**Telemedicine Updates | January 2022**

**Fallon Health**

Fallon is covering telemedicine visits for all members for both COVID-19 and non-COVID-19 related services for all members. Cost sharing will be waived for COVID 19 related services. Additionally, until further notice, for telehealth visits providers will be reimbursed at the same rate as an in-person visit.

For full details of the policy, please visit the payment policies page on our provider portal at <http://www.fchp.org/en/providers/criteria-policies-guidelines/payment-policies.aspx>



**CIGNA**

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| Since the COVID-19 pandemic began, Cigna has taken important steps to deliver timely accommodations to providers and customers, helping to ensure that customers have continued access to COVID-19 diagnostic services, testing, and treatment in safe settings.**Reinstituting and extending interim accommodations**With the recent surge of COVID-19 cases resulting in increased strain on providers, we are making a number of accommodations to support you.* The facility-to-facility transfer authorization waiver for Cigna commercial and Cigna Medicare Advantage customers has been reinstituted, and is in place effective immediately for all transferring facilities through March 31, 2022.
* Interim credentialing accommodations are extended through March 31, 2022.
* The authorization approval window will be extended from three months to six months on request from a provider.

**Billing place of service 10 for virtual care services**CMS [recently announced](https://urldefense.com/v3/__https%3A/wlink.graphnet.com/maximail/link.htm?trlnkid=157273A97306A207499885__;!!CvMGjuU!qpMufmsSupgXFKbaPuiXKEW1ZFuB7znx-pujX3_1DJ8VWtbfYSMZsVswIJftdM3QBNZ86pUn$) updates to their place of service (POS) guidelines for virtual care by revising the description of existing POS code 02 and adding new POS code 10. CMS has indicated POS 10 is effective January 1, 2022, but will not be available to bill for Medicare until April 1, 2022.In the interim, Cigna commercial still asks providers to bill with a typical face-to-face place of service (e.g., POS 11), and to not bill POS 10 until further notice. This will help ensure that providers continue to receive face-to-face reimbursement rates. Cigna Medicare Advantage expects to align with CMS guidelines to accept POS 10 on April 1, 2022.**eConsult services remain covered, but cost-share now applies**Throughout the pandemic, we have covered certain eConsult codes without customer cost-share. Please note that while these codes continue to be covered as part of our interim COVID-19 guidelines, cost-share now applies for all commercial eConsult services, effective January 1, 2022. We therefore encourage providers who intend to leverage an eConsult to obtain consent from their patients prior to initiating an eConsult with another provider. This will help avoid any surprise billing scenarios for your patients with commercial Cigna coverage. **Submitting vaccine administration claims for patients with Medicare Advantage plans**For 2020 and 2021, Medicare payment for COVID-19 vaccine administration for beneficiaries enrolled in Medicare Advantage plans were made through the original fee-for-service Medicare program. CMS asked providers to submit claims for administering the COVID-19 vaccine to the CMS Medicare Administrative Contractor (MAC) using product-specific codes for each vaccine approved.However, as of January 1, 2022, providers should submit vaccine administration claims directly to Cigna Medicare Advantage for patients enrolled in a Cigna Medicare Advantage plan.**Get all the latest updates**We updated our dedicated [commercial](https://urldefense.com/v3/__https%3A/wlink.graphnet.com/maximail/link.htm?trlnkid=157272A97306A207499885__;!!CvMGjuU!qpMufmsSupgXFKbaPuiXKEW1ZFuB7znx-pujX3_1DJ8VWtbfYSMZsVswIJftdM3QBHdswNdn$) and [Medicare Advantage](https://urldefense.com/v3/__https%3A/wlink.graphnet.com/maximail/link.htm?trlnkid=157271A97306A207499885__;!!CvMGjuU!qpMufmsSupgXFKbaPuiXKEW1ZFuB7znx-pujX3_1DJ8VWtbfYSMZsVswIJftdM3QBPKz5I1I$) COVID-19 website pages on December 29, 2021 to highlight these updates and more. Please visit the sites often to get the latest information.**Thank you again for the quality care you provide and for all that you’re doing to help our customers.**

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| Visit CignaforHPC.com |

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Cigna’s current Virtual Care policy can be found on [www.cignaforhcp.com](https://urldefense.com/v3/__http%3A/www.cignaforhcp.com__;!!CvMGjuU!u_k9m2XW3Uc7rgzmpPYt9nBC7NRi2-0Xcdf3cnKvpJ87GNicmKVIwdxfGdGrZnaWCOa_-pww$) .

[CHCP - Resources - Virtual Care (cigna.com)](https://urldefense.com/v3/__https%3A/static.cigna.com/assets/chcp/resourceLibrary/medicalResourcesList/medicalDoingBusinessWithCigna/medicalDbwCVirtualCare.html__;!!CvMGjuU!u_k9m2XW3Uc7rgzmpPYt9nBC7NRi2-0Xcdf3cnKvpJ87GNicmKVIwdxfGdGrZnaWCEV2I-GO$)

**Humana Military | TRICARE**

Tricare have not received any new or further directive from the government regarding any changes for telemedicine. At this point, no new update to the telemedicine policy. Please continue to review Tricare COVID-19 policy regularly. [TRICARE East providers (humanamilitary.com)](https://www.humanamilitary.com/provider/)

**Blue Cross Blue Shield Ma**

As you know, many provisions of the Consolidated Appropriations Act (CAA) of 2021 and the Transparency in Coverage Final Rule began impacting our members starting **Jan. 1, 2022**. As providers caring for our members, some of these provisions may impact you as well.

Here are highlights of these federal requirements. We’ll continue to publish more information as it becomes available. We advise you to consult with your own legal advisors for information on the obligations that may apply to your practice.

**Provider directory (plan years beginning on or after Jan. 1, 2022)**

CAA requires provider directory information to be verified **every 90 days**. Providers and health insurers have roles in fulfilling this requirement to maintain an accurate directory for members.  [Read more on the new requirements.](https://provider.bluecrossma.com/ProviderHome/myportal/home/news/news/claims-coding-payment/all%20networks/consolidated%20appropriations%20act%20and%20transparency%20in%20coverage%20%28non-secure%29/%21ut/p/z1/pVLbboJAEP0aHnGGq9g30SpqrVKDyr6YBZdLCixd0Ma_L7VNY1svTbpvM3suMycDBNZACrpPY1qnvKBZU_vE3DjqqKdMLJwNzeUA3Qe9Y6ltD9E1YXUE4LfXRftJtTXE4UwFcsrHkdpH915xFtpgomFPP8s_Vfob_wqAXJ9_Cf4c_P0hnr64P8V-o8n1WVdAzkC-x3FLYwwkznjwkX23CDQrBiJYxAQTrZ1o2kldl9WdhBKWgu_TbdMPsh0LBa-qnLZCnks4__xxeM4kzA8lFzXNJEyOdcWoCJNzBgmvalhf0gW_Cah9MSCzSWCfslfwCi7yZoPF-7plmG7BD1Rq6bqJsqbohqyjFskdK2JyZFk0ZJRSg1Jw8JaD-U-H8a17WHXtr3MgCpS553nFQX6OprURGHG-6duPMnHfANq229M%21/dz/d5/L2dBISEvZ0FBIS9nQSEh/?1dmy&urile=wcm%3apath%3a%2Fprovider%2Bportal%2Bcontent%2Blibrary%2Fprovider%2Bcentral%2Fnews%2Foffice%2Bsupport%2Fall%2Bnetworks%2Fconsolidated%2Bappropriations%2Bact%2B-%2Bnew%2Bdirectory%2Brequirements%2B%2528non-secure%2Band%2Bsecure%2B-%2Bnon-dentists%2529)

**Machine-readable files**

Health insurers are required to publicly display certain health care price information via machine-readable files on their websites beginning July 1, 2022. These machine-readable files will include negotiated rates with in-network providers, allowed amounts for out-of-network providers and may include prescription-drug pricing.

**Member ID cards (plan years beginning on or after Jan. 1, 2022)**

The CAA requires that member ID cards include deductible information and out-of-pocket maximums. Starting in the 2nd quarter of 2022, we will begin re-issuing cards in the new format. Members’ current cards remain valid for all services. and member ID numbers will not change. Members who have questions about their new ID card can contact the Member Services 1-800 on the back of their card.

**Continuity of Care (plan years beginning on or after Jan. 1, 2022)**

Most of our group and fully insured plans include a period of continuity of care at in-network reimbursement rates when a provider leaves our networks. Continuity of care applies to members who are undergoing active treatment for a serious or complex condition, pregnant, or a terminal illness. The CAA requires up to 90 days of continued, in-network care for affected members when:

* A provider’s network status changes (note that this does not include for-cause terminations)
* A group health plan changes health insurance issuer, resulting in the member no longer having access to a participating provider in our network.

For members who qualify for continuity of care, you will need to accept payment at the in-network rate.

**No Surprises Act (beginning on Jan. 1, 2022)**

Under the No Surprises Act, most out-of-network providers will no longer be allowed to balance bill patients for the difference between the provider's charge and the allowed amount for:

* Emergency services ([learn about the updated definition of emergency services](https://provider.bluecrossma.com/ProviderHome/myportal/home/news/news/claims-coding-payment/all%20networks/consolidated%20appropriations%20act%20and%20transparency%20in%20coverage%20%28non-secure%29/%21ut/p/z1/pVLbboJAEP0aHnGGq9g30SpqrVKDyr6YBZdLCixd0Ma_L7VNY1svTbpvM3suMycDBNZACrpPY1qnvKBZU_vE3DjqqKdMLJwNzeUA3Qe9Y6ltD9E1YXUE4LfXRftJtTXE4UwFcsrHkdpH915xFtpgomFPP8s_Vfob_wqAXJ9_Cf4c_P0hnr64P8V-o8n1WVdAzkC-x3FLYwwkznjwkX23CDQrBiJYxAQTrZ1o2kldl9WdhBKWgu_TbdMPsh0LBa-qnLZCnks4__xxeM4kzA8lFzXNJEyOdcWoCJNzBgmvalhf0gW_Cah9MSCzSWCfslfwCi7yZoPF-7plmG7BD1Rq6bqJsqbohqyjFskdK2JyZFk0ZJRSg1Jw8JaD-U-H8a17WHXtr3MgCpS553nFQX6OprURGHG-6duPMnHfANq229M%21/dz/d5/L2dBISEvZ0FBIS9nQSEh/?1dmy&urile=wcm%3apath%3a%2Fprovider%2Bportal%2Bcontent%2Blibrary%2Fprovider%2Bcentral%2Foffice%2Bresources%2Fbilling%2Band%2Breimbursement%2Fbilling%2Bguidelines%2Band%2Bresources%2Fbilling%2Bguidelines%2Band%2Bresources-%2Banonymous))
* Out-of-network care during a visit to an in-network facility
* Out-of-network air ambulance services, if patients’ benefit plan covers in-network air ambulance services.



[**https://provider.bluecrossma.com/ProviderHome/myportal/home/news/news/claims-coding-payment/all%20networks/consolidated%20appropriations%20act%20and%**](https://provider.bluecrossma.com/ProviderHome/myportal/home/news/news/claims-coding-payment/all%20networks/consolidated%20appropriations%20act%20and%25)

**Boston Medical Center HealthNet Plan**

#### In accordance with the State response to COVID-19 management, BMC HealthNet Plan will cover telephonic visits in addition to telehealth visits for our members until further notice. Please see codes for each telehealth visit type below. **Will providers be paid for regular E&M visits billed with a POS 02 for MassHealth or QHP Members?**

**Updated 3/5/21**

Yes, providers will be paid for regular E&Ms with a POS 02.  Providers may render the telehealth service via audio-only or a combination of audio and video modalities. Rates of payment for services delivered via telehealth will be the same as rates of payment for services delivered via traditional (e.g., in-person) methods. Follow the below rules for billing the E&M’s with a POS 02.

The test for whether you can bill something to MassHealth telehealth is:

1. Were you able to bill it to MassHealth and be paid before?
2. Is it clinically appropriate to be delivered via telehealth?
3. Are you conforming to the guidance in Appendix A of the Provider Bulletin 289?
4. Is it medically necessary for the member?

If “Yes” to these four inquires of validation, then the visit can be billed and paid by MassHealth or any MassHealth managed care entity at the same rates as if rendered in person.

•       All services should be billed with the same CPT codes as when a face-to-face visit is performed.

•       Must add POS 02 on claim

[See all MassHealth publications pertaining to COVID-19](https://www.mass.gov/info-details/masshealth-coronavirus-disease-2019-covid-19-providers).

<https://www.bmchp.org/I-Am-A/Provider/COVID-19-Resources>

**Harvard Pilgrim Health Care**

The Centers for Medicare and Medicaid Services (CMS) has instituted a new place of service (POS) code related to telehealth services, as well as revised the description of the existing POS code 02, and Harvard Pilgrim has updated our billing requirements related to commercial and StrideSM (HMO) Medicare Advantage members to reflect these changes.

These updates to telehealth POS coding are intended to better meet overall industry needs through greater specificity. Going forward, POS 02 will be used to report telehealth services rendered in a location other than the patient’s home, whereas POS 10 will denote telehealth services rendered in the patient’s home. The updated/new descriptions are as follows:

**POS 02: Telehealth Provided Other than in Patient’s Home**
The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.

**POS 10: Telehealth Provided in Patient’s Home**
The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.

For correct coding, please report all telemedicine/telehealth claims with either POS 02 or POS 10, depending on the setting in which the visit was conducted.

**New telemedicine/telehealth modifiers**
CMS has also developed the following new modifiers, which are now available:

* FQ – The service was furnished using audio-only communication technology
* FR – The supervising practitioner was present through two-way, audio/video communication technology

To promote further specificity and paint a more accurate picture of the telehealth encounter, you can supplement POS 02 or POS 10 with the appropriate modifier.

For more information, please refer to Harvard Pilgrim’s updated [Interim Telemedicine/Telehealth Payment Policy (COVID-19 Pandemic)](https://www.harvardpilgrim.org/provider/wp-content/uploads/sites/7/2020/07/H-6-TELEMEDICINE_INTERIM-PM.pdf).

*Editor’s note 1/7/2022: Article updated for clarification on use of POS 02 and POS 10 in claims.*

<https://www.harvardpilgrim.org/provider/new-and-updated-telehealth-place-of-service-codes/>

**Tufts Health Plan**

Out-of-Network Authorization Policies for COVID-19 Services – Effective as outlined below

If a member's plan requires a referral or authorization to received out-of-network (OON) services, Tufts Health Plan has reinstated such requirements for the OON services listed below when related to a COVID-19 diagnosis for all plans with the exception of Massachusetts Commercial products, Tufts Health Direct, Tufts Health Together and Tufts Health Unify: Inpatient care

* Post-acute care, including inpatient rehab, skilled nursing facilities, long-term acute care (LTAC), and/or home care following an inpatient admission
* Primary care or outpatient behavioral health services

<https://tuftshealthplan.com/covid-19/provider/coronavirus-updates-for-providers>

<https://tuftshealthplan.com/documents/providers/payment-policies/covid19-telehealth>

**United Health Care**

**COVID-19 testing-related services**

You will have $0 cost-share (copay, coinsurance or deductible) for COVID-19 testing-related services via in-person or [**virtual visits**](https://www.uhc.com/health-and-wellness/health-topics/covid-19/telehealth-virtual-care) during the national public health emergency period, currently scheduled to end Jan. 15, 2022. This coverage applies to in-network and out-of-of-network visits for Medicare Advantage, Exchange, Individual and Employer-sponsored health plans. For individuals enrolled in [**UnitedHealthcare Community Plans**](https://www.uhccommunityplan.com/), state variations and regulations may apply during this time. Benefits will be reviewed in accordance with the member’s health plan.

**COVID-19 treatment**

If you get sick with COVID-19, your health care provider may prescribe treatments. For COVID-19 treatment, cost-sharing will be according to the member’s benefit plan. You will be responsible for any copay, coinsurance, deductible or out-of-network costs. This coverage applies to Medicare Advantage, Exchange, Individual and Employer-sponsored health plans.For members enrolled in [**UnitedHealthcare Community Plans**](https://www.uhccommunityplan.com/), state provisions and regulations may apply during this time.

[COVID-19 temporary provisions date guide - UnitedHealthcare (uhcprovider.com)](https://urldefense.com/v3/__https%3A/www.uhcprovider.com/content/dam/provider/docs/public/resources/news/2020/covid19/COVID-19-Date-Provision-Guide.pdf__;!!CvMGjuU!ubo2t8vfCmhDu3hs84TNZS91Hw9FtMP3F_Fvd4s1gfUsZlejz5hDzyNvZbwrzo-4MCMaoF1B$)

[Telehealth | UHCprovider.com](https://urldefense.com/v3/__https%3A/www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19/covid19-telehealth-services/covid19-telehealth-services-telehealth.html__;!!CvMGjuU!ubo2t8vfCmhDu3hs84TNZS91Hw9FtMP3F_Fvd4s1gfUsZlejz5hDzyNvZbwrzo-4MJsHgkzb$) Telehealth Billing Guide:

[UnitedHealthcare Telehealth Services: Care Provider Billing Guidance (uhcprovider.com)](https://urldefense.com/v3/__https%3A/www.uhcprovider.com/content/dam/provider/docs/public/resources/news/2020/Telehealth-Patient-Scenarios.pdf__;!!CvMGjuU!ubo2t8vfCmhDu3hs84TNZS91Hw9FtMP3F_Fvd4s1gfUsZlejz5hDzyNvZbwrzo-4MBXD_fM0$)

<https://www.uhcprovider.com/content/provider/en/searchresult.html#q=covid-19&sort=relevancy>