Federal, state and commercial payer policies have quickly evolved in response to COVID-19. Not all polices are the same, but there are themes, and we’ve compiled relevant examples here to be an initial resource. These changes can be helpful for community practices looking to sustain crucial cash flow and likely help practices enhance operations in the post-COVID-19 era. Telehealth has been an emerging service, now centerstage and very unlikely to reverse. Once the US is through this crisis, the question will move to which providers figure out the best way to maintain and operationalize telehealth and when, not if, payers at the federal, state, or commercial level begin to take a closer look at telehealth billing and compliance.

For now, here are recommendations and highlights of new guidelines by payer:

Medicare pays for office, hospital, and other visits furnished via telehealth without geographic or place of service limits as of March 6, 2020.

- May be provided by doctors, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, registered dieticians, nutritionists, and clinical social workers
- Must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient
- Paid the same rate as traditional in-person visits
**How to Operationalize Telehealth During COVID-19 Crisis**

- HHS OCR exercising HIPPA enforcement discretion
- HHS OIG providing flexibility to reduce or waive cost-sharing
- HHS audit discretion

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Codes</th>
<th>Relationship</th>
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</table>
| Telehealth Visits     | A visit with a provider that uses telecoms                                   | Most common codes: 99202-99215 (office visits)  
|                       |                                                                             | G0425-G0427 (telehealth, ED)           | New or established patients |
|                       |                                                                             | G0406-G0408 (telehealth, SNF)                  |
| Virtual Check-ins     | 5 to 10-minute check-in via telecoms or remote evaluation of image sent by patient | G2012, G2010                           | Established patients |
| E-Visits              | Communication through an on-line portal                                      | 99421, 99422, 99423, G2061, G2062, G2063 | Established Patients |

Note: Many of these Medicare policy changes are likely to remain after the current health crisis.

Source: CMS Medicare Telehealth guidance/FAQ, March 2020
### Commercial Payer Telehealth Policies Evolving – Four Examples Illustrate Options, New Rules

Most commercial plans are, generally, trying to follow Medicare guidance as closely as possible. For example, use of an E&M code with a GT modifier is often recommended for billing, unless it is a certain setting or type of patient (e.g. ESRD). Some payers are waiving the previous requirement that there be a pre-existing provider-patient relationship and are also making sure they have fees on all the codes. Some had been non-covered or by report.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Cost for Patients</th>
<th>Telephonic v. Telehealth</th>
<th>How to Get Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS of Kansas</td>
<td>No cost to patients</td>
<td>Telephone (audio-only) visits can be used for the virtual visit</td>
<td>Use place of service 02 and GT modifier. Standard telehealth CPT code 99244 can generally be used for most telehealth services; however, bill most appropriate code for service provided</td>
</tr>
<tr>
<td>Empire BCBS</td>
<td>No cost to patients for in-network. OON telehealth visits are also covered if member’s benefit plan has OON benefits, but cost share possible</td>
<td>Covering both, but not for: chiropractic services, physical, occupational, and speech therapies</td>
<td>Bill office visit (99201-99215) telehealth claims will require Place of Service (POS) code “02” and either modifier 95 or GT</td>
</tr>
<tr>
<td>Horizon BCBS</td>
<td>No cost to patients for in-network providers. For covered services provided by telemedicine from an out-of-network provider, cost sharing is NOT waived</td>
<td>Relaxing its telemedicine rules to allow members to receive covered services by telephone</td>
<td>Will accept the following codes for audio-only telehealth services: 99441, 99442, 99443</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Will continue to accept claims for tele services when modifiers 95 or GT are appended to CPT or HCPCS codes that ordinarily describe face-to-face services including but not limited to professional services related to COVID-19 diagnosis or treatment</td>
</tr>
<tr>
<td>Regence BCBS</td>
<td>The member’s copay, coinsurance and deductible will apply to telehealth services</td>
<td>Can conduct the telehealth visit with your patient using audio or video; following HHS’ lead on discretion with respect to HIPAA compliant platform requirements</td>
<td>For claims to process correctly and for you to receive reimbursement consistent with an in-office visit, the place of service (POS) must be either POS 11 or intensive outpatient (IOP). The GT modifier will indicate that the services were rendered via telehealth</td>
</tr>
</tbody>
</table>

*Note: Payer policies changing regularly (check payer sites / bulletins for updates); self insured plans evolving*
**States Beginning to Adjust Tele Policies, Expanding Billable Codes – Four Examples Highlight Options**

<table>
<thead>
<tr>
<th>State</th>
<th>Policy Highlights</th>
</tr>
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| Colorado    | Health First Colorado (state’s Medicaid program) is temporarily expanding its telemedicine policy to authorize the following:  
• Expanding definition of telemedicine services to include telephone only and live chat modalities  
• Authorizing Federally Qualified Health Centers (FQHCs), Rural Health Clinic (RHCs), and Indian Health Services to bill encounters for telemedicine visits  
• Adding certain Physical Therapy, Occupational Therapy, Home Health, Hospice and Pediatric Behavioral Therapy services to the list of eligible interactive audiovisual telemedicine services |
| Michigan    | • Prior to March 20, 2020, state policy required both audio and visual service delivery.  
• Policy has now been expanded so that all codes on the telemedicine database (which includes primary care, behavioral health and others) will be allowed for the delivery method telephonic (audio) only |
| Texas       | • Telemedicine, including the use of telephone only, may be used to establish a physician-patient relationship. This expanded use of telemedicine may be used for diagnosis, treatment, ordering of tests, and prescribing for all conditions.  
• For all license and permit holders regulated by the TMB, the agency will take into account extenuating circumstances surrounding the completion of license/permit renewal requirements such as renewal deadlines and completion of continuing education hours. |
| Rhode Island| • The patient location requirement for telemedicine has been relaxed and patients may now receive telemedicine services at any location  
• The prohibition against audio-only telephone conversations and limitations on video conferencing are suspended to expand the availability of telemedicine  
• All clinically appropriate, medically necessary telemedicine services delivered by in-network providers will be reimbursed at rates not lower than services delivered in-person |
Advocacy Response Evolving

Financial Considerations
While public policy and legislation favors coverage and expanding access, very little information addresses actual financial impact to patients and beneficiaries.

– We are still at the relative beginning of the annual benefit period, so high deductible health plans and the forthcoming rise in uninsured mean bad debt and uncompensated care overall will most likely continue to increase.
– One recent study revealed the average cost to treat COVID-19 without complications for someone with employer insurance is projected to be almost $10k, with complications that figure doubles.
– A plan to mitigate bad debt and work with patients experiencing financial hardships will be critical in controlling the financial fallout of treating COVID-19. All providers should be concerned with their current outstanding patient receivables, as well as future patient receivables.

With such a gloomy outlook on future cash flow many associations have also submitted letters to congressional leaders with suggestions on how to assist them during a time of need. America’s Essential Hospitals (AEH) is the leading champion for hospitals and health systems dedicated to high-quality care.

– AEH submitted request seeking low interest loans, similar to the loans issued by the Small Business Association for Economic Injury Disaster relief
– Access to these loans with increased loan limits will help providers
– National Rural Health Association (NRHA) also submitted a letter to congressional leaders urging them to expand access to grants for rural providers, as well as easing restrictions and requirements. While expanding grants and state/federal funding will be important, the time associated with the process may take longer than providers can afford to wait. Decline in elective and ‘non-essential’ healthcare services will be detrimental to a provider’s cash flow, so they will need to utilize telehealth to lessen impact
COVID-19 Call Series:
Friday March 27, 2020, 2:00 PM (ET)

A Q&A With Payers & Providers on the Front Lines

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Dial-In (US) Toll-free: 800-874-4559
Conference ID (enter after dialing): 87861083
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