Southwestern Health Resources

Texas Health Resources® UTSouthwestern Medical Center®

COVID-19 PROVIDER ALERTS
October 30, 2020

The following updates have been made to the SWHR COVID-19 Resource Center, including the comprehensive grid outlining payer telemedicine information.

AETNA

COVID-19 Telemedicine Policy
Aetna COVID-19 Telemedicine Expansion

The use of telemedicine is encouraged as a first line of defense to limit potential COVID-19 exposure in physician offices. Through September 30, 2020, Aetna extended all member cost-sharing waivers for covered in-network telemedicine visits for outpatient behavioral and mental health counseling services for their Commercial Plans. Self-insured plans offer this waiver at their own discretion. Aetna's liberalized coverage of Commercial telemedicine services, as described in its telemedicine policy, will now extend through **Dec. 31, 2020**.

COVID-19 Resource Page
Aetna Covid-19 Resource Page

Verifying Telemedicine Benefits (Real Time Eligibility (RTE), Payer Portals or Phone)
Currently RTE nor Availity do not reflect if an ASO includes the Telemedicine benefit nor if there is an exclusive vendor. Please call to verify; Aetna is working on a potential solution.

Cost-Sharing
Aetna's liberalized coverage of Commercial telemedicine services, as described in its telemedicine policy, will now extend through **December 31, 2020**.

- Aetna extended all member cost-sharing waivers for covered in-network telemedicine visits for outpatient behavioral and mental health counseling services through December 31, 2020. Aetna self-insured plan sponsors offer this waiver at their discretion.
- Cost share waivers for any in-network covered medical or behavioral health services telemedicine visit for Aetna Student Health plans are extended until December 31, 2020.

- Medicare Advantage will continue to waive cost shares for in-network primary care and specialist telehealth visits, including outpatient behavioral and mental health counseling services through December 31, 2020.

Aetna will waive member cost-sharing for inpatient admissions for treatment of COVID-19 or health complications associated with COVID-19. This policy applies to all Aetna-insured Commercial and Medicare Advantage plans and is effective immediately for any such admission through December 31, 2020. Self-insured plan sponsors offer this waiver at their discretion.

Prior Auth Changes Regarding COVID-19

Aetna COVID-19 Communications Update: Temporary Changes in Prior Authorization/Precertification and Admissions Protocols

Referral Requirements

To address circumstances where PCP offices are closed due to COVID-19, Aetna has relaxed the PCP rule so no referral is necessary for Medicare Advantage plans. Aetna has not changed its PCP referral requirements for commercial plans.

BCBSTX

Telemedicine Policy (Baseline)

BCBS Telemedicine and Telehealth Services
Future State Telehealth - BCBSTX has started to discuss future state SWHR is request additional information

COVID-19 Resource Page

BCBSTX COVID-19 Preparedness
BCBSTX COVID-19 FAQs
BCBSTX COVID-19 Medicare FAQs

COVID-19 Coding Resources

Clinical Payment and Coding Policy Telemedicine and Telehealth Services

CIGNA

Telemedicine Policy (Baseline)

*Traditional Telemedicine Policy — Prior Exclusive to e.g., MDLive/WellMD; NOTE: Cigna expanded temporarily due to COVID-19

Oct. 16, 2020 Cigna announced a permanent Virtual Care Reimbursement Policy for commercial medical services effective **Jan 1, 2021**. *May be delayed if COVID-19 virtual care guidelines are extended. Only applies to Commercial Members as Medicare members will continue to follow the Medicare virtual care guidance.

COVID-19 Telemedicine Policy
Cigna COVID-19 Interim Billing Guidelines

In an effort to make it as easy as possible for Cigna customers to access timely and safe care, while ensuring that providers can continue to deliver necessary services in safe settings, Cigna will allow providers to bill a standard face-to-face visit for all virtual care services, including those not related to COVID-19, through Dec. 31, 2020.

As federal guidelines continue to evolve in support of the COVID-19 pandemic, Cigna is proactively extending customer cost-share waivers and other administrative benefits through at least October 31, 2020. Cigna is also extending their interim virtual care and eConsult guidelines through at least **Dec. 31, 2020.**

COVID-19 Resource Page
Cigna COVID-19 March Press Release
Cigna COVID-19 Interim Billing Guidelines

COVID-19 Coding Resources
Cigna COVID-19 Interim Billing Guidelines
Effective Aug. 1, 2020, Antibody testing will only be covered for ages 21 and younger.
Traditional Telemedicine Codes (e.g., 99201-99205; 99211-99215)

YES – Synchronous and **Audio-only temporarily – until Dec. 31, 2020**. Bill with POS services WOULD have been rendered if not during PHE (i.e., POS 11). Virtual and eConsults visits policy, as is of 7/17/20, has been extended to **Dec. 31, 2020.**

In an effort to make it as easy as possible for Cigna customers to access timely and safe care, while ensuring that providers can continue to deliver necessary services in safe settings, Cigna will allow providers to bill a standard face-to-face visit for all virtual care services, including those not related to COVID-19, through **Dec. 31, 2020**.

Virtual Check-Ins (G2012/G2010)
YES —
- Must be performed by a licensed provider
- Cost-share will be waived until **Oct. 31, 2020**
- Coverage applies until **Dec. 31, 2020**

Telephonic (99441-99443)
NO – see "Traditional Telemedicine Codes" section

E-Visits (99421-99423, G2061-G2063)
NO

Exclusions based on Patient Coverage?
NO — although during normal business operations all Cigna Commercial ASO Clients (Self-Funded Employer Groups) use exclusive telemedicine vendors. During COVID-19 Cigna has stated they will allow in network providers see their patients and **not require**

to use the exclusive Telemedicine vendors. ASOs that have prior excluded Telemedicine from their benefit plans will temporarily allow telemedicine billing by in network providers. **NOTE:** There is a short opt out period for ASOs but Cigna has stated they do not believe ASOs will limit their employees access to care**. Fully Insured Policies** are required to by state statute to include telemedicine benefit. TDI is marked on ID Cards.

Verifying Telemedicine Benefits (Real Time Eligibility (RTE), Payer Portals or Phone)

Since Cigna normally has exclusive vendors perform all Telemedicine services. Cigna does not list any benefit information on RTE or Payer Portals. It is recommended to call the Cigna C/S to verify.

Cost-Sharing

See Cigna COVID-19 Interim Billing Guidelines for full details

COVID-19 Related services

- Suspected/Likely COVID-19 exposure - Cost-share will be waived only for COVID-19 related services when providers bill the appropriate ICD10 code and modifier CS (Modifier CR or condition code DR can also be billed instead of CS)
- Confirmed COVID-19 case - Cost-share will be waived only when providers bill the appropriate ICD10 code (U07.1). Note that billing B97.29 will no longer waive cost-share. Effective August 1, 2020, U07.1 must be billed to waive cost-share for treatment of a confirmed COVID-19 diagnoses
- COVID-19 Lab Testing - Cost-share will be waived only when providers bill codes in the COVID-19: In Vitro Diagnostic Testing coverage policy or outlined in Cigna COVID-19 Interim Billing Guidelines.

Non COVID-19 Related

- Virtual Screening telephone consults (G2012) - Cost-share will be waived for all services (including non COVID-19 related services) until October 31, 2020
- Non COVID-19 virtual visit (i.e. telehealth) - Standard cost-share will apply
- In-office visit not related to COVID-19 Standard cost-share will apply

Prior Authorization Changes Regarding COVID-19

Prior authorization (i.e., precertification) is not required for evaluation, testing, or treatment for services related to COVID-19. Treatment is supportive only and focused on symptom relief. Prior authorization for treatment follows the same protocol as any other illness based on place of service and according to plan coverage. Generally, this means routine office, urgent care, and emergency visits do not require prior authorization. Delays in timely filing of claims or the ability to request an authorization due to COVID-19 would be considered an extenuating circumstance in the same way we view care in middle of a natural catastrophe (e.g., hurricane, tornado, fires, etc.). Cigna has only released relaxed PA requirements for Hospitals at this time. Cigna will factor in the current strain on health care systems and will incorporate this information into retrospective reviews.

Prior authorizations remain required for advanced imaging or scheduled surgeries.

Referral Requirements

Effective immediately, primary care physician referrals for specialist office visits are being waived temporarily through the end of the year for Individual & Family Plans (IFP) and through Oct. 31, 2020 for SureFit plans. Suspending the referral requirement will allow providers and Clinical Intake teams to better focus on COVID-19 critical care needs during this time. Claims will not be denied due to lack of referral for these services.

If a provider calls or faxes in a referral for an IFP or SureFit plan customer, they will receive a message indicating that Cigna is waiving the referral requirement through the specified time period.

Please note that HMO and other network referrals are still required, so providers should continue to follow the normal process that is in place today.

Timely Filing Extensions

Will providers who can't submit claims or request authorizations or file claims on time because of staffing shortages be penalized?

Cigna will make every effort to accommodate facilities and provider groups who are adversely affected by COVID-19, as appropriate. For all claims and appeals with timely filing periods that expired on or after March 1, 2020, timely filing periods will be extended until the end of the "Outbreak Period," which lasts until sixty (60) days after the expiration of the National Public Health Emergency (PHE). The Outbreak Period currently ends December 22, 2020, but it is subject to extension. At that time, those claims and appeals will be accepted and processed if submitted within the number of days that remained under the timely filing period as of March 1, 2020.

Prior authorization is not required for evaluation, testing, or medically necessary treatment of Cigna customers related to COVID-19. For other services that do require authorization, we will not deny administratively for failure to secure authorization (FTSA) if the care was emergent, urgent, or if extenuating circumstances applied. Delays in timely filing of claims or the ability to request an authorization due to COVID-19 would be considered an extenuating circumstance in the same way we view care in middle of a natural catastrophe (e.g., hurricane, tornado, fires, etc.).

Accelerated Payments

N/A

Audit Changes

- Cigna will also closely monitor and audit claims for inappropriate services that should not be performed virtually (including but not limited to: acupuncture, all surgical codes, anesthesia, radiology services, laboratory testing, administration of drugs and biologics, infusions or vaccines, and EEG or EKG testing).

HUMANA

COVID-19 Telemedicine Policy

Telemedicine Expansion
Humana COVID-19 FAQ - updated June 17, 2020
Humana COVID-19 Testing FAQs - updated Oct. 16, 2020
Humana Telehealth FAQs
Humana Telehealth and Other Virtual Services

Temporary expansion of telehealth service scope and reimbursement rules: To ease systemic burdens arising from COVID-19 and support shelter-in-place orders, Humana is encouraging the use of telehealth services to care for its members. Humana will temporarily reimburse for telehealth visits at the same rate as in-office visits. In order to qualify for reimbursement, telehealth visits must meet medical necessity criteria, as well as all applicable coverage guidelines. Humana understands that not all telehealth visits will involve the use of both video and audio interactions. For providers or members who don't have access to secure video systems, we will temporarily accept telephone (audio-only) visits. These visits can be submitted and reimbursed as telehealth visits. Please follow CMS or state-specific guidelines and bill as you would a standard telehealth visit.

Prior Authorization Changes Regarding COVID-19

As of Oct. 16, 2020 - Humana CMO Update
Humana is reinstating authorization requirements for COVID-19 related diagnoses for Medicare Advantage and commercial plans. Medicaid and commercial plans will continue to follow state regulations and existing state executive orders as applicable.

Humana is providing advanced notice so you can prepare for this change. Availity and telephonic authorization tools will continue to provide an approval upon submission of a COVID-19 related authorization request or notification through Oct. 23, 2020, and no process changes are required through that date. Humana will reinstate authorization requirements on COVID-19 diagnoses for Medicare Advantage and commercial plans for authorizations requested on or after Oct. 24, 2020.

This return to Humana's standard authorization policy applies to participating/in-network and non-participating/out-of network providers. As we resume regular authorization processes, Humana will continue to monitor local situations and adjust policy accordingly. This includes continuing to suspend authorizations wherever a state executive order to do so exists.

There are no prior authorization requirements related to COVID-19 testing.

UHC

COVID-19 Telemedicine Policy

UHC Summary of COVID-19 Dates by Program Grid – updated Oct.12, 2020

Medicare Advantage –

- COVID-19 related services – UnitedHealthcare will extend the expansion of telehealth access for in- and out-of-network providers through the national public health emergency period, currently scheduled to end **Dec. 31, 2020**. From Jan. 1, 2021 through the national public health emergency period, currently scheduled to end Jan. 20, 2021, UnitedHealthcare will cover all in-network and out-of-network telehealth services as outlined in the current CMS guidelines.
- Non-COVID-19 related services – UnitedHealthcare will extend the expansion of telehealth access for in- and out-of-network providers through the national public health emergency period, currently scheduled to end **Dec. 31, 2020**. From Jan. 1, 2021 through the national public health emergency period, currently scheduled to end Jan. 20, 2021, UnitedHealthcare will cover all in-network and out-of-network telehealth services as outlined in the current CMS guidelines.
- (See the Medicare Advantage section on UHCprovider.com/covid19 > Telehealth)

Commercial –

- COVID-19 related services – UnitedHealthcare will extend the expansion of telehealth access for in-network providers for COVID-19 testing and treatment through **Dec. 31, 2020**. From Jan. 1, 2021 and beyond, UnitedHealthcare will cover all in-network telehealth services as outlined in current CMS guidelines and additional codes as outlined in our telehealth reimbursement policy.
- Non-COVID-19 related services – For in-network providers, UnitedHealthcare will extend the expansion of telehealth access through **Dec. 31, 2020.** From Jan. 1, 2021, UnitedHealthcare will cover all in-network telehealth services as outlined in the current CMS guidelines and additional codes as outlined in our telehealth reimbursement policy.
- (See the Individual and Fully Insured Group Market Health Plan section on UHCprovider.com/covid19 > Telehealth)
- The temporary policy changes apply to members whose benefit plans cover telehealth services and allow those patients to connect with their doctor through live, interactive audio-video or audio-only visits.

E-Visits (99421-99423, G2061-G2063)

Additional Details

UnitedHealthcare will reimburse providers when members communicate with their doctors using online patient portals, using CPT® codes 99421-99423 and HCPCS codes G2061- G2063.

For these e-visits, the member must generate the initial inquiry, and communications can occur over a seven-day period.

Cost-Sharing

UHC Summary of COVID-19 Dates by Program Grid – updated Oct. 12, 2020

Medicare Advantage –

- COVID-19 related services -
  - COVID-19 Testing -UnitedHealthcare will extend the expansion of telehealth access for in- and out-of-network providers through the national public health emergency period, currently scheduled to end -Jan. 20, 2021.
  - COVID-19 Treatment - From February 4, 2020 through Dec. 31, 2020, UHC is waiving cost sharing for in-network and out-of-network telehealth treatment visits.
- Non-COVID-19 related UnitedHealthcare extended the cost share waiver for telehealth services for in- and out of-network primary care providers through Dec. 31, 2020. As of October 1st, 2020, cost sharing for non-primary care telehealth services will be adjudicated in accordance with the member's benefit plan.

Commercial –

- COVID-19 related services
  - COVID-19 Testing -UnitedHealthcare will extend the expansion of telehealth access for in- and out-of-network providers through the national public health emergency period, currently scheduled to end Jan. 20, 2021.
  - COVID-19 Treatment - From February 4, 2020 through Dec. 31, 2020, UHC is waiving cost sharing for in-network telehealth treatment visits.

- Non-COVID-19 related services – For in-network providers, UnitedHealthcare extended the expansion of telehealth access through Sept. 30, 2020. As of Oct 1, 2020, benefits will be adjudicated in accordance with the member's benefit plan.

Prior Authorization Changes Regarding COVID-19

Program or Benefit Scenario	Health Plan*	Date Details	Additional Details
Diagnostic Radiology for COVID-19 testing and testing-related services (diagnostic imaging)	Medicaid and Individual and Group Market health plans* No notice is necessary for Medicare	Prior authorization is not required through the national public health emergency period, currently scheduled to end Jan. 20, 2021.	• Providers are asked to submit a notification for CPT® codes 71250, 71260, 71720 for members with a COVID-19 diagnosis or suspected diagnosis.
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	Medicare Advantage, Medicaid and Individual and Group Market health plan members*	For prior authorizations approved before Oct. 1, 2019, a new authorization is required.	• Providers may complete a face-to-face assessment either through an in-person visit or using telehealth.
		Prior authorizations that were approved on or after Oct. 1, 2019, were extended through Sept. 30, 2020.	• Prior authorization requirements resumed June 1, 2020. For new prior authorizations, providers may complete a face-to-face assessment either through an in-person visit or by telehealth.
		For prior authorizations for equipment and supply deliveries from March 31, 2020, through May 31, 2020.	• Changes to notification and delivery requirements for equipment and supplies
Embryo Cryopreservation	Individual and Group Market fully insured health plans with infertility benefits*	No prior authorization is required for embryo cryopreservation from March 17, 2020, through April 30, 2020	• Temporary change in embryo cryopreservation coverage for members who started an IVF cycle and were ready for retrieval and embryo transfer, which was interrupted mid-cycle by COVID-19 restrictions.

Program or Benefit Scenario	Health Plan*	Date Details	Additional Details
Medical, Behavioral Health and Dental Services – Extensions of Existing Prior Authorizations	Medicare Advantage, Medicaid and Individual and Group Market health plans*	90-day extension based on original authorization date with an end date or date of service between March 24, 2020 and May 31, 2020. Prior authorizations on or after April 10, 2020 will not be subject to extension.	• For example: For a prior authorization with an original end date or date of service of April 30, 2020, the prior authorization would extend through July 29, 2020.
Post-Acute Care Admission	Medicare Advantage, Medicaid and Individual and Group Market health plans*	Prior authorization suspended from March 24, 2020 through May 31, 2020.	• Applies to admissions for long-term acute care facilities, acute inpatient rehabilitation and skilled nursing facilities.
Site of Service Reviews	Medicaid and Individual and Group Market fully insured health plans*	Prior authorization suspended from March 24, 2020 through May 31, 2020.	• Applies to nearly 2,000 surgical codes
Transfers to a New Provider	Medicare Advantage, Medicaid and Individual and Group Market health plans*	Prior authorization suspended from March 24, 2020 through May 31, 2020.	• Prior authorization not required when a member moves to a different yet similar site of care for the same service (e.g., hospital transfers or practice transfers).

Referral Requirements

- **Medicare Advantage:** As a result of the emergency order, beginning March 1, 2020: UHC is not enforcing referral for Medicare Advantage plans during the national public health emergency period.
- **Individual and Group Market Health Plans:** Consistent with existing policy, members do not need a referral for emergency care. All other standard referral requirements continue to apply. If a patient is unable to contact their primary care provider (PCP), they can contact Member Services for assistance with a referral. The number for Member Services can be found on their health plan ID card.

Timely Filing Extensions

Medicare Advantage –

Additional Details

- If the Centers for Medicare & Medicaid Services (CMS) issues further guidance on timely filing, UnitedHealthcare will adhere to that guidance.
- UHC standard timely filing requirements apply to claims that exceeded requirements prior to the national emergency period.**

Commercial –

Additional Details

- Timely filing requirements have been extended an additional 60 days following the last day of the national emergency period.** This regulatory guidance has been issued by the IRS and the U.S. Department of Labor (Employee Benefits Security Administration).
- UHC standard timely filing requirements apply to claims that exceeded requirements prior to the national emergency period.**

MEDICAID

COVID-19 Telemedicine Policy
COVID-19 Telemedicine Extension – Update: **Nov. 30, 2020**

Traditional Telemedicine Codes (e.g., 99201-99205;99211-99215)
YES — Synchronous virtual care required per traditional HHSC telemedicine policy (Medicaid); **audio-only temporarily until Nov. 30, 2020.**

Virtual Check-Ins (G2012/G2010)
NO — HHSC/TMHP is allowing audio-only billed under standard E&M codes with Modifier 95 from March 20 until **Nov. 30, 2020**.

Telephonic (99441-99443)
NO — HHSC/TMHP is allowing audio-only billed under standard E&M codes with Modifier 95 from March 20 until **Nov. 30, 2020**.

Cost-Sharing
N/A Medicaid Products; CHIP Waiver of CHIP Co-payments
To assist families in accessing care during the COVID-19 response, HHSC is waiving office visit co-payments for all CHIP members for services provided from March 13, 2020, until **Nov. 30, 2020**.

Cost Share CHIP Waiver – updated **Nov. 30, 2020**

Prior Authorization Changes Regarding COVID-19
COVID-19 Guidance for New and Initial Prior Authorizations Extended to Oct. 23, 2020 – updated July 30, 2020
TMHP To Extend Existing Prior Authorizations by 90 days – updated July 31, 2020