinsurance, or deductibles for customers.

This includes customers enrolled in Cigna's employer-sponsored plans in the United States, Medicare Advantage, Medicaid, and the Individual & Family plans available through the Affordable Care Act. Organizations that offer Administrative Services Only (ASO) plans will also have the option to cover coronavirus testing as a preventive benefit.

Q: What is a typical process for a patient to get screened and tested for COVID-19?

Per the CDC, as well as state and local public health departments, it is recommended that patients first be screened virtually (i.e., by phone or video) by a clinician for potential COVID-19 symptoms.

Typical COVID-19 testing decision factors include:

- Local epidemiology of COVID-19
- The clinical course of illness
- Fever (subjective or confirmed)
- Symptoms of acute respiratory illness (e.g., cough, difficulty breathing) and risk factors (e.g., travel history, exposure to a COVID-10 patient)
- Any close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
- History of travel from affected geographic areas within 14 days of symptom onset

Getting tested after screening:

- After a positive screen, the clinician will refer a patient to a physician’s office, urgent care center, hospital, “drive thru” specimen collection center, or other facility that is equipped to collect specimens in order to test for COVID-19
- Any physician, nurse practitioner, or physician assistant who has an approved testing kit may properly administer the test (i.e., specimen collection)
- The test is sent by the provider to an approved laboratory, where the specimen is tested for COVID-19
- The laboratory communicates the results to the provider within a few days, who communicates the results to the patient

Providers are also encouraged to test for other causes of respiratory illness, including infections such as influenza.

Q: What is a specimen collection center? What is the benefit of referring patients to one instead of a physician's office?

A specimen collection center is found at or adjacent to a hospital or other health care facility, and typically includes a specially designated area to collect specimens from potentially infected patients. These centers continue to be set up throughout the country by local health systems as a safer, quicker, and more efficient way of screening and testing patients.

Specimen collection centers set up to screen and test patients for COVID-19 typically employ health care personnel who adhere to CDC recommendations for infection prevention and control (IPC). This includes specialized equipment to prevent the spread of the virus.

Q: How does a provider properly collect the specimen for commercial laboratory testing?

Commercial laboratories have reported that many tests have not been able to be performed by the laboratory due to improper specimen collection.

Providers should follow the guidance below from a commercial laboratory to ensure that they properly collect and ship the COVID-19 specimens:

- LabCorp Specimen Collection and Shipping Instructions for COVID-19 Testing
- LabCorp Specimen Collection Visual Demonstration for COVID-19 Testing

For more information, please visit LabCorp's and Quest's website.

Q: If a patient screens positive for risk of COVID-19, but their local provider cannot perform the test – and do not know where else to refer the patient – what should the provider do?

If a provider determines their patient needs a COVID-19 test, but is not able to conduct the test themselves, providers should work with their local health department or an affiliated hospital to determine where their patients can go in their community to get tested. Providers are encouraged to call ahead and work with their patient to take proper isolation precautions when referring them for testing.

We recognize that the availability of COVID-19 testing kits varies based on location and may not currently meet the demand. National commercial labs with testing capabilities (e.g., LabCorp and Quest) are currently reaching out to local offices for more information on education and workflows. We are closely monitoring the availability of test kits, and will share more information as it becomes available.

Additionally, commercial laboratories like LabCorp and Quest have noted that they can supply physicians with test kits and will pick up the specimen.

For more information, please visit LabCorp's and Quest's website.

Q. When will a commercial laboratory test kit be available and who has it?

A commercial laboratory test for COVID-19 is now available. A health care provider must order the test for COVID-19.

As of March 11, in addition to the CDC and state health agencies, commercial laboratories LabCorp and Quest are offering testing for COVID-19. Additional laboratories – including local hospital systems – are also beginning to test. Providers should contact LabCorp or Quest – or their local hospital system – to confirm specific testing information and locations.

Q: Can the specimen collection be done at a patient service center, such as a local LabCorp or Quest location?

No. LabCorp and Quest will not collect specimens directly from patients. Collecting the specimen can only be done by a physician, physician assistant, or nurse practitioner in a physician's office, specimen collection center, urgent care center, hospital, or other facility that is equipped to collect specimens. Laboratory patient service centers are not equipped to collect specimens.

Q: When does a public health facility run a test versus that same test being sent to a commercial laboratory like LabCorp or Quest?

There are currently three ways to get COVID-19 tests: through a public health facility, commercial laboratory (e.g., LabCorp and Quest), or hospital. Public health departments are primarily focused on large epicenter outbreaks and public health emergency situations, while providers, virtual care providers, and health systems are typically more focused on individual patients with risk concerns or symptoms.

Depending on the person's identification, acuity, and location, they may get any one of these tests. All approved tests that are sent to an approved laboratory can properly be tested for the presence of COVID-19.

Q: Are there any prior authorizations required for COVID-19 testing?

No. Prior authorization is not required for COVID-19 testing.

COVID-19 MEDICAL TREATMENT

Q: Will Cigna waive customer co-pay and cost-sharing requirements for in-network services related to COVID-19 physician visits?

Yes. All customer co-pay and cost-share for any in-network screening and diagnosis related to COVID-19 will be waived. This includes:

- The initial COVID-19 screening (virtually, in an office, or at an emergency room, urgent care center, “drive thru” specimen collection center, or other facility)
- Testing (i.e., specimen collection by clinician)
- Laboratory test (i.e., performed by state, hospital, or commercial laboratory)

Even if the test results come back negative for COVID-19, or the provider does not believe the patient needs to be tested for COVID-19, the visit will still be covered without customer cost-share if the patient initially displays COVID-19 related symptoms (e.g., fever, cough, and difficulty breathing) or there is a concern of exposure. The provider will need to code appropriately to indicate COVID-19 related screening.

Q: Are there any prior authorizations required for COVID-19 treatment?

No. Prior authorization (i.e., precertification) is not required for evaluation, testing, or treatment for services related to COVID-19. Treatment is supportive only and focused on symptom relief.

Prior authorization for treatment follows the same protocol as any other illness based on place of service and according to plan coverage. Generally, this means routine office, urgent care, and emergency visits do not require prior authorization.

Q: Are referral requirements to see other physicians, specialists, or facilities being waived?

Referral requirements will remain the same as for any other illness according to plan coverage.

Q: What behavioral health resources does Cigna offer customers who may experience anxiety or other behavioral health-related issues as a result of COVID-19?

Cigna recommends using our Employee Assistant Program (EAP) or other behavioral health services, when available. EAP clinicians are available 24-hours a day, seven days a week.

In addition, many Cigna behavioral health providers offer telehealth services. Patients can visit myCigna.com to search for behavioral health providers who offers these services. Patients are also encouraged to ask their current behavioral health provider if they will begin extending virtual and telehealth services to their patients. We also provide behavioral health telehealth services through Amwell or MDLive.

For individuals who do not have health benefits or employee assistance program benefits through Cigna but could benefit from talking with a qualified representative, the toll-free number***,*** *866.912.1687,* will be open 24 hours a day, seven days a week, for as long as necessary. The service is open to anyone, free of charge, to help people manage their stress and anxiety so they can continue to address their everyday needs. Callers may also receive referrals to community resources to help them with specific concerns, including financial and legal matters.

Q: Is Cigna making a recommendation on where customers with COVID-19 symptoms should be steered (e.g. an urgent care center or emergency room for screening and testing instead of an office visit)?

Per the CDC, we recommend customers call ahead to their primary care provider or use telehealth if they develop a fever or symptoms of a respiratory illness, such as coughing or difficulty breathing, or have been in close contact with a person known to have coronavirus, or if they live in, or have recently visited, an area with ongoing spread.

Both primary care physicians and telehealth providers will work with the state's public health department and the CDC to determine if they need to be tested for coronavirus.

Q: Will providers who can't submit claims or request authorizations or file claims on time because of staffing shortages be penalized?

Cigna will make every effort to accommodate facilities and provider groups who are adversely affected by COVID-19, as appropriate.

We may request to review the care that was provided for medical necessity post-service.

Prior authorization is not required for evaluation, testing, or medically necessary treatment of Cigna customers related to COVID-19. For other services that do require authorization, we will not deny administratively for failure to secure authorization (FTSA) if the care was emergent, urgent, or if extenuating circumstances applied. Delays in timely filing of claims or the ability to request an authorization due to COVID-19 would be considered an extenuating circumstance in the same way we view care in middle of a natural catastrophe (e.g., hurricane, tornado, fires, etc.).

COVID-19 VIRTUAL CARE

Q: Will Cigna allow in-network providers to provide virtual care?

Yes. We are making it easier for customers to be treated virtually by their physicians who have the ability to offer virtual care. All providers can deliver virtual care to Cigna customers when the services are billed consistently with the guidance on pages 3-5. We are implementing this enhanced measure through May 31, 2020 to protect our customers by mitigating exposure risks and alleviating transportation barriers.

We are also working on a permanent Virtual Care Reimbursement Policy that will continue to allow providers in our network to offer virtual care after June 1, 2020. More information about this policy will be shared with providers in the coming months. In the meantime, our COVID-19 virtual care guidance will remain in effect until at least May 31, 2020.

Q: How will Cigna cover virtual care for COVID-19 related services?

When providers follow the billing guidance on pages 3-5, we will cover virtual care as follows:

- For COVID-19 related screening (i.e., quick phone or video consult):
  - By contracted physician in Cigna's network: No cost-share for customer
  - By virtual vendor (e.g., Amwell or MDLive): No cost-share for customer
- For non-COVID-19 related services (e.g., oncology visit, routine follow-up care)
  - By contracted physician in Cigna's network: Reimbursable at standard office visit rates.
  - By virtual vendor (e.g., Amwell or MDLive): Reimbursable at standard rates currently in place today.

STATE MANDATES

Q: How is Cigna complying with state mandates related to COVID-19, such as customer cost share, virtual care policies, testing covered at 100%?

Cigna health plans comply with all state mandates as applicable. We are actively reviewing all COVID-19 state mandates and will continue to share more details around coverage, reimbursement, and cost-share as it is available.

CIGNA BUSINESS CONTINUITY

Q: What are Cigna's contingency plans to ensure appropriate staffing for customer service, claim review, authorization requests, etc.?

Cigna has been actively engaged in business continuity planning to better protect our employees and serve our customers and plan participants during an emergency situation.

Maintaining business operations is a core area of planning:

- Cigna has a matrix of call and claim and health care facilitation centers in multiple locations around the United States and abroad. The systems capability in place gives the company the flexibility to re-route calls to other facilities as necessary in order to help ensure business continuity. We have employed this system for natural disasters such as hurricane season or during other weather-related facilities closures.
- Cigna has systems capability and flexibility, with the option to further expand these capabilities as warranted, to allow many of our employees to work from home in the event of an outbreak. Depending on the circumstances, we may encourage that practice in the event of any widespread disease.
- Cigna travel guidelines and restrictions have been developed and implemented to minimize the spread of the virus within the Cigna employee population and to generally minimize the spread of the virus from region to region, or country to country.

Q: What are Cigna/Express Scripts plans to sustain pharmacy inventories in the event of a drug shortage?

Cigna recently announced that we would provide free home delivery of up to 90-day supplies for Rx maintenance medications available through the Express Scripts Pharmacy and 24/7 access to pharmacists.

Additionally, we are well prepared to ensure we can meet the medication needs of our members so they can stay healthy. Our drug sourcing teams have a long-established risk monitoring tool that maps the origins of drug products around the globe and allows us to monitor supplies and adjust our inventory procurement to mitigate shortages. We have been monitoring this situation for several weeks, and have made adjustments to our procurement to ensure we have adequate inventories to meet demands.

Our business continuity team has been monitoring the COVID-19 situation for several weeks, and has been planning for potential scenarios. Our Chief Clinical Officer, Dr. Steve Miller, is leading a COVID-19 readiness center that will continue to monitor all aspects of this situation and ensure we can help our employees, clients, and customers be prepared.

Ensuring the health and safety of our employees, clients, and members is our top priority, and we are committed to communicating more information as it is available.

Q: Who do I contact if I have more information?

If you have additional questions about how Cigna is responding to COVID-19, please call Cigna Customer Service at 1.800.88Cigna (882.4462) or contact your local provider services representative or contractor, if applicable.

Medicare Telehealth Frequently Asked Questions (FAQs)
March 17, 2020

1. **Q: How will recently enacted legislation allow CMS to utilize Medicare telehealth to address the declared Coronavirus (COVID-19) public health emergency?**

   A: The Coronavirus Preparedness and Response Supplemental Appropriations Act, as signed into law by the President on March 6, 2020, includes a provision allowing the Secretary of the Department of Health and Human Services to waive certain Medicare telehealth payment requirements during the Public Health Emergency (PHE) declared by the Secretary of Health and Human Services January 31, 2020 to allow beneficiaries in all areas of the country to receive telehealth services, including at their home.

2. **Q: What does this mean? What payment requirements for Medicare telehealth services are affected by the waiver?**

   A: Under the waiver, limitations on where Medicare patients are eligible for telehealth will be removed during the emergency. In particular, patients outside of rural areas, and patients in their homes will be eligible for telehealth services, effective for services starting March 6, 2020.

3. **Q: Why wasn't this done before?**

   A: Current telehealth law only allows Medicare to pay practitioners for services like routine visits furnished through telehealth under certain circumstances. For example, the beneficiary receiving those services must generally be located in a rural area and in a medical facility. Where the beneficiary receives those services is known as the "eligible originating site." The beneficiary's home is generally not an eligible originating site, but under the new 1135 waiver, this will be waived during the emergency. This will now allow telehealth services to be provided in all settings – including at a patient's home.

4. **Q: What services can be provided by telehealth under the new emergency declaration?**

   A: CMS maintains a list of services that are normally furnished in-person that may be furnished via Medicare telehealth. This list is available here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes. These services are described by HCPCS codes and paid under the Physician Fee Schedule. Under the emergency declaration and waivers, these services may be provided to patients by professionals regardless of patient location.

   Medicare pays separately for other professional services that are commonly furnished remotely using telecommunications technology without restrictions that apply to Medicare Telehealth. These services, including physician interpretation of diagnostic tests, care management services and virtual check-ins, are normally furnished through communication technology.

5. **Q: Would physicians and other Qualified Providers be able to furnish Medicare telehealth services to beneficiaries in their homes?**

   A: Yes. The waiver temporarily eliminates the requirement that the originating site must be a physician's office or other authorized healthcare facility and allows Medicare to pay for telehealth services when beneficiaries are in their homes or any setting of care.

6. **Q: Who are the Qualified Providers who are permitted to furnish these telehealth services under the new law?**

   A: Qualified providers who are permitted to furnish Medicare telehealth services during the Public Health Emergency include physicians and certain non-physician practitioners such as nurse practitioners, physician assistants and certified nurse midwives. Other practitioners, such as certified nurse anesthetists, licensed clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals may also furnish services within their scope of practice and consistent with Medicare benefit rules that apply to all services. This is not changed by the waiver.

7. **Q: Will CMS enforce an established relationship requirement?**

   A: No. It is imperative during this public health emergency that patients avoid travel, when possible, to physicians' offices, clinics, hospitals, or other health care facilities where they could risk their own or others' exposure to further illness. Accordingly, the Department of Health and Human Services (HHS) is announcing a policy of enforcement discretion for Medicare telehealth services furnished pursuant to the waiver under section 1135(b)(8) of the Act. To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

8. **Q: Is any specialized equipment needed to furnish Medicare telehealth services under the new law?**

   A: Currently, CMS allows for use of telecommunications technology that have audio and video capabilities that are used for two-way, real-time interactive communication. For example, to the extent that many mobile computing devices have audio and video capabilities that may be used for two-way, real-time interactive communication they qualify as acceptable technology.

   The new waiver in Section 1135(b) of the Social Security Act explicitly allows the Secretary to authorize use of telephones that have audio and video capabilities for the furnishing of Medicare telehealth services during the COVID-19 PHE. In addition, 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. For more information: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

9. **Q: How does a qualified provider bill for telehealth services?**

   A: Medicare telehealth services are generally billed as if the service had been furnished in-person. For Medicare telehealth services, 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.

10. **Q: How much does Medicare pay for telehealth services?**

    A: Medicare pays the same amount for telehealth services as it would if the service were furnished in person. For services that have different rates in the office versus the facility (the site of service payment differential), Medicare uses the facility payment rate when services are furnished via telehealth.

11. **Q: Are there beneficiary out of pocket costs for telehealth services?**

    A: The use of telehealth does not change the out of pocket costs for beneficiaries with Original Medicare. Beneficiaries are generally liable for their deductible and coinsurance; however, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

12. **Q: How long does the telehealth waiver last?**

    A: The telehealth waiver will be effective until the PHE declared by the Secretary of HHS on January 31, 2020 ends.

13. **Q: Can hospitals, nursing homes, home health agencies or other healthcare facilities bill for telehealth services?**

    A: Billing for Medicare telehealth services is limited to professionals. (Like other professional services, Critical Access Hospitals can report their telehealth services under CAH Method II). If a beneficiary is in a health care facility (even if the facility is not in a rural area or not in a health professional shortage area) and receives a service via telehealth, the health care facility would only be eligible to bill for the originating site facility fee, which is reported under HCPCS code Q3014. But the professional services can be paid for.

14. **Q: Can qualified providers let their patients know that Medicare covers telehealth?**

    A: Yes. Qualified providers should inform their patients that services are available via telehealth.

15. **Q: Should on-site visits conducted via video or through a window in the clinic suite be reported as telehealth services?**

    A: Services should only be reported as telehealth services when the individual physician or professional providing the telehealth service is not at the same location as the beneficiary.

16. **Q: How is this different from virtual check-ins and e-visits?**

    A: A virtual check-in pays professionals for brief (5-10 min) communications that mitigate the need for an in-person visit, whereas a visit furnished via Medicare telehealth is treated the same as an in-person visit, and can be billed using the code for that service, using place of service 02 to indicate the service was performed via telehealth. An e-visit is when a beneficiary communicates with their doctors through online patient portals.

17. **Q: Are the telehealth services only limited to services related to patients with COVID-19?**

    A: No. The statutory provision broadens telehealth flexibility without regard to the diagnosis of the patient. This is a critical point given the importance of social distancing and other strategies recommended to reduce the risk of COVID-19 transmission, since it will prevent vulnerable beneficiaries from unnecessarily entering a health care facility when their needs can be met remotely. For example, a beneficiary could use this to visit with their doctor before receiving another prescription refill. However, Medicare telehealth services, like all Medicare services, must be reasonable and necessary under section 1862(a) of the Act.

18. **Q: Will CMS require specific modifiers to be applied to the existing codes?**

    A: CMS is not requiring additional or different modifiers associated with telehealth services furnished under these waivers. However, consistent with current rules, there are three scenarios where modifiers are required on Medicare telehealth claims. In cases when a telehealth service is furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii, the GQ modifier is required. When a telehealth service is billed under CAH Method II, the GT modifier is required. Finally, when telehealth service is furnished for purposes of diagnosis and treatment of an acute stroke, the G0 modifier is required.

19. **Q: What flexibilities are available in the Medicaid program to provide care via telehealth for individuals who are quarantined or self-isolated to limit risk of exposure?**

    A: States have broad flexibility to cover telehealth through Medicaid. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services. A state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

    More information is available:
    https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html

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KNOWLEDGE • RESOURCES • TRAINING

PRINT-FRIENDLY VERSION

TELEHEALTH SERVICES

Target Audience: Medicare Fee-For-Service Providers

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

TABLE OF CONTENTS

Learn about these Medicare telehealth services topics:

- Originating sites
- Distant site practitioners
- Telehealth services
- Telehealth services billing and payment
- Telehealth originating sites billing and payment
- Resources
- Helpful websites and Regional Office Rural Health Coordinators

Medicare pays for specific (Part B) physician or practitioner services furnished through a telecommunications system. Telehealth services substitute for an in-person encounter.

ORIGINATING SITES

An originating site is the location where a Medicare beneficiary gets physician or practitioner medical services through a telecommunications system. The beneficiary must go to the originating site for the services located in either:

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

The Health Resources and Services Administration (HRSA) decides HPSAs, and the Census Bureau decides MSAs. To see a potential Medicare telehealth originating site's payment eligibility, go to HRSA's Medicare Telehealth Payment Eligibility Analyzer.

Providers qualify as originating sites, regardless of location, if they were participating in a Federal telemedicine demonstration project approved by (or getting funding from) the U.S. Department of Health & Human Services as of December 31, 2000.

Beginning July 1, 2019, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act removes the originating site geographic conditions and adds an individual's home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder.

Each December 31 of the prior calendar year (CY), an originating site's geographic eligibility is based on the area's status. This eligibility continues for a full CY. Authorized originating sites include:

- Physician and practitioner offices
- Hospitals
- Critical Access Hospitals (CAHs)
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNFs)
- Community Mental Health Centers (CMHCs)
- Renal Dialysis Facilities
- Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis
- Mobile Stroke Units

Note: Medicare does not apply originating site geographic conditions to hospital-based and CAH-based renal dialysis centers, renal dialysis facilities, and beneficiary homes when practitioners furnish monthly home dialysis ESRD-related medical evaluations. Independent Renal Dialysis Facilities are not eligible originating sites.

Beginning January 1, 2019, the Bipartisan Budget Act of 2018 removed the originating site geographic conditions and added eligible originating sites to diagnose, evaluate, or treat symptoms of an acute stroke. Go to MLN Matters® article, New Modifier for Expanding the Use of Telehealth for Individuals with Stroke to learn how to use the new modifier for billing.

DISTANT SITE PRACTITIONERS

Distant site practitioners who can furnish and get payment for covered telehealth services (subject to State law) are:

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs) and clinical social workers (CSWs)
  - CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or get paid for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.
- Registered dietitians or nutrition professional

TELEHEALTH SERVICES

You must use an interactive audio and video telecommunications system that permits real-time communication between you at the distant site, and the beneficiary at the originating site.

Transmitting medical information to a physician or practitioner who reviews it later is permitted only in Alaska or Hawaii Federal telemedicine demonstration programs.

CY 2019 Medicare Telehealth Services

Service	HCPCS/CPT Code
Telehealth consultations, emergency department or initial inpatient	G0425–G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	G0406–G0408
Office or other outpatient visits	99201–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	99231–99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	99307–99310
Individual and group kidney disease education services	G0420–G0421
Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction furnished in the initial year training period to ensure effective injection training	G0108–G0109
Individual and group health and behavior assessment and intervention	96150–96154
Individual psychotherapy	90832–90838
Telehealth Pharmacologic Management	G0459
Psychiatric diagnostic interview examination	90791–90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90963

CY 2018 Medicare Telehealth Services (cont.)

Service	HCPCS/CPT Code
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 2–11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90964
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 12–19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90965
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older	90966
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age	90967
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 2–11 years of age	90968
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 12–19 years of age	90969
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	90970
Individual and group medical nutrition therapy	G0270, 97802–97804
Neurobehavioral status examination	96116
Smoking cessation services	G0436, G0437, 99406, 99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	G0396, G0397
Annual alcohol misuse screening, 15 minutes	G0442
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	G0443
Annual depression screening, 15 minutes	G0444

CY 2018 Medicare Telehealth Services (cont.)

Service	HCPCS/CPT Code
High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	G0446
Face-to-face behavioral counseling for obesity, 15 minutes	G0447
Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	99495
Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	99496
Advance Care Planning, 30 minutes	99497
Advance Care Planning, additional 30 minutes	99498
Psychoanalysis	90845
Family psychotherapy (without the patient present)	90846
Family psychotherapy (conjoint psychotherapy) (with patient present)	90847
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	99354
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	99355
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service)	99356
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service)	99357
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit	G0438

CY 2018 Medicare Telehealth Services (cont.)

Service	HCPCS/CPT Code
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit	G0439
Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth	G0508
Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	G0509
Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making	G0296
Interactive Complexity Psychiatry Services and Procedures	90785
Health Risk Assessment	96160, 96161
Comprehensive assessment of and care planning for patients requiring chronic care management	G0506
Psychotherapy for crisis	90839, 90840
Prolonged preventive services	G0513, G0514

A physician, NP, PA, or CNS must furnish at least one ESRD-related “hands on visit” (not telehealth) each month to examine the beneficiary’s vascular access site.

TELEHEALTH SERVICES BILLING AND PAYMENT

Submit professional telehealth service claims using the appropriate CPT or HCPCS code.

If you performed telehealth services "through an asynchronous telecommunications system", add the telehealth GQ modifier with the professional service CPT or HCPCS code (for example, 99201 GQ). You are certifying the asynchronous medical file was collected and transmitted to you at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii.

Submit telehealth services claims, using Place of Service (POS) 02-Telehealth, to indicate you furnished the billed service as a professional telehealth service from a distant site. As of January 1, 2018, distant site practitioners billing telehealth services under the CAH Optional Payment Method II must submit institutional claims using the GT modifier.

Bill covered telehealth services to your Medicare Administrative Contractor (MAC). They pay you the appropriate telehealth services amount under the Medicare Physician Fee Schedule (PFS). If you are located in, and you reassigned your billing rights to, a CAH and elected the Optional Payment Method II for outpatients, the CAH bills the telehealth services to the MAC. The payment is 80 percent of the Medicare PFS facility amount for the distant site service.

TELEHEALTH ORIGINATING SITES BILLING AND PAYMENT

HCPCS Code Q3014 describes the Medicare telehealth originating sites facility fee. Bill your MAC for the separately billable Part B originating site facility fee.

Note: The originating site facility fee does not count toward the number of services used to determine payment for partial hospitalization services when a CMHC serves as an originating site.

RESOURCES

Telehealth Services Resources

For More Information About…	Resource
Telehealth Services	CMS.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html CMS.gov/Medicare/Medicare-General-Information/Telehealth CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
Physician Bonuses	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1246598.html

Hyperlink Table

Embedded Hyperlink	Complete URL
Health Professional Shortage Area	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses
Medicare Telehealth Payment Eligibility Analyzer	https://data.hrsa.gov/tools/medicare/telehealth
New Modifier for Expanding the Use of Telehealth for Individuals with Stroke	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10883.pdf
Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act	https://www.congress.gov/bill/115th-congress/house-bill/6

HELPFUL WEBSITES

American Hospital Association Rural Health Care
https://www.aha.org/advocacy/small-or-rural

Critical Access Hospitals Center
https://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html

Disproportionate Share Hospitals
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html

Federally Qualified Health Centers Center
https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

Health Resources and Services Administration
https://www.hrsa.gov

Hospital Center
https://www.cms.gov/Center/Provider-Type/Hospital-Center.html

Medicare Learning Network®
http://go.cms.gov/MLNGenInfo

National Association of Community Health Centers
http://www.nachc.org

National Association of Rural Health Clinics
https://narhc.org

National Rural Health Association
https://www.ruralhealthweb.org

Rural Health Clinics Center
https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Rural Health Information Hub
https://www.ruralhealthinfo.org

Swing Bed Providers
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html

Telehealth
https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth

Telehealth Resource Centers
https://www.telehealthresourcecenter.org

U.S. Census Bureau
https://www.census.gov

REGIONAL OFFICE RURAL HEALTH COORDINATORS

To find contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues, refer to CMS.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf.