Health Plan Policies, Procedures and Practices

New **Updated.** **Blank cell – Awaiting health plan response.**

A. Billing Under the Emergency Order

B. Alternative Treatment Locations

C. Telehealth

D. Provider Workflow

A. Billing under the Emergency Order

For all of your plans, will you cover 100% of the cost of COVID testing in an outpatient setting without patient deductible or cost share?		
Consensus Position		Health plans provide 100% coverage, as outlined in the OIC Emergency Order above, except where self-funded groups opt out of that coverage.
Aetna	Yes	Aetna will cover the cost of the COVID-19 test, as well as the cost of a health care provider, urgent care center or emergency room visit that results in the ordering or administration of a test for COVID-19. Coverage is provided with no cost share to the member.

For all of your plans, will you cover 100% of the cost of COVID testing in an outpatient setting without patient deductible or cost share?		
		Health care providers should refer to Aetna's website for the most current information: https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html
Amerigroup	Yes	Health plan has no Self-insured plan sponsors
CHPW	Yes	Health plan has no Self-insured plan sponsors
Cigna	Most	Self-insured plan sponsors will be able to opt-out of this program at their discretion
Coordinated Care	Yes	When medically necessary diagnostic testing or medical screening services are ordered and/or referred by a licensed health care provider, we will cover the cost of medically necessary COVID-19 tests and the associated physician visit. Copayment, coinsurance and/or deductible cost-sharing requirements will be waived for medically necessary COVID-19 diagnostic testing and/or medical screening services.
First Choice (TPA and PPO)	Varies by our Payers' Plans	First Choice Health is a PPO network that does not define the benefits. Please reach out to the individual Payers to confirm benefits. As an administrator for our self-funded health Plans, we are complying with the Families First Coronavirus Act, specifically the "Health Provisions"
KP-NW	Yes	Most of our health plans require use of in-network providers for non-emergency services, and the COVID-19 testing and visit would be covered without deductible or cost-sharing. If a health plan covers services from out-of-network providers, then the COVID-19 testing and visit would be covered from those providers without deductible or cost-sharing. We monitor access to in-network providers, and if members cannot access care from an in-network provider, we will assist members in accessing care from out-of-network providers, and in such circumstances the COVID-19 testing and visit will be covered without deductible or cost-sharing. Health plan has no Self-funded plan sponsors
KP -WA	Most	Most of our health plans require use of in-network providers for non-emergency services, and the COVID-19 testing and visit would be covered without deductible or cost-sharing. If a health plan covers services from out-of-network providers, then the COVID-19 testing and visit would be covered from those providers without deductible or cost-sharing. We monitor access to in-network providers, and if members cannot access care from an in-network provider, we will assist members in accessing care from out-of-network providers, and in such circumstances the COVID-19 testing and visit will be covered without deductible or cost-sharing. Self-insured plan sponsors will be able to opt-out of this program at their discretion
Labor & Industries		

For all of your plans, will you cover 100% of the cost of COVID testing in an outpatient setting without patient deductible or cost share?		
Medicaid FFS	Yes	Medicaid does not have copays or deductible. Covered at 100%
Molina	Yes	Health plan has no Self-insured plan sponsors
Pacific Source	Most	PacificSource is also covering all outpatient, urgent care and emergency room visits, testing and radiology (applicable chest x-rays) at 100%, if billed with a COVID-19 DX (B342, B9729, U071, Z03818, Z20828). If the patient is admitted to the hospital, regular member benefits apply. Self-insured plan sponsors will be able to opt-out of this program at their discretion
Premera	Most	Premera will cover 100% of the cost of the COVID-19 lab test and the associated visit resulting in no cost share for the fully insured members. Self-funded employer groups will apply this approach but may opt out of this arrangement.
Providence	Most	Providence will cover 100% of the cost of the COVID-19 lab test and the associated outpatient visit resulting in no cost share for our fully insured members. We are supporting self-insured plan sponsors who choose to implement the same or similar coverage, however, self-insured plan sponsors are able to opt-out of this coverage at their discretion.
Regence	Most	We will cover the cost of the COVID-19 test and an associated office visit with no cost-share for fully insured members – including members of high-deductible plans – if a provider determines the COVID-19 test is necessary. We are working with our self-funded employers to implement similar cost share arrangements when directed, and with federal officials to ensure coordination of benefits for Medicare members.
UHC	Most	UnitedHealthcare is waiving member costs for COVID-19 testing provided at approved locations in accordance with the U.S. Centers for Disease Control and Prevention (CDC) guidelines. This coverage applies to Medicare and Medicaid members as well as our commercial insured members. We are also supporting self-insured employer customers who chose to implement similar actions.

Under the Emergency Order, health plans will cover the entire cost, prior to deductible and with no patient cost share, of code U0002 (COVID testing) and, in the outpatient setting, the associated E&M visit (with diagnosis code of U07.1).		
In situations where U0002 is billed by the lab and the E&M visit is billed by the provider, how should providers submit the claim with the E&M visit -- so that it is clear that E&M visit is to be covered under the Emergency Order (since the testing will be billed by the lab)?		
Consensus Position		
Aetna		Coding and claim submission question are being evaluated at this time. Health care providers should refer to Aetna's website for the most current information:

Under the Emergency Order, health plans will cover the entire cost, prior to deductible and with no patient cost share, of code U0002 (COVID testing) and, in the outpatient setting, the associated E&M visit (with diagnosis code of U07.1).		
In situations where U0002 is billed by the lab and the E&M visit is billed by the provider, how should providers submit the claim with the E&M visit -- so that it is clear that E&M visit is to be covered under the Emergency Order (since the testing will be billed by the lab)?		
		https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html
Amerigroup		
CHPW		We expect the CR modifier, or one of the COVID diagnosis or related diagnosis put out by CDC (https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf
Cigna		
Coordinated Care		Providers should bill the appropriate E/M code with the appropriate diagnosis codes including U07.1 and those found here: https://www.hca.wa.gov/assets/billers-and-providers/billing-for-COVID-CPC-03-2020.pdf
First Choice (TPA and PPO)		When COVID-19 diagnosis code U07.1 is appropriately coded with an E&M code, this will indicate it's for COVID-19. If U07.1 is not effective or appropriate due to an initial visit, then refer to the recommended diagnosis coding from the CDC- (https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf
KP-NW		
KP -WA		
Labor & Industries		
Medicaid FFS		For providers that can bill for an E/M service, the testing is part of the E/M service. If the client comes in to the provider's office just for the specimen collection, then the provider can bill 99211 for the service.
Molina		
Pacific Source		
Premera		When the provider can provide a diagnosis of COVID-19, U07.1, the diagnosis should be billed on the claims for the E&M visit. However, since the initial visit is to diagnose the patient, the COVID-19 is not expected to be available at the time of the visit. When the COVID-19 diagnosis is not available, the E&M code should be billed with one of the appropriate ICD-10 diagnosis codes related to possible COVID-19 exposure as defined by the CDC. (https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf) Premera will waive the cost share associated with the initial E&M visit when the visit is billed on the same claim as the COVID-19 lab testing. When the E&M visit is billed separately, a review will be done to identify the testing related visit. When the related visit is not identified, the E&M claim will be adjusted as identified by the provider or the member.
Providence		
Regence		The associated E&M visit should be billed with diagnosis code U07.1.

Under the Emergency Order, health plans will cover the entire cost, prior to deductible and with no patient cost share, of code U0002 (COVID testing) and, in the outpatient setting, the associated E&M visit (with diagnosis code of U07.1).		
In situations where U0002 is billed by the lab and the E&M visit is billed by the provider, how should providers submit the claim with the E&M visit -- so that it is clear that E&M visit is to be covered under the Emergency Order (since the testing will be billed by the lab)?		
		There may be additional recommended billing guidelines as we begin to receive more COVID-19 coded claims. Providers should refer to our websites for the most current information: • Regence: https://www.regence.com/provider/home • Asuris: https://www.asuris.com/provider/home • BridgeSpan: https://www.bridgespanhealth.com/provider/home
UHC		

When do you anticipate that providers should submit claims to you for COVID testing?		
Consensus Position	Now	Claims can be submitted now, in some cases, the health plan will hold claims until the systems are configured (with pricing) to process the claims accurately
Aetna	Now	Aetna is complying with the CMS coding and pricing guidelines for COVID-19 lab testing. CMS adopted two CPT codes, (U0001) and (U0002), for COVID-19 testing. Local Medicare Administrative Contractors (MACs) are responsible for developing the payment amount for claims they receive for these newly created HCPCS codes in their respective jurisdictions until Medicare establishes national payment rates. In addition, AMA created a new CPT code that streamlines novel coronavirus testing offered by hospitals, health systems and laboratories. This new code, 87635, is effective immediately for use in reporting this testing service. Aetna will accept CPT code 87635 or HCPCS Level II U0002 for the COVID-19 testing Health care providers should refer to Aetna's website for the most current information: https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html
Amerigroup	Now	Provider can submit claims for COVID testing (retroactive to 2/4/20 dates of service) at any time. Amerigroup will hold claims until our systems are configured to process the claims accurately.
CHPW	Now	Provider can bill for dates of service 02/01/2020 and forward
Cigna	04/01	Laboratories are asked to hold any claims for COVID-19 using code this until April 1, 2020 to ensure proper reimbursement.
Coordinated Care	Now	The new codes are loaded in our system to pend until configuration is complete; once complete, we will release the claims for payment. If you submitted claims previously that rejected, please resubmit your claim.
First Choice (TPA and PPO)	Now	Codes are loaded. Claims may be processed manually until system set up is complete.
KP-NW	04/01	Submitted COVID-19 claims will be placed in a hold status until coding and pricing information is updated in the system. Our configuration for automatic processing is targeted to be ready by 4/1.

When do you anticipate that providers should submit claims to you for COVID testing?		
KP-WA	Now	COVID-19 claims can be submitted and will be processed manually at this time. Our configuration for automatic processing is targeted to be ready by 4/1.
Labor & Industries		
Medicaid FFS	Now	Provider can submit claims for COVID testing (retroactive to 2/4/20 dates of service) at any time. Some claims may need to be resubmitted for dual eligible clients
Molina	Now	
Pacific Source	Now	Submit claims using the correct CPT codes; claims that are denied should be resubmitted with the correct codes
Premera	Now	
Providence	Now	Our systems are currently configured to accept COVID testing claims, however our systems are not yet configured to adjudicate the claims. As such, we can accept claims but the claims will be pended until we finalize configuring our systems with rates.
Regence	Now	Our systems are currently accepting claims.
UHC	4/1	We ask that care providers hold claims for processing until April 1, 2020.

If a claim was billed for COVID testing after the order (March 5th) and it was billed with an incorrect code how should it be rebilled so that it is adjudicated under the order?		
Consensus Position		
Aetna		
Amerigroup		
CHPW		Provider should send a corrected claim, with the new billing guidance.
Cigna		
Coordinated Care		If the provider feels the claim was not adjudicated probably based on evolving guidance, they can submit a corrected claim within the timeframes specified in their contract or in our Provider Handbook for reprocessing. They may also call our Customer Service Center to ask us to review their claim if they don't feel it was processed correctly as billed.
First Choice (TPA and PPO)		
KP-NW		
KP -WA		
Labor & Industries		
Medicaid FFS		The addition of the CR modifier to the claim will allow the claim to pay.
Molina		
Pacific Source		
Premera		This Probably depends on whether the claim was paid or denied or something else. More than likely the diagnosis and lab test codes were not established for some of the prior submissions so if the claim was paid, I am not sure they need total resubmit. If the claim was denied, I think the reason for the denial would determine whether to rebill or not. If the "rebill" reason is to remove member cost share, then the provider should be coding the claim correctly. If services were performed after the date of the order (3/5/2020 WA, 3/3/2020 AK), then the provider could rebill using the new COVID-19 lab testing codes U0001, U0002.

If a claim was billed for COVID testing after the order (March 5th) and it was billed with an incorrect code how should it be rebilled so that it is adjudicated under the order?		
		If the services were performed prior to the date of the order, there would be no adjustment needed as the cost shares are being waived if services are performed as of the date of the order.
Providence		
Regence		
UHC		

B. Alternative Treatment Locations

Are ED services provided in tents and patient cars covered and if so, how should they be billed?		
Consensus Position:	Yes	Tents and/or patient cars located in close proximity to the ED in which ED staff provide COVID care or non-COVID care will be considered extensions of the ED. Claims for that care should use Place of Service Code – 23 Emergency Room – Hospital, with Modifier CR for professional billing and Condition Code DR for institutional billing.
Aetna	Yes	Health care providers should refer to Aetna's website for the most current information: https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html
Amerigroup		
CHPW	Yes	CHPW is following the consensus position
Cigna		
Coordinated Care	Yes	Tents and cars in proximity to the facility will be considered an extension of the facility and paid accordingly. We follow all HCA and CMS guidance in this regard.
First Choice (TPA and PPO)	Yes	First Choice is following the consensus position
KP-NW **KP -WA**	Yes	Kaiser is following the consensus position When billing, the Place of Service codes should align most closely with the facility, staff and/or function being performed at that care site.
Labor & Industries		
Medicaid FFS	Yes	If services are provided in a tent or in a patient car that is located in proximity to, or as an extension of the emergency room, use POS 23 and the CR modifier for all professional services and use the DR modifier for the facility fee
Molina	Yes	Molina is following the consensus position
Pacific Source	Yes	Pacific Source is following the consensus position
Premera	Yes	Premera is following the consensus position
Providence		
Regence	Yes	Regence is following the consensus position
UHC		

Are outpatient services provided in patient cars covered and if so, how should they be billed?		
Consensus Position	Yes	Patient cars located in the parking lot of a clinic in which clinic staff provide COVID care or non-COVID care will be considered extensions of the clinic. Claims for that care should use Place of Service Code as follows: • 15 – Mobile: If the car is used as a drive up COVID testing site where a specimen is taken • 11 – Office: If the clinic is not hospital owned • 19 – Off Campus – Outpatient Hospital: If the clinic is hospital owned but not on the hospital campus
Aetna	Yes	Health care providers should refer to Aetna's website for the most current information: https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html
Amerigroup		
CHPW	Yes	CHPW is following the consensus position
Cigna		
Coordinated Care	Yes	CCW is following the consensus position.
First Choice (TPA and PPO)	Yes	First Choice is following the consensus position
KP-NW **KP -WA**	Yes	Kaiser is following the consensus position . When billing, the Place of Service codes should align most closely with the facility, staff and/or function being performed at that care site.
Labor & Industries		
Medicaid FFS	Yes	Patient cars located in the parking lot of a clinic in which clinic staff provide COVID care or non-COVID care will be considered extensions of the clinic. Claims for that care should use Place of Service Code as follows: • When collecting specimens to test for COVID-19 that is not associated with an E/M visit HCA is allowing CPT code 99001 to be billed. • Bill with the POS that is most relevant for the situation (typically the POS you currently bill with): - For provider clinics that are not hospital owned, use POS 11 with CR modifier - For hospital owned/associated and off campus, use POS 19 and the CR modifier - For visits outside of emergency rooms, use POS 23 and the CR modifier - For visits in drive up sites that do not fit in the examples above, use the POS 15 and the CR modifier
Molina	Yes	Molina is following the consensus position
Pacific Source	Yes	Pacific Source is following the consensus position

Are outpatient services provided in patient cars covered and if so, how should they be billed?		
Premera	Yes	Premera is following the consensus position
Providence		
Regence	Yes	Regence is following the consensus position
UHC		

Are services provided in non-licensed space and/or non-licensed beds covered and if so, how should they be billed?		
Consensus Position	Yes	Claims for services to COVID and non-COVID patient provided in non-licensed space and/or non-licensed beds should be submitted with the Place of Service Code most closely associated with the staff/function being performed in that space/bed as if the space/bed was licensed If the additional space is on hospital grounds, then the sponsoring hospital site of service and all policies and procedures would apply. If the additional space were off a hospital campus such as a naval ship or large tented or other temporary structure then the policies and procedures of the sponsoring organization would apply.
Aetna	TBD	Aetna is evaluating this question. Health care providers should refer to Aetna's website for the most current information: https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html
Amerigroup		
CHPW	Yes	CHPW is following the consensus position
Cigna		
Coordinated Care		CCW is following all HCA and CMS guidance, or OIC mandates
First Choice (TPA and PPO)	Yes	First Choice is following the consensus position
KP-NW	Yes	Kaiser is following the consensus position . When billing, the Place of Service codes should align most closely with the facility, staff and/or function being performed at that care site.
KP -WA		
Labor & Industries		
Medicaid FFS	Varies	Medicaid is currently determining how these will be covered and billed. It would be based on services being rendered in those beds/spaces
Molina	Yes	Molina is following the consensus position
Pacific Source	Yes	Pacific Source is following the consensus position
Premera	Yes	Premera is following the consensus position
Providence		
Regence	Yes	Regence is following the consensus position
UHC		

C. Telehealth

Per HHS announcement re telehealth: :www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html		
What provider-patient interaction methods will be considered telehealth and how should they be billed?		
Consensus Position	Yes	Methods of interactions between providers and COVID & non-COVID patient outlined in the announcement would be considered telehealth and should be billed appropriately in accordance with CMS guidelines
Aetna	TBD	For the next 90 days, until June 4, 2020, Aetna will waive member cost sharing for a covered telemedicine visit regardless of diagnosis. Aetna members are encouraged to use telemedicine to limit potential exposure in physician offices. Cost sharing will be waived for all virtual visits through the Aetna-covered Teladoc® offerings and in-network providers. Self-insured plan sponsors will be able to opt-out of this program at their discretion. For the 90-day period, Aetna has added the following HCPCS codes below. All telemedicine services not noted will be covered according to Aetna's current policy. All other telemedicine coverage is stated in the Aetna Telemedicine policy which is available to providers on the NaviNet and Availity portals. The following codes require an audiovisual connection: • G2061, G2062, G2063 - 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 • H0015 GT or 95 - 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 • H0035 GT or 95 - Mental health partial hospitalization, treatment, less than 24 hours. • H2012 GT or 95 - Behavioral health day treatment, per hour. • H2036 GT or 95 - Alcohol and/or other drug treatment program, per diem • S9480 GT or 95 - Intensive outpatient psychiatric services, per diem • 97151 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. • 97155 GT or 95 - Adaptive behavior treatment with protocol modification, administered by QHP, which may include

Per HHS announcement re telehealth: :www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
What provider-patient interaction methods will be considered telehealth and how should they be billed?

simultaneous direction of a technician working face to face with a patient.

- 97156 GT or 95 - Family adaptive behavior treatment guidance administered by QHP, with parent/guardian
- 97157 GT or 95 - Multiple-family group adaptive behavior treatment guidance, administered by QHP, with multiple sets of parents/guardians
- 98970, 98971, 98972 - 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.
- 99421, 99422, 99423 - 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.

The following codes require an audiovisual connection or telephone:

- G2010 - 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.
- 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.
- 98966, 98967, 98968 - 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.
- 99441, 99442, 99443 - 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

Per HHS announcement re telehealth: :www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html		
What provider-patient interaction methods will be considered telehealth and how should they be billed?		
		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. • 90791, 90792; GT or 95 - Psychiatric diagnostic interview examination • 90832, 90833, 90834, 90836, 90837, 90838; GT or 95 - Individual psychotherapy • 90839, 90840; GT or 95 - Psychotherapy for crisis; first 60 minutes; or each additional 30 minutes • 90845; GT or 95 – Psychoanalysis • 90846, 90847, 90853; GT or 95 - Family or group psychotherapy • 90863; GT or 95 - Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services • 96116; GT or 95 - Neurobehavioral status examination *Behavioral Health* IOP Procedure codes - televideo only • H0015 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. • H2012 Behavioral health day treatment, per hour. • S9480 Intensive outpatient psychiatric services, per diem. PHP Procedure codes - televideo only • H0035 Mental health partial hospitalization, treatment, less than 24 hours. • H2036 Alcohol and/or other drug treatment program, per diem. .Health care providers should refer to Aetna's website for the most current information: https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html
Amerigroup		
CHPW		CHPW follows state and Federal guidelines for the proper interaction methods and billing regulations. During this crisis the regulations have been

Per HHS announcement re telehealth: :www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html		
What provider-patient interaction methods will be considered telehealth and how should they be billed?		
		lightened and CHPW is allowing phone, telehealth, and billing as if in the office per usual where there is a hardship to do otherwise.
Cigna		
Coordinated Care		CCW is following all HCA and CMS guidance, or OIC mandates
First Choice (TPA and PPO)	Yes	First Choice is following the consensus position
KP-NW **KP -WA**		We don't place restrictions on the platforms used by our contracted providers to deliver telemedicine services, however, providers must bill in accordance with CMS telehealth billing guidelines.
Labor & Industries		If an E&M code allows for telephone/telehealth, telehealth visit for the E&M code is reimbursed at the same rate as the in-person version. And it is coded with POS = 2
Medicaid FFS		Medicaid will be covering a variety of telemedicine options. For information on billing these services, please see our FAQ page at https://www.hca.wa.gov/information-about-novel-corona-virus-covid-19
Molina		Please see Molina's telehealth policy
Pacific Source		Pacific Source is following the consensus position
Premera		Please see Premera's telehealth policy. https://www.premera.com/wa/provider/reference/payment-policies-search/?q=Telehealth&af1eq=&hpp=20&p=PBC-PaymentPolicy& The 2020 CPT code book contains significant new guidance on telehealth services as well and should be a standard reference.
Providence		Effective March 6, 2020 Providence Health Plan has enacted a temporary emergency policy to reimburse contracted providers for telehealth services without requiring an originating site. Providers may be paid for services performed by two-way video connections where the patient is calling from a personal device. No contract amendments or provider attestations will be required for reimbursement under this emergency policy. Our contracted providers may access this emergency policy to learn more by visiting the ProvLink provider portal at https://phpprovider.providence.org/portal/login
Regence		Regence is temporarily expanding the services that can be offered by in-network providers via telehealth. The visits are considered the same as in-person visits and are paid consistently with in-person visits. We are following the U.S. Department of Health and Human Services' guidance with respect to HIPAA compliant platform requirements (e.g. SKYPE, Facetime, etc. are allowed). Under this expansion for claims to process correctly, claims must be submitted with POS 11 or IOP and the GT modifier. (Note: To receive reimbursement consistent with an in-office visit, the POS must be either 11 or IOP. The GT modifier will indicate that the services were rendered via telehealth.) We will continue to cover the medical and behavioral health codes, as outlined in our Virtual Care Reimbursement Policy. However, providers should submit the codes in the policy with POS 11 or IOP and the GT modifier to be reimbursed consistent with an in-person visit.

Per HHS announcement re telehealth: :www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html		
What provider-patient interaction methods will be considered telehealth and how should they be billed?		
		Providers should refer to our websites for the most current information and Virtual Care Reimbursement Policy: • Regence: https://www.regence.com/provider/home • Asuris: https://www.asuris.com/provider/home • BridgeSpan: https://www.bridgespanhealth.com/provider/home
UHC		

Will a phone call with a patient be considered telehealth if there is no video feed, i.e. just voice interaction over the phone? If so, how should it be billed?		
Consensus Position		
Aetna		For the next 90 days Aetna will cover minor acute evaluation and management services care services rendered via telephone. A visual connection is not required. For general medicine and behavioral health visits – a synchronous audiovisual connection is still required. Aetna's telemedicine policy is available to providers on the NaviNet and Availity portals.
Amerigroup		
CHPW	Yes	CHPW is allowing telephone services based on HCA and the CMS guidelines. We are also paying these services at the E&M level of care, versus the lower telephone rate.
Cigna		
Coordinated Care		CCW is following all HCA and CMS guidance, or OIC mandates
First Choice (TPA and PPO)	YES	Bill per CMS telemedicine billing guidelines.
KP-NW **KP -WA**	Possibly	Depending on how the communication occurs (e.g., Skype audio vs. traditional telephone) the service could be billed via CMS telemedicine billing guidelines or CMS billing guidelines for telephone services (99441-99443).
Labor & Industries		
Medicaid FFS	Yes	The following codes are to be used when current practice for providing services is not an option (face to face, telemedicine) and there are extraordinary circumstances involved.

Code	Description
99441	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 minutes of medical discussion
99442	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

Will a phone call with a patient be considered telehealth if there is no video feed, i.e. just voice interaction over the phone? If so, how should it be billed?		
		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; 11-20 minutes of medical discussion
		99443 — 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; 21-30 minutes of medical discussion
		99421 — Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
		99422 — Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
		99423 — Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
Molina	Yes	Please see Molina's telehealth policy
Pacific Source	TBD	Currently evaluating phone-only services
Premera	Yes	Please see Premera's telehealth policy. https://www.premera.com/wa/provider/reference/payment-policies-search/?q=Telehealth&af1eq=&hpp=20&p=PBC-PaymentPolicy& The 2020 CPT code book contains significant new guidance on telehealth services as well and should be a standard reference.
Providence		Contracted providers may access our telehealth policy by visiting the ProvLink provider portal at https://phpprovider.providence.org/portal/login
Regence	Yes	For claims to process correctly, claims must be submitted with POS 11 or IOP and the GT modifier. (Note: To receive reimbursement consistent with an in-office visit, the POS must be either 11 or IOP. The GT modifier will indicate that the services were rendered via telehealth.). We will continue to cover the medical and behavioral health codes, as outlined in our Virtual Care Reimbursement Policy.
UHC		

Will telehealth be a covered service for patients new to that provider?		
Consensus Position		
Aetna	Yes	For the next 90 days, until June 4, 2020, Aetna will waive member cost sharing for a covered telemedicine visit regardless of diagnosis. Aetna members should use telemedicine as their first line of defense in order to limit potential exposure in physician offices. Health care providers should refer to Aetna's website for the most current information: https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html

Will telehealth be a covered service for patients new to that provider?		
Amerigroup		
CHPW		
Cigna	Yes	During this crisis
Coordinated Care		CCW is following all HCA and CMS guidance, or OIC mandates
First Choice (TPA and PPO)	Yes	First Choice Health is following the CMS expanded coverage guidelines for new and established patients
KP-NW	Yes	
KP -WA		
Labor & Industries		
Medicaid FFS	Yes	Telemedicine services for established and non-established patients will be covered. For telephone and online digital E and M, which are typically covered for non-established patients, Medicaid is allowing use of codes 99441-99443, 99421-99423 for both new or established patients, accompanied by the CR modifier, and billed at the line level
Molina	Yes	
Pacific Source	Yes	We are following CMS expanded coverage guidelines, which does allow telehealth visits for both new and established patients
Premera	Yes	A new patient may be provided with telehealth services
Providence		
Regence	Yes	A new patient may be provided with telehealth services
UHC		

D. Provider Workflow

Will the pre-authorizations be extended longer than 90 days? If so, by how much?		
Consensus Position		
Aetna		
Amerigroup		
CHPW		
Cigna		
Coordinated Care	TBD	We are still researching this question.
First Choice (TPA and PPO)	TBD	Extensions will be considered on a case by case basis.
KP-NW		
KP -WA		
Labor & Industries		
Medicaid FFS	Yes	Most authorization are 6 months/ 12 months depending on the services. If by chance, the authorization is less than 6/12 months the provider can request an extension.
Molina		
Pacific Source		
Premera	TBD	Currently investigating an approach to prior authorization
Providence		
Regence		
UHC		

As providers begin to treat suspected and actual COVID patients, they are trying to get paperless in the room (less contamination). As such, providers would like to not have to get the patient to sign any forms		
Can any patient signature requirements be waived for COVID patients, e.g. Medicare MOON?		
Consensus Position		
Aetna		
Amerigroup		
CHPW		CHPW will accommodate per consensus or guidance from the HCA or the CMS.
Cigna		
Coordinated Care		CCW is following all HCA and CMS guidance, or OIC mandates
First Choice (TPA and PPO)		We are also not aware of any group contractual requirement and believe that the signatures needed are consent to treat or HIPAA Notice receipt. On the HIPAA Notice or the consent to treat, signatures are possibly required by the provider to protect themselves. The HIAA notice provided by the provider to the customer is not a FCHA requirement but rather a provider obligation as the covered entity.
KP-NW		
KP -WA		
Labor & Industries		
Medicaid FFS		
Molina		
Pacific Source		
Premera		We are not aware of any group contractual requirement and believe that the signatures needed are consent to treat or HIPAA Notice receipt. On the HIPAA Notice or the consent to treat, signatures are possibly required by the provider to protect themselves – not Premera. The HIAA notice provided by the provider to the customer is not a Premera Privacy requirement but rather a provider obligation as the covered entity.
Providence		
Regence		
UHC		