



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

***Updated as of 4-3-2020**

Questions from MMS and MHA to MAHP with regard to Covid-19 Coverage and Reimbursement policies March 27, 2020

Please be advised, the responses below are in line with the Division of Insurance's Bulletins 2020-02 and 2020-04 and apply only to fully-insured commercial plans. Providers are advised to consult individual plan's provider communications for plan-specific details, including expansion of coverage and billing instructions.

1. Seeking clarification on exactly what services will have patient cost sharing waived. Our understanding is that it is waived for all testing for coronavirus regardless of where the testing happens (i.e. physician office, urgent care center, drive through lab, hospital ED). Is that correct?
 - a. Cost-sharing is waived for testing that happens at in-network doctors' offices, urgent care centers, or emergency rooms.
 - b. If a member is unable to access testing from in-network providers, cost-sharing is waived at out-of-network doctors' offices, urgent care centers, or emergency rooms.

2. Is patient cost sharing (deductible, copay, co-insurance) being waived for all in person treatment for coronavirus regardless of the setting? Or are only copayments being waived for in person treatment?
 - a. Under Bulletin 2020-02, cost-sharing is not waived for in-person treatment for Coronavirus. However, individual plans may waive cost sharing. Please see the attached chart for details regarding each plan's policies.
 - b. Copayments are waived for medically necessary Coronavirus treatment, in accordance with DPH and CDC guidelines, at in-network doctors' offices, urgent care centers, or emergency rooms; and at

out-of-network doctors' offices, urgent care centers, or emergency rooms when in-network alternatives are not available.

3. All patient cost sharing is waived for treatment via telehealth for coronavirus. Telehealth Including phone evaluations. Is that correct?
 - a. Yes. When delivered via telehealth by in-network providers, cost-sharing is waived for medically necessary Coronavirus treatment in accordance with DPH and CDC guidelines.

4. Telehealth visits for all other diagnoses unrelated to coronavirus will still have the usual patient cost sharing? How is that being communicated to members?
 - a. Yes. Telehealth visits for all other diagnoses unrelated to coronavirus will continue to have the usual cost-sharing.
 - b. Information is being communicated via member portals and public facing FAQ websites.

5. Will all telehealth visits, regardless of the diagnosis, be paid at the same rate as an in-person visit would have been reimbursed? Including the cost share amount (copay).
 - a. For the duration of Governor Baker's emergency Order, unless carriers have specific agreements with a provider regarding reimbursement for services delivered via telehealth, Carriers will reimburse providers for services delivered via telehealth at least at the rate of reimbursement that the Carrier would reimburse for the same services when provided via in-person methods.
 - b. This reimbursement does not include facility fees for distant or originating sites.

6. Will there be coverage for PT, OT, nutrition and similar services delivered via telehealth? For hospital-based services, these are billed under the hospital NPI as facility fees with no professional component. Assuming they are covered, how will they be reimbursed since facility fees are prohibited?

- a. Please MAHP chart and individual plan provider communications for details regarding coding and billing policies for telehealth services.
7. Will the plans all be developing consistent coding and billing policies for telehealth services? Including use of modifiers and place of service codes? How will telephonic consults be coded?
 - a. Please MAHP chart and individual plan provider communications for details regarding coding and billing policies for telehealth services.
8. For services where patient copayments or cost-sharing is waived, will plan payments to providers include the patient liability amount?
 - a. Yes. Please MAHP chart and each plan's provider communication for details.
9. The governor is reducing restrictions around providing telehealth across state lines. How will this be reimbursed?
 - a. Policy in development – we will update as more information is available.
10. When do the plans expect to have guidance on telehealth coding billing and coverage clarifications, and will it be the same coding/rules for all plans?
 - a. See question 7 above.
11. How will plans be addressing health plan credentialing? Will there be an expedited process to support the emergency licensing regulations put in place by the state?
 - a. At a high-level, providers rendering services as part of the coronavirus pandemic will be enrolled urgently through an expedited credentialing process. These providers will be designated in the health plan system as coronavirus providers with an end date of September 1, 2020 and will not be included in provider directories unless requested. These providers will need to go to full credentialing

- if they intend to stay on with the practice they are enrolled to after September 1, 2020 (date may change subject to State of Emergency).
- b. Residents and fellows will not be enrolled, as they are eligible to bill under supervision, and can already provide services.

12. Self-funded plans – we understand that the DOI bulletin expects plans to encourage employers to opt into the same provisions set forth for fully funded plans. Is there any way that the plans can provide a list of employer groups who are doing this or somehow share with providers? How should providers handle these situations since they often have no idea of the payer arrangement? This is what is posted on the DPH website – appears to contradict in terms of self-funded coverage; we have only seen guidance from DOI:

TELEHEALTH: The Department of Public Health has issued guidance that requires all commercial insurers, self-insured plans, and the Group Insurance Commission are required to cover medically necessary telehealth services related to COVID-19 testing and treatment. Insurers must do this without requiring cost-sharing of any kind – such as co-pays and coinsurance – for testing and treatment. [PRESS RELEASE | ORDER](#)

Further, The DPH Commissioner was on a call on Tuesday and noted COVID-19 covered services include all clinically appropriate medically necessary covered services – so should we assume all services have cost sharing waived – is that correct?

- a. Self-insured plans are governed by ERISA and are not subject to the DOI Bulletins. Further, DPH does not regulate the health plans – information related to health plan requirements should come from the DOI.

- b. The second federal stimulus package (H.R. 6201 as amended) expands coverage of testing for COVID-19 without cost-sharing to include self-insured plans.
 - c. MAHP member plans are encouraging self-insured businesses to provide coverage as defined under the DOI bulletin for fully-insured plans.
- 13. For patients who technically don't qualify for homebound but need services, are plans (including Medicare advantage) waiving regulations on who qualifies for homebound services?
 - a. Please see individual plan provider communications for details regarding approach to homebound services.
- 14. Will plans be waiving prior authorization requirements for non-emergent, medically necessary ambulance transport so that hospitals can quickly get patients transferred to post-acute services or home?
 - a. Please see individual plan provider communications for details regarding approach to PA for non-emergency transport.
 - i. AllWays: Hospital transfer by non-emergent ambulance to a SNF, Inpatient Acute Rehab or LTAC. These ambulance transports qualify as "interfacility transportation" and are covered w/ no auth. There is currently an auth requirement on 'non-emergent medically necessary ambulance transportation' to HOME.
 - ii. BMCHP: Non-emergent medical transportation is covered for our MH members without PA (unless >50 miles of MA border). There is no PA required medically necessary inpatient facility to inpatient facility ambulance transfers for any product. For QHP members, NEMT transfers from inpatient to home are not a covered benefit.
 - iii. Fallon: Still assessing.
 - iv. HPHC: Not at this time.
 - v. THP: Yes.

15. We understand that plans have waived prior auth requirements for admission to SNF, Rehab, and for home health care. Does this include LTAC facilities as well?
- a. Plans that have LTAC benefits for members will waive prior authorization for admission to LTAC under Bulletin 2020-10.
16. How will plans reimburse for the specimen collection and triage at COVID-19 drive through testing sites along with billing instructions for this.
- a. Currently, the reimbursement for specimen collection and triage at COVID-19 drive through testing sites are included in the reimbursement for CPT code 87635. This aligns with current policies set forth by the Centers for Medicare and Medicaid Services (CMS).
 - b. Will be updated as more information becomes available.
17. Will the provider's home be considered an acceptable location for the provision of telehealth services? MassHealth has confirmed that "distant site" is defined as "wherever the provider is located at the time of the call" and "Home" is allowable. We need clarification from the commercial plans.
- a. Yes
18. Can practices/providers see **new patients** for non-COVID and COVID-related services via telehealth? How will this be covered?
- a. Yes, under DOI Bulletin 2020-04, Carriers will telehealth delivered to new patients by in-network providers. For an initial appointment with a new patient, the provider must review the patient's relevant medical history and any relevant medical records with the patient before initiating the delivery of any service.
 - b. Coverage will be in line with the requirements under Bulletin 2020-02 and Bulletin 2020-04.

19. Will carriers expand their recent agreement to waive the prior authorization requirement to include home infusion providers? Specifically, will carriers agree to transfer an existing PA given to a hospital infusion center to the designated home infusion provider or waive the requirement to secure a new PA for the home infusion provider for the next 90 days?
- a. Policy in development. MAHP is raising this with our Board Policy Committee to ensure executive attention on the issue.