As of June 4, 2020

Responses by Kevin Beagan, Deputy Commissioner, DOI to Questions Posed in April/May 2020 MHA/MMS Conference Calls

(Please note that I may not always agree with what was characterized by callers within questions, but have tried to maintain most questions as posed to be responsive to what was requested.)

Please note that this Q&A only applies to insured health plans subject to Division of Insurance review.

Division of Insurance

- Which health plans does the Division regulate?
  The Division only has authority over insured health benefit plans, which are insured products that are directly purchased by an individual or employer from an insurance carrier. Carriers are expected to be in compliance with Massachusetts rules for all insured health products issued in Massachusetts.

The Division does not have authority over the following:

- Government plans, including Medicare, Medicaid, the Group Insurance Commission;
- Self-funded employer-sponsored plans, even where the employer uses the services of an insurance carrier to administer claims payments; or
- Out-of-state insurance carriers where the employee lives in Massachusetts but whose coverage is issued through an employer located in another state.

- Can you please provide best info for providers to contact the DOI if there is an issue with the insurer that we are unable to resolve?
  During this period under which the Governor's Executive Order applies, providers should contact Kevin Beagan, Deputy Commissioner, Health Care Access Bureau within the Division of Insurance, at either kevin.beagan@mass.gov or 617-521-7323.

Scope of Coverage

- Can audiology, nutrition and dietician services be billed as telehealth?
  If a telehealth service is covered by a health plan and the provider can provide the service consistent with the provisions of Bulletin 2020-04, it should be covered according to the Bulletin for the duration of the Governor's Emergency Order.

- Can providers see patients who are out of state temporarily?
  Health care providers must practice according to the scope of their license. Many have questioned how this applies under COVID-19 when individuals may be located outside Massachusetts and certain states have expanded state licensing laws to allow persons to practice in other states. If a provider is allowed under appropriate licensing laws to practice in the state where the patient is located, then this should be covered under the telehealth requirements subject to the terms of the network and plan offerings that govern the treatment.

Coding and Billing

- Why don't payers uniformly use CPT codes for telemedicine visits?
  The insurance carriers implemented Bulletin 2020-04 in short order to take steps to prevent the spread of COVID-19. Consequently, they set up codes and systems necessary to become operational

quickly. The Division is in conversation with many about what framework may apply to telemedicine after the expiration of the Governor's Emergency Order.

- What are the CPT codes, modifiers, and POS codes (if applicable) for COVID-19 testing, treatment, and telemedicine visits for each health plan?
- When adjudicating claims with COVID lab tests (*i.e.*, CPT 87635, U0002), payers' processes for adjudicating claims are different with respect to whether their systems only accept the CPT/HCPCS code, or the ICD-10 codes, or both. Is there a way to clarify the processes?
- Please clarify the policies for payments and cost sharing for labs with non-COVID-19 CPT codes on the claim.
  See attached list of all billing codes used by the insurance carriers, which clarifies each company's billing processes and ways to address cost sharing. The attached list includes CPT codes, modifiers, and place of service codes for testing, treatment, and telemedicine visits, including high throughput testing and telephone-only telehealth visits, in effect as of the date of the publication of the list. As to the codes and payment policies utilized by an individual carrier's health plan, network providers shall refer to provisions included within their contracts with their payer. If any providers have questions about specific codes and specific payers, they should contact the payer, and if not satisfied by the payer, then contact Kevin Beagan at 617-521-7323.

- Because payers have been making ongoing changes to Telehealth on a frequent basis, with modifiers/POS and rates, will the payers be looking back at claims that we have submitted and have been paid since the date the emergency order went into effect, especially if they have made rate changes and increased rates? Or are we expected to resubmit these claims?
  If any providers have questions about claims submission processes for specific payers, they should contact the payer, and if not satisfied by the payer, then contact Kevin Beagan at 617-521-7323.

- Which payers are accepting the 2 high through-put COVID testing codes (U0003 and U0004)?
  My understanding is that all the carriers are accepting U0003 and U0004.

- Which payers are allowing the COVID specimen collection charges G2023 and G2024?
  If any providers have questions about specific codes and specific payers, they should contact the payer, and if not satisfied by the payer, then contact Kevin Beagan at 617-521-7323.

- How should providers bill MassHealth Managed Care Entities?
  The Division of Insurance does not have jurisdiction over any government plans, including MassHealth. Providers will need to contact MassHealth for information used by that agency.

Facility Fees

- Clarification of hospital billing for telehealth services. The DOI Bulletin prohibits billing of facility fees, yet also says that telehealth would be paid on parity within person visits?
  Where contractually required for in-person services, health plans should continue to pay facility fees for an in-person visits provided via telehealth during the duration of the Governor's Executive Order.

- Can you clarify that when someone bills globally, it includes components of technical/professional for a private or hospital-based practice (for example). By contrast, the split bill includes a prof fee and then a technical claim by a hospital or outpatient hospital clinics; the prof fee is a professional service (a professional entity) and then the technical (hospital) fee helps to cover costs of resources and tools to provide the services. This occurs for hospital owned clinics that have physician services (different entity) performing work in them.
  - A global bill is one entity
  - Split (2 bills) are two different entities.
  - Can you get that clarified? Covering a global bill because it comes from one entity vs covering a technical/professional split billing doesn't seem accurate. Again, these split bills occur in hospital owned clinics whose services are performed by doctors employed by a different company. If the technical claim isn't covered, how is the hospital made whole for the support staff, space, etc. to support these services?

Where contractually required for in-person services, health plans should continue to pay facility fees for an in-person visit provided via telehealth during the duration of the Governor's Executive Order.

Cost-Sharing

- Is cost-sharing waived for any and all care provided during the period of the Governor's Executive Order? Is there cost-sharing for non-COVID-19 diagnoses?
- Given we are doing telehealth to reduce patient risk of exposure to COVID-19, why isn't every telehealth visit considered to be related to COVID-19?
- Psychiatrists and other behavioral health specialists are seeing patients who have anxiety due to the risk of COVID-19. Will there be no copays and no cost sharing by patients for that treatment?

  The Governor's Executive Order and DOI Bulletin 2020-04 are clear about how cost-sharing is to be applied to testing/treatment for COVID-19. DOI identified that there would not be cost-sharing for COVID-19 testing and treatment. All other non-COVID-19 services being delivered via telehealth are subject to the plan's cost-sharing according to the terms of the insured's coverage. Some plans have chosen to waive cost sharing for non-COVID-19 related services. Providers and subscribers should check with the health plan for specific policies.

- When patients present to the hospital Emergency Department with COVID-19 symptoms but are not eligible for testing, is that visit and any services within that visit subject to cost-sharing?

  Cost-sharing is waived only for COVID-19 testing or treatment. If there is not any testing or treatment for COVID-19, then cost-sharing should apply.

- Should cost-sharing be waived for other lab tests done during the same day or same visit as a COVID-19 test? Would the patient liability amounts be waived for those as well?

  Generally, for non-COVID-19 testing and treatment done during a visit, cost-sharing will apply according to the terms of the provider's contract with the carrier. Some plans have chosen to waive cost sharing for non-COVID-19 related services. Providers and subscribers should check with the health plan for specific policies.

- Should cost-sharing be waived for inpatient and outpatient non-COVID-19 services performed during the same visit?

Generally, for non-COVID-19 testing and treatment done during a visit, cost-sharing will apply according to the terms of the provider's contract with the carrier.

- Should cost-sharing be waived for treatment of suspected COVID-19 cases that are subsequently ruled out?
  Testing and diagnosis related to COVID-19 is covered without cost-sharing, but any subsequent treatment that is billed to a carrier is subject to cost-sharing according to the terms of the provider's contract with a health plan.

- Governor Baker's executive order mandated that telehealth be paid at rates "not lower than the rates of payment established by the carrier for services delivered via traditional methods," and "carriers are required to cover these services without any cost-sharing. How are providers supposed to be made whole for the treatment that they provide? "
  According to Bulletin 2020-04, providers are to be paid the same as their professional billing for an in-person visit, including any waived cost sharing for COVID-19 testing and treatment. Bulletins 2020-02 and 2020-04 have indicated that there should not be cost-sharing for in-network COVID-19 testing and treatment. However, all non-COVID-19 testing and treatment would be subject to the same cost-sharing (copayments, coinsurance, and deductibles) that apply to visits under the patient's health plan unless the plan has voluntarily waived these charges, in which case the provider should receive the full allowed amount – including telehealth services. Providers and subscribers should check with each plan about their procedures.

Modalities

- Looking for clarification around the statutory requirement for audio-visual telehealth. Can Carriers refuse to cover telephone-only calls?
  The Governor's Emergency Order and Bulletin 2020-04 make clear that carriers are not permitted to place any requirements on the technologies used to deliver telehealth services (including any limitations on audio-only or on live-video technologies) Provided that the patient is in an insured health plan, the services are covered, and the telehealth visit is consistent with what is described in Bulletin 2020-04, carriers are required to make any such covered services available via telehealth without limitations on the technology used during the period of the Emergency Order. If there are concerns about any insurance carrier not acting consistently with Bulletin 2020-04, it should be brought to the attention of the Division of Insurance at (617) 521-7323.

- Is Zoom a covered modality for telehealth?
  During the duration of the Governor's Emergency Order, carriers may not limit the method of telehealth. The Division has heard concerns raised about the security of certain telehealth platforms and understands that the technology platform has addressed these concerns. The security of telehealth platforms will need to be addressed as we are looking beyond the Governor's Emergency Order.

Telemedicine Coverage after the Expiration of Emergency Order

- What work is ongoing to ensure telehealth coverage beyond Governor Baker's exec order ensuring coverage beyond the state of emergency? Surely even once the state of emergency has lifted, patients are going to be hesitant to come into the hospital setting.

- As physicians we are going to have to be judicious with our resources and ongoing stewards of social distancing and will have to be cautious with our approach with how rapidly we bring patients back into our in-person clinics (to help avoid things like packed waiting rooms and back to back appointments as we adjust to a new normal).
- We will want to be particularly careful about our elderly and immunosuppressed patients. Ensuring ongoing telehealth coverage beyond the state of emergency is going to be essential and universal buy-in from our insurers will be key.

  We are engaged in conversations about this at this time. We know that the conditions of the Executive Order only apply while the public health emergency is in effect. Despite this time limitation, in the interests of continuing public health for Massachusetts residents, a plan that promotes continued access while ensuring long-term sustainability is a reasonable expectation held by all. The conditions of any further guidance on this topic will be important in order to craft transition rules towards that consensus goal.

- Is the DOI looking at keeping the requirement that telehealth be reimbursed at 100% of CPT code reimbursement after the emergency?

  Bulletin 2020-04 applies for the duration of the Governor's Emergency Order. There will need to be discussions among all stakeholders about the availability of telehealth services following the expiration of the Emergency Order.

- Is there any progress in unified and simplified billing and coding guidelines that will be agreed upon across all insurers?

  Our agency is discussing this issue with stakeholders about telehealth following the expiration of the Governor's Emergency Order. The Division of Insurance also issued Bulletin 2020-15 on April 30, 2020, regarding the relaxation of certain administrative procedures during the COVID-19 emergency. The Division indicated that it expected carriers to do the following:

  "Explore ways to streamline coding and billing policies to reduce the administrative complexity of coding for claims. Carriers should look for all ways to facilitate coding of claims and reduce the development of special codes that may differ from one Carrier to another or that differ from Medicare guidance. Carriers are encouraged to discuss these issues by and between Carriers in order to accomplish this goal during the emergency period."

Administrative Issues:

- Are insurance companies waiving the requirement of obtaining insurance referrals to medical specialists or behavioral health providers?

  The Division of Insurance issued Bulletin 2020-15 on April 30, 2020 regarding the relaxation of certain administrative procedures during the COVID-19 emergency. Although there were not specific references to non-COVID-19 outpatient services, we are looking for carriers to develop appropriate administrative processes to help facilitate the delivery of care.