GREY LEDGE
MEDICAL MANAGEMENT
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***MEMORANDUM***

***To:*** ***GLMM Clients***
***From:*** ***Karen Marcoux, CPC, Sharon Parayno, CPC, Sue Kandzerski, CPC, JoAnn Beahm, CPC***
***Date:*** ***December 2, 2020***
***Subject:*** ***Highlights from MA RI MGMA- Annual RI Payor Day Meeting***

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The following information was shared by the Rhode Island insurance companies at the recent Annual RI Payor Day meeting, hosted by the MA/RI MGMA.

***United HealthCare*** **Rebecca Lennon** (612) 383-4301 Rebecca_M_lennon@uhc.com

- 2021 Evaluation & Management Coding Updates - UnitedHealthcare is currently in the process of updating the verbiage in the Evaluation & Management policy for all lines of business to incorporate the 2021 changes. UnitedHealthcare will also be implementing pricing changes effective 1/1/2021, in accordance with the providers contract with UnitedHealthcare.
- 2021 Telehealth Policy Updates - Medicare Advantage plans will continue to follow current CMS guidelines for billing requirements.
- Providers were sent a notification letter back in September 2020, to participating PCPs and Specialists in RI and MA. This notification letter was to notify providers that UnitedHealthcare will not be enforcing gatekeeper referral requirements for the remainder of 2020 and for 2021 for HMO plans. UnitedHealthcare has also mentioned that the "referral requirement" noted on the patient's ID card or in Link will still show that a referral is required. The language in the letter lets providers know that claims will be processed and referral requirements is not enforced for the remainder of 2020. 2021 ID cards will have updated language on the card.
- Credentialing updates - a faster and easier online credentialing platform called Onboard Pro has been launched. Most of the demographic and credentialing information will be automatically retrieved as it is connected with CAQH ProView. Onboard Pro is for new care providers not yet linked to a group contract. Help with Onboard Pro can be directed to Network Management Resource team at 866-574-6088, option 1 or by email to swproviderservices@uhc.com.
- In December 2020, referalLink and TrackIt will be retiring from the legacy Link. Starting in October you can continue managing patient referrals and accessing TrackIt in the new Link experience. On screen tips will be available at referalLink and TrackIt to walk you through the features so the transition to the new Link experience should be seamless.

- Throughout the remainder of 2020 United Healthcare will phase out sending paper checks for payment. If you have not already done so, please be sure to sign up for Automated Clearing House/direct deposit. For more information, and to sign up for ACH/direct deposit, visit UHCprovider.com/payment.
- Prior authorization and notification requirements are being updated. To see current prior authorization requirements for all plans, please visit: UHCprovider.com/priorauth>Advanced Notification and Plan Requirements Resources> Select a plan type.

***Medicare*** ***Lori Langevin*** (401) 862-9632 lori.langevin@anthem.com

- Modifier CR (catastrophe/disaster related) is not a required modifier on telehealth services.
- Modifier CS (cost sharing) are required on and after DOS 3/18/2020 on E&M codes only. This allows 100% reimbursement of the Medicare fee schedule. The CS modifier is used to identify the service as subject to the cost-sharing waiver for COVID-19 testing-related services and the provider should not charge Medicare patient's any coinsurance and/or deductible amounts for the services.
- Telehealth POS is equal to what it would have been if the service was performed as a face to face encounter in the absence of the PHE.
- CMS.gov can be searched for additional Coronavirus Disease 2019 guidance by clicking the learn more feature. Also, you can see a complete list of Telehealth Services under the Medicare tab under Telehealth>List of Telehealth Services.
- www.NGSMedicare.com can be searched to learn more and stay up to date with the latest Coronavirus news.
- Telehealth Documentation should include the same documentation as if the services took place as a face to face encounter except a statement is needed to indicate service was telehealth, along with patient location, provider location, names of all persons participating in the telemedicine service and their role in the encounter. Time based services should always have a start and stop time and total time should be documented.
- Medicare will consider CPT 99072 (additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a PHE as defined by law, due to respiratory-transmitted infectious disease) as a bundled service.

***Harvard Pilgrim Health*** ***Kelli Macey*** (617) 509-3405 Kelli_macey@harvardpilgrim.org

- Harvard Pilgrim is waiving all member cost share including copays, deductible or coinsurance for all telemedicine services, not just for COVID-19 services.
- Services must be delivered by an in-network provider for dates of service of 3/6/2020 – 12/31/2020 for commercial and Medicare Advantage members.
- For service dates through December 31, 2020, Harvard Pilgrim will suspend prior authorizations that are needed on elective admissions at acute care facilities and acute inpatient admission at acute care, skilled nursing facilities, long-term acute care and rehab facilities.
- Providers will be reimbursed for Telemedicine/Telehealth services at the same rates as if the services were delivered in a face to face visit.
- HPHC will adopt the new coding and documentation guidelines as of 1/1/2021 for CPT codes for new patients of 99202, 99203, 99204 and 99205 and established patient CPT

codes 99211, 99212, 99213, 99214 and 99215. CPT code 99201 will be deleted. Fee schedules and policies will be updated as appropriate.

- Prolonged service CPT codes of 99354, 99355 and 99356 will be revised. There will also be new add on codes created to report additional physician time in 15-minute increments. These add on codes will be reported in conjunction with codes 99205 or 99215.
- HPHConnect offers authorization upgrades, resource pages and authorization information. HPHConnect can be accessed from Harvard Pilgrims provider website at www.harvardpilgrim.org/provider.
- Harvard Pilgrim is introducing new products for 2021. Maine's Choice Plus HMO (Maine), Options HMO (New Hampshire), Focus CT HMO (CT and all Harvard Pilgrim providers across New England that are considered in-network) and Network Choice CT PPO (CT).
- Keeping provider information up-to-date is vital. Harvard Pilgrim asked that all providers making changes to submit a "Complete Change Form" and send to PPC@harvardpilgrim.org.
- Claim Review Request for filing limit, referral, payment & clinical policy appeals must be submitted on a Request for Claim Review Form. Include relevant documentation and submit information withing filing limits. Harvard Pilgrim also reminded providers that it is 90 days from date of denial for 1st level of appeal. 2nd level of appeal is 90 days from 1st appeal decision letter. Please include a separate form for each claim, a copy of the claim and any information to support your appeal.
- CPT 99072 (additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a PHE as defined by law, due to respiratory-transmitted infectious disease) is non reimbursable with Harvard Pilgrim Healthcare.

***Aetna*** ***Ryan Benton*** BentonR@aetna.com

- As of 3/6/2020, Aetna has expanded their telemedicine policy to pay at 100% of the contracted rate for an in-person visit. This policy is temporary and applies to all specialties and has been extended to 12/31/2020.
- There are no geographic restrictions other than the provider can only render services in the state(s) where licensed. All providers may render telehealth services covered by policy within the scope of licensure. Rural vs. Urban setting does not apply.
- On October 14, 2020, CMS announced an expansion of telemedicine services, which included guidance on reimbursement for a number of telemedicine codes. CPT 93797, 93798, 93750, 95970, 95971, 95972, 95983, 95984, G0422, G0423 & G0424.
    - Aetna Commercial claims will be retroactively approved back to 3/6/2020 for the above services.
    - Aetna Medicare claims for these services are effective 10/14/2020 and will not be retroactively approved.
- For the 2021 E&M changes, the prolonged services component is under review as part of new code handling, but Aetna is planning to accept the other E&M changes in relation to the documentation. For example, if records are requested, Aetna will look for documentation to be in the records regarding medical decision making (MDM) or time. The Aetna E&M payment policy is available in the provider portal under Aetna Payer Spaces>Resources.

- CPT 99072 (additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a PHE as defined by law, due to respiratory-transmitted infectious disease) is considered incidental to the primary procedure and no additional payment will be made.
- Aetna requires MDs (excluding Radiology, Anesthesiology, Pathology & Emergency Medicine) and NPs (only when acting as a PCP) to be credentialed.
- Credentialing applications can be submitted online at https://www.aetna.com/health-care-professionals/contact-aetna.html. Please make sure CAQH is up-to-date and Aetna has permission to view the provider's records.
- Credentialing can take 45-60 days for completed applications. Once completed, please reach out to Ryan Benton for the next steps to take at bentonr@aetna.com
- Aetna has officially transitioned to Availity portal on 5/30/2020 instead of Navinet. Availity portal offers a number of features for providers including, claim status, Provider Demographic Updates, Authorization, Referral Requests and Access to EOB's.
- Go to www.availity.com/aetnaproviders and click on the appropriate icon. The first person in the office who registers will become the Availity administrator. The Availity administrator will grant and maintain access to Availity for the entire practice. Typically, this should be set up by the physician directly.
- Aetna will hold training sessions.
    - Working with Aetna on Availity - This training sessions is on the 1st Tuesday of every month @ 2:00 – 3:15 p.m. The training sessions will review the Learn how to Contact Us feature, navigate the website and utilize a number of tools.
    - Provider Onboarding – This training session is on the 2nd and 3rd Tuesday of every month @ 1:00 – 2:00 p.m. The training session will have a general overview of Availity, highlighted by updating provider data and where to access policy, claim, eligibility and patient benefit data.
    - Claim Management – This training session is on the 3rd Thursday of every month @ 2:00 – 3:00 p.m. The training session will teach you how to utilize Aetna's suite of claims tool. Also, claim status, online EOB's and claim reconsideration.
    - Authorizations and Precertification – This training sessions is on the 2nd Wednesday of every month @ 2:00 – 3:00 p.m. The session will provide an overview of Aetna's authorization and precertification process for practices and facilities. It will also cover referrals, as well as Pre-certification CPT code search, inquires and status updates.

***Blue Cross Blue Shield of RI*** ***Marissa Calicchia Marisa.Calicchia@bcbsri.org***

- Telemedicine/Telehealth & Telephone services temporary policy is effective 3/18/2020 and is set to expire on 12/31/2020. This temporary policy allows coverage for all clinically appropriate and medically necessary covered health services. Reimburses services at 100% of the in-office allowable amount. The temporary policy also waives cost share (copays, deductibles and coinsurances).
- BCBS RI has self-funded groups that can choose to opt out of the cost share waiver. To obtain a list of groups that are currently opted out. See the Alerts & Updates section of the secure provider portal at BCBSRI.com. Go to: "Self-funded opt out groups for telemedicine cost share"

- As of 10/1/2020, BCBSRI will require 95 modifier on all claims filed for services provided by Real-Time Interactive Audio & Video Telecommunications systems. Claims can continue to be filed with POS 02 and modifier CR. However, placing modifier 95 in the first modifier position and CR modifier in the second position.
- Telephone only services filed as of 10/1/2020 will require POS 02 and modifier CR.
- BCBSRI will have all Temporary COVID policies on the BCBSRI provider portal under the letter "T".
- The following services require authorization unless service is COVID-19 related
  - Urgent & Emergent in-patient level care
  - Long Term Acute Care
  - Acute Inpatient Rehabilitation level of care
  - Skilled Nursing Services
- The following services require referrals
  - Blue Chip for Medicare: Per CMS referrals will continue to be waived for Blue Chip for Medicare members.
  - Blue Chip Commercial: Referrals are required for plans that require a referral.
- BSBSRI will continue to follow the industry standard for correct coding rules for E&M codes billed after 1/1/2021.
- BCBSRI will adopt the level of decision-making table and will allow coding to be based on MDM or total time.
- BCBSRI is currently awaiting updates on the status of the proposed prolong service codes and will make a policy determination once final guidance is received.
- It is a requirement for all providers to attest their information quarterly with BCBSRI & CMS. Updating provider data and demographics is also a requirement outlined in the providers contracts with BCBSRI. Accurate information allows patients to use the, find a doctor tool to locate providers. Provider data is located on the provider portal at BCBSRI.com under Update Practice Info.
- BCBSRI Provider Relations will send out email blasts for important notifications or reminders. To be added to the email blast list, contact ProviderRelations@bcbsri.org.
- BCBSRI will be hosting the future of telemedicine webinars in November, December and January. The topic to be discussed is New Telemedicine Payment Policies for Medicare & Commercial products as of 1/1/2021.

***Tufts Health Plan*** Al Means

- Tufts Health Plan recommends using the latest versions of Mozilla Firefox & Google Chrome for an optimal working experience with their website.
- Visit this page regularly, https://tuftshealthplan.com/provider/provider-information/coronavirus-updates-for-providers, for the most up-to-date information about Tufts Health Plan's policies and coverage pertaining to COVID-19. The website offers other resources including COVID-19 Diagnostic Testing and Treatment ▪ Telehealth/Telemedicine ▪ Referrals and Out-of-Network Authorizations ▪ Utilization Management ▪ Claims and Billing Guidelines ▪ Other Benefit Information ▪ Credentialing ▪ Etc.
- Tufts Health Plan stated that all policies that have been put in place with connection to COVID-19 situation and are not intended to be permanent changes. Unless otherwise noted, all policies are effective beginning with dates of service starting on March 6,

2020. Any policy Tufts Health Plan has without an end date listed or for which it states "until further notice," will be evaluated by Tufts Health Plan. Tufts Health Plan will continue to evaluate their policies with the state emergencies and other regulations and will aim to provide at least four-week notice in advance of any termination to the policy.

- Behavioral Health - Prior Authorization and Notification is not required for the following services: ▪ Applied Behavioral Analysis (ABA) for all products ▪ Children's Behavioral Health Initiative (CBHI) for Tufts Health Together ▪ Behavioral Health for Children and Adolescents (BHCA) for Massachusetts Commercial products ▪ Home-Based Therapeutic Services (HBTS) for Tufts Health RITogether. Providers are still responsible for confirming the service is covered by the individual treatment plan and the member meets medical necessity criteria for the service
- For the duration of the COVID-19 emergency, Behavioral Health providers that do not have fax capabilities can email any clinical information to the appropriate Tufts Health Plan email address, as outlined below: Commercial (including Tufts Health Freedom Plans): BHPriorAuthCommercial@tufts-health.com ▪ Tufts Health Public Plans (Tufts Health Direct, Tufts Health Together MassHealth MCO Plan and Accountable Care Partnership Plans, Tufts Health RITogether and Tufts Health Unify): THPPBHRequests@tufts-health.com ▪ In the email subject line, include the product name and type of service you are emailing information about.
- Waiving Member Costs • There are no out-of-pocket costs for medically necessary coronavirus testing, counseling and vaccinations. Tufts Health Plan is also waiving member cost shares, including co-payments, coinsurance, and deductibles for medically necessary in-person coronavirus treatment.
- For dates of service after July 20, 2020, pre-COVID coverage policies and benefits (including applicable cost share) will apply for out of-network (OON) telemedicine. In-network telehealth guidelines will remain in place until further notice.
- For Telehealth/Telemedicine services • Members who receive services by telehealth/telemedicine from Tufts Health Plan network providers will have no cost share. • Tufts Health Plan Commercial members (not including Direct) can use the telehealth solution powered by Teladoc: teladoc.com/tuftshealthplan.
- Tufts Health Plan has also increased access to refill prescription drugs: • Allow for early refills • Allow refills for up to a 90-day supply to the extent consistent with clinical guidelines (except for controlled substances).
- Some highlights of the COVID-19 telehealth/telemedicine policies include: ▪ Tufts Health Plan will compensate in-network providers at 100% of their contracted rate for services rendered in person, as specified in provider agreements. The telehealth reduction will not apply. ▪ The policy applies for all diagnoses and is not specific to a COVID-19 diagnosis. ▪ All Tufts Health Plan contracting providers may provide telemedicine services to members for all medical and behavioral health care encounters for both new and existing patients. ▪ Prior authorization is not required for in-network telehealth services. ▪ Tufts Health Plan will waive member cost share for in-network telehealth services. This includes both facility and professional services. Providers should not collect a copay from members.
- For professional claims providers should submit claims for telehealth visits as outlined below. Commercial & Tufts Health Direct should submit claims with POS 02. Tufts Medicare Preferred should submit in accordance with CMS guidelines, submit claims with modifier 95 to indicate a telehealth visit. Tufts Health Plan SCO & Tufts Health

Unify should submit claims in accordance with CMS and MassHealth guidelines, submitting claims with modifier GT or 95 and POS 02. Tufts Health Together should submit claims in accordance with MassHealth requirements with modifier GT and POS 02.

- Tufts Health RITogether Claims and Enrollment Reminder: Effective September 1, 2020. As part of the system implementation for Tufts Health RITogether claims and enrollment, providers contracted for both Massachusetts and Rhode Island Tufts Health Public Plans products will begin receiving combined payment information. For questions regarding this system change, call Tufts Health Public Plans Provider Services (RI) at 844.301.4093.
- Tufts Health Plan is currently in the process of reviewing the upcoming 2021 E/M Coding and Documentation Policies. Tufts Health Plan is expecting to follow the AMA guidelines. Tufts Health Plan will have more information in the upcoming months.
- Tufts Health Public Plans - Submission of Provider Payment Disputes can be done by email during the COVID-19 pandemic. Providers may email disputes and corrected claim requests for Tufts Health Public Plans with a completed Request for Claim Review Form. This form can be found in the Forms section of the Provider Resource Center. In addition to a completed form for each claim, all supporting documentation must be included in the email. ▪ Submissions without the Request for Claim Review Form will be returned to the submitter. ▪ Email submissions to: THPP_Provider_Disputes@tufts-health.com
- Tufts Health Plan's Integration of MHK Medical Management System – Tufts Commercial, Tufts Medicare Preferred HMO, Tufts Health Direct and Tufts Health Together recently integrated the MHK medical management system into its secure Provider portal (including Behavioral Health Services). As part of this change, providers logged in to the secure Provider portal can use the MHK system to • Complete requests for inpatient and outpatient services • Attach documentation • Check authorization requests • Receive a reference number online • In some cases, providers may receive an approval at the time of entry. The status of the request is available in real time. MHK Provider Portal User Guide is available in the Resource Center on Tufts Health Plan's public Provider website.
- New Secure Provider Portal for Tufts Health RITogether - Effective January 2021. Tufts Health Provider Connect, the secure Provider portal used for Tufts Health RITogether, will be replaced by the secure Provider portal currently utilized by all other Tufts Health Plan lines of business. ▪ The secure Provider portal allows providers and office staff to access claim information, submit and view referrals, view and make updates to member care plans, and more. ▪ Any Tufts Health RITogether provider that is not currently registered for the secure Provider portal will need to register. ▪ Step-by-step instructions on how to register will be available on Tufts Health Plan's public Provider website. ▪ Providers who are already registered do not need to take any additional action. ▪ Tufts Health Provider Connect claims data, for Tufts Health RITogether members for dates of service on or after April 26, 2019, will be available on the secure Provider portal. For more information, refer to the FAQs on Tufts Health Plan's public Provider website.
- Secure Provider Portal Registration at Tuftshealthplan.com. Click on Registration Instructions for the secure Provider portal. Click on Get Started.

- Guides and Resources for Providers can be found at tuftshealthplan.com/provider/training/guides-andresources.
- Webinars – Interactive Training can be found at tuftshealthplan.com/provider/training/webinars
- Provider Update - One Newsletter for all products. Register to receive Provider Update by email. The online registration form can be found on the Provider News section of the website, Tuftshealthplan.com. Click "Register Now" to complete and submit the form.
- CPT 99072 (additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a PHE as defined by law, due to respiratory-transmitted infectious disease) is considered a non-covered service.

***US Family Health Plan*** Stephanie Tooley Stephanie.Tooley@USFamilyHealth.org

- Payer ID – 04298.
- Submit USFHP claims and referrals through Tufts portal or via paper (USFHP referral forms) • Specific member information and questions if a Prior Authorization is required call: 1.800.818.8589.
- Credentialing - Providers must be credentialed with Tufts Health Plan – commercial product before they can become a provider with USFHP • Providers must be affiliated with an in-network USFHP hospital • PCPs have a unique USFHP ID.
- Provider Updates - ALL PCP updates need to be communicated to USFHP directly.
- Log onto www.usfamilyhealth.org to check if provider information is correct.
- Telemedicine Billing - US Family Health Plan / TRICARE is not subject to state mandates. As of May 12, 2020, through the expiration of the President's national emergency for the COVID-19 outbreak. USFHP is accepting GQ, GT, and 95 Modifiers. Telephone only office visits will be covered represented by – CPT 99441-99443; 98966-98968; HCPCS G2012. Routine physicals are not covered for telehealth. US Family Health Plan is temporarily waiving any cost sharing and copayments for all covered in-network telehealth services.
- USFHP updates are located on the website's home page along with the provider manual at www.usfamilyhealth.org.
- USFHP also has a e-newsletter called Heart to Heart. If interest please send an email to stephanie.tooley@usfamilyhealth.org.

***2021 Evaluation and Management Changes*** ***Mike Enos, CPC-I, CPMA, CEMC***

- Background on E&M Coding
  Evaluation and Management are the most widely used ranges of CPT codes, as they are used by providers across all specialties. Services describe evaluation of the patient's condition and management options selected. Codes in this section are categorized by the type of encounter, the patient's status, the place of service and in some cases the patient's age.
  Some E/M categories are divided into 3 levels of service, some are divided into 5 levels of service. Examples include 99231, 99232, 99233,
  99211, 99212, 99213, 99214, 99215.

The higher the level of service, the higher the levels of RVUs (relative value units) are assigned. The documentation must show the extra time and effort to support the higher level of service. Documentation Guidelines were developed by the AMA and CMS. Providers can choose to use coding guidelines created in 1995 or 1997 when coding their visits.

  - 1995 Guidelines ¬ Problem-oriented history of present illness ¬ Review of Systems ¬ PFSH ¬ Multi-system exam ¬ Medical Decision-Making Complexity
  - 1997 Guidelines ¬ Interval history of chronic illness(es) ¬ Review of Systems ¬ PFSH ¬ Detailed single or multiple system exam ¬ Medical Decision-Making Complexity
  - 1995 vs. 1997 Guidelines – Main difference between the two is the exam component

- E&M Coding changes go into effect Jan 1, 2021.
- CPT code 99201 will be deleted but there are some situations in which you may still need to report 99201, such as those entities that will not immediately adopt the 2021 CPT code changes, including workers compensation payers or other HIPAA exempt payers such as auto insurance.
- The approved revisions to 99202 – 99215 require that a medically appropriate history and examination be performed. The history and exam do not impact coding. Instead, the E/M service level is chosen by the level of medical decision making OR by the total time spent by the rendering provider before, during and after the appointment on the day of the encounter.
  - Medical Decision-Making Revisions include - Number/Complexity of Problems Addressed Amount/Complexity of Data to be reviewed and Analyzed Risk of Complications and/or Morbidity or Mortality of Patient Management
- Time alone may be used to select the appropriate code level for the E/M codes except for 99211.
- Time may be used to select a code level for the E/M codes whether or not counseling and/or coordination of care dominates the service.
- For coding purposes, time is calculated based upon the total time spent by the rendering provider on the date of the encounter. It includes both the face-to-face and non-face-to-face time spent by the provider on the day of the encounter. This includes time in activities that require the physician and does not include time in activities normally performed by clinical staff.
- New Prolonged Services Codes 99XXX– This is a new code that will be created and available as of 1/1/2021.
  Prolonged office or other outpatient evaluation and management service (beyond the total time of the primary procedure which has been selected using total time) requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes
- The New Prolonged Service code would only be reported with new and established patient office visit codes when the code selection is based on time spent. This means it is only applicable to codes 99205 and 99215. Additional units may be added as needed.

- Services Reported Separately –
  Any specifically identifiable procedure or service performed on the date of E/M services may be reported separately. The actual performance or interpretation of diagnostic tests during a patient encounter are not included in determining the levels of E/M services when reported separately. If a test or study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, then it should be considered to be part of the visit's medical decision making.