Temporary Telemedicine/Telephone-only Services for COVID-19 Pandemic

Policy Statement

In accordance with State of Rhode Island "Fourth Supplemental Emergency Declaration – Expanding Access to Telemedicine Services", Executive Order 20-06 issued on March 18, 2020 along with the State of Rhode Island Office of Health Insurance Commissioner ("OHIC") guidance Bulletin 2020-01, entitled "Emergency Telemedicine Measures to Address and Stop the Spread of COVID-19" issued on March 20, 2020, Neighborhood is **temporarily** expanding access to telemedicine services as outlined in this policy.

Scope

This policy applies to

☒**Medicaid** *excluding Extended Family Planning (EFP)*
☒**INTEGRITY**
☒**Commercial**

This policy is separate and distinct from Neighborhood's traditional Telemedicine Services Payment Policy, which will remain in effect during the timeframe this policy is in effect.

This policy applies to medical services provided via telemedicine during the COVID-19 pandemic. For information on behavioral health services provided via telemedicine/telephone-only please contact OPTUM Behavioral Health.

This policy is effective for dates of service on or after March 18, 2020. For dates of service prior to March 18, 2020, please refer to the Neighborhood policies that were in effect for prior dates of service.

Neighborhood reserves the right to implement, modify, and terminate this temporary policy without the contractual sixty-day notification that is normally required under Neighborhood contracts with its providers. Notification of implementation, modification, or termination of this policy will be communicated to providers via notice on Neighborhood's COVID-19 Provider Guidance website

Prerequisites

All services must be medically necessary to qualify for reimbursement. Neighborhood may use the following criteria to determine medical necessity:

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Industry accepted criteria such as Interqual
- EOHHS recommendations
- Clinical Medical Policies (CMP)

It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Clinical Medical Policies.

Please contact Provider Services at 1-800-963-1001 for questions related to this policy.

Reimbursement Requirements

Neighborhood reserves the right to audit medical records as well as administrative records related to adherence to all the requirements of this policy, e.g. to verify the nature of the services provided, the medical necessity and clinical appropriateness to provide such service via telemedicine and/or telephone as well the appropriateness of the level of evaluation and management coding.

Documentation requirements for a telemedicine/telephone-only service are the same as those required for any face-to-face encounter.

Prior authorization requirements will be waived for the telemedicine/telephone-only services outlined in this policy.

Telemedicine/telephone-only services are covered when all of the following criteria are met:

- The patient is present/participates at the time of service.
- Services must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via face-to-face interaction.
- Services must be medically necessary and otherwise covered under the member's benefit plan.
- Services must be within the provider's scope of license.
- A permanent record of the telemedicine/telephone-only communication(s) must be documented/maintained as part of the patient's medical record.

Neighborhood will reimburse telemedicine/telephone encounters at 100% of the in-office allowable for any clinically appropriate, medically necessary covered health service.

Coverage Inclusions

In an effort to support social distancing efforts by reducing the need for in-person treatment, during the timeframe this policy is in effect, Neighborhood will temporarily allow for all clinically appropriate, medically necessary covered health services to be provided through telemedicine/telephone-only for any health conditions when billed by the following provider types:

- Primary care physicians
- All Medical Specialists - defined as any MD, DO, NP and PA
- Optometrists
- Doctors of Podiatric Medicine (DPM's)
- Chiropractors (DC)
- Lactation Consultants
- Physical, Occupational and Speech Therapists
- Diabetes Educators
- Nutritionists
- Midwifes
- Urgent Care Centers
- Emergency Departments
- Retail Based Clinics

Per OHIC Bulletin 2020-01, professional providers are allowed to provide service to any patient, regardless of the patient's originating site. This includes service for a patient residing in a nursing facility or is undergoing treatment in an inpatient hospital setting.

Coverage Exclusions

- Services rendered through email, text, fax, or patient portal.
- Telemedicine that occurs the same day as a face-to-face visit, when performed by the same provider and for the same condition.
- Patient communications incidental to E&M services, including, but not limited to reporting of test results or provision of educational materials.
- Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.
- Any telemedicine/telehealth or telephonic encounter conducted by office staff, RNs, LPNs, etc.
- Services that are not clinically appropriate to be billed through telemedicine/ telephone such as, a chiropractor may not bill for manual manipulation services

and a physical therapist may not bill for manual therapy services via telemedicine/ telephone.

- Telemedicine/telehealth services provided through the following public facing video communication applications.

Claim Submission

Telemedicine is not considered a distinct benefit and is covered as a place of service. Place of Service (POS) 02 (when patient is not located in their home) or POS 10 (effective 4/1/22, when patient is located in their home) must be on the claim to indicate that the service was delivered via telemedicine/telephone only.

Claims must include modifier "CR", defined as: Catastrophe/Disaster Related

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Adjustments, corrections, and reconsiderations must include the required forms. All submissions must be in compliance with National Claims Standards.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Documentation Requirements

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

Member Responsibility

Neighborhood will waive member cost share for Commercial plans for services outlined in this temporary policy. Providers should NOT collect cost share from a member in accordance with this policy.

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Document History

Date	Action
04/08/22	Update: Added New POS 10 under Claim Submission to align with CMS requirement, effective 4/01/2022.
05/11/21	Format Update Only. No content changes
07/27/20	Update: Language regarding Implementation, Modification, and Termination of policy added. Remove effective date.
07/17/20	Update: Expected policy effective date in accordance with Executive Order 20-52 issued 7/3/20.
07/13/20	Update: Expected policy effective date extended per 6/26 extension of Executive Order 20-31
06/04/20	Update: Expected policy effective date extended per extension of Executive Order 20-31.
05/07/20	Update: Expected policy effective date per Executive Order 20-31
04/13/20	Update: remove 'effective until' date of 4/17 per Executive Order 20-18
03/31/20	Update: Add emergency department, Add OHIC language regarding patient location, Add authorization language, update documentation requirements.
03/26/20	Update: Documentation Requirements and Cost Share Waiver Requirements
03/18/20	Policy Effective