SHARP Health Plan Sharp Health Plan Policy & Procedure

Number: HS_CP_T2 -MA **Title:** Medicare Telehealth Services **Division(s):** Health Services, Operations and Finance **Department(s):** Health Services, Legislative and Regulatory Affairs, Contracting, and Data/IS **Owner (Title):** Chief Medical Officer	**Product Line** (check all that apply)**:** ☐ All ☐ Group HMO ☐ Individual HMO ☐ PPO ☐ POS ☒ Medicare ☐ N/A
Relevant Regulatory/Accrediting Agencies/Citations (specify): ☒ CMS: ☐ DMHC: Health and Safety Code Section 1374.13 and 1374.141 ☐ NCQA-HP: ☐ NCQA-WHP: ☐ OTHER:	
Approved by: (Signature of VP /CMO) 	**Approval date:** **9/27/2023**

I. BENEFIT STATEMENT:

Any service reviewed and approved by this Sharp Health Plan Clinical Policy must be a covered benefit according to the member's evidence of coverage (EOC). Since benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in this clinical policy, decisions are subject to all terms and conditions of the applicable benefit plan. Benefit determinations should be based in all cases on the member's contract benefits in effect at the time of service.

All reviewers must first identify member eligibility and all decisions of this clinical policy are subject to current state and/or federal law. Clinical policy does not constitute plan authorization, nor is it an explanation of benefits. In the event of a conflict, a member's benefit plan, EOC, always supersedes the information in the Clinical Policies.

II. PURPOSE:

This Policy and Procedure establishes Sharp Health Plan's (Plan) guidelines for Medicare Telehealth services.

III. REGULATORY:

A. **Consolidated Appropriations Act 2023** y". SEC. 4113. ADVANCING TELEHEALTH BEYOND COVID–19.

IV. (a) REMOVING GEOGRAPHIC REQUIREMENTS AND EXPANDING ORIGINATING SITES FOR TELEHEALTH SERVICES.—Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended— (1) in paragraph (2)(B)(iii)— (A) by striking "With" and inserting "In the case that the emergency period described in section

1135(g)(1)(B) ends before December 31, 2024, with"; and (B) by striking "that are furnished during the 151-day period beginning on the first day after the end of the emergency period described in section 1135(g)(1)(B)" and inserting "that are furnished during the period beginning on the first day after the end of such emergency period and ending December 31, 2024"; and (2) in paragraph (4)(C)(iii)— (A) by striking "With" and inserting "In the case that the emergency period described in section 1135(g)(1)(B) ends before December 31, 2024, with"; and (B) by striking "that are furnished during the 151- day period beginning on the first day after the end of the emergency period described in section 1135(g)(1)(B)" and inserting "that are furnished during the period beginning on the first day after the end of such emergency period and ending on December 31, 2024". (b) EXPANDING PRACTITIONERS ELIGIBLE TO FURNISH TELE- HEALTH SERVICES.— Section 1834(m)(4)(E) of the Social Security Act (42 U.S.C. 1395m(m)(4)(E)) is amended by striking "and, for the 151-day period beginning on the first day after the end of the emergency period described in section 1135(g)(1)(B)" and inserting "and, in the case that the emergency period described in section 1135(g)(1)(B) ends before December 31, 2024, for the period beginning on the first day after the end of such emergency period and ending on December 31, 2024". (c) EXTENDING TELEHEALTH SERVICES FOR FEDERALLY QUALI-FIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—Section 1834(m)(8)(A) of the Social Security Act (42 U.S.C. 1395m(m)(8)(A)) is amended by striking "during the 151-day period beginning on the first day after the end of such emergency period" and inserting "in the case that such emergency period ends before December 31, 2024, during the period beginning on the first day after the end of such emergency period and ending on December 31, 2024". (d) DELAYING THE IN-PERSON REQUIREMENTS UNDER MEDICARE FOR MENTAL HEALTH SERVICES FURNISHED THROUGH TELEHEALTH AND TELECOMMUNICATIONS TECHNOLOGY.— (1) DELAY IN REQUIREMENTS FOR MENTAL HEALTH SERVICES FURNISHED THROUGH TELEHEALTH.—Section 1834(m)(7)(B)(i) of H. R. 2617—1441 the Social Security Act (42 U.S.C. 1395m(m)(7)(B)(i)) is amended, in the matter preceding subclause (I), by striking "on or after the day that is the 152nd day after the end of the period at the end of the emergency sentence described in section 1135(g)(1)(B))" and inserting "on or after January 1, 2025 (or, if later, the first day after the end of the emergency period described in section 1135(g)(1)(B))". (2) MENTAL HEALTH VISITS FURNISHED BY RURAL HEALTH CLINICS.—Section 1834(y) of the Social Security Act (42 U.S.C. 1395m(y)) is amended— (A) in the heading, by striking "TO HOSPICE PATIENTS"; and (B) in paragraph (2), by striking "prior to the day that is the 152nd day after the end of the emergency period described in section 1135(g)(1)(B))" and inserting "prior to January 1, 2025 (or, if later, the first day after the end of the emergency period described in section 1135(g)(1)(B))". (3) MENTAL HEALTH VISITS FURNISHED BY FEDERALLY QUALIFIED HEALTH CENTERS.— Section 1834(o)(4) of the Social Security Act (42 U.S.C. 1395m(o)(4) is amended— (A) in the heading, by striking "TO HOSPICE PATIENTS"; and (B) in subparagraph (B), by striking "prior to the day that is the 152nd day after the end of the emergency period described in section 1135(g)(1)(B))" and inserting "prior to January 1, 2025 (or, if later, the first day after the end of the emergency period described in section 1135(g)(1)(B))". (e) ALLOWING FOR THE FURNISHING OF AUDIO-ONLY TELEHEALTH SERVICES.—Section 1834(m)(9) of the Social Security Act (42 U.S.C. 1395m(m)(9)) is amended by striking "The Secretary shall continue to provide coverage and payment under this part for telehealth services identified in paragraph (4)(F)(i) as of the date of the enactment of this paragraph that are furnished via an audio-only telecommunications system during the 151-day period beginning on the first day after the end of the emergency period described in section 1135(g)(1)(B)" and inserting "In the case that the emergency period described in section 1135(g)(1)(B) ends

before December 31, 2024, the Secretary shall continue to provide coverage and payment under this part for telehealth services identified in paragraph (4)(F)(i) as of the date of the enactment of this paragraph that are furnished via an audio-only communications system during the period beginning on the first day after the end of such emergency period and ending on December 31, 2024". (f) USE OF TELEHEALTH TO CONDUCT FACE-TO-FACE ENCOUNTER PRIOR TO RECERTIFICATION OF ELIGIBILITY FOR HOSPICE CARE DURING EMERGENCY PERIOD.—Section 1814(a)(7)(D)(i)(II) of the Social Security Act (42 U.S.C. 1395f(a)(7)(D)(i)(II)) is amended by striking "and during the 151-day period beginning on the first day after the end of such emergency period" and inserting "and, in the case that such emergency period ends before December 31, 2024, during the period beginning on the first day after the end of such emergency period described in such section 1135(g)(1)(B) and ending on December 31, 2024". (g) STUDY ON TELEHEALTH AND MEDICARE PROGRAM INTEG- RITY.— H. R. 2617—1442 (1) IN GENERAL.— (A) STUDY.—The Secretary shall conduct a study using medical record review, as described in subparagraph (C), on program integrity related to telehealth services under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.). (B) SCOPE OF STUDY.—In conducting the study under subparagraph (A), the Secretary shall review and analyze information (to the extent that such information is available) on the duration of telehealth services furnished, the types of telehealth services furnished, and, to the extent feasible, the impact of the telehealth services furnished on future utilization of health care services by Medicare beneficiaries, such as the utilization of additional telehealth services or in-person services, including hospitalizations and emergency department visits. The Secretary may also review and analyze information on— (i) any geographic differences in utilization of telehealth services; (ii) documentation of the care and methods of delivery associated with telehealth services; and (iii) other areas, as determined appropriate by the Secretary. (C) MEDICAL RECORD REVIEW.—In conducting the study under subparagraph (A), the Secretary shall conduct medical record review of a sample of claims for telehealth services with dates of service during the period beginning on January 1, 2022, and ending on December 31, 2024. For such claims with a date of service during the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), the Secretary shall only conduct medical record review of those claims that have undergone standard program integrity review (as defined in paragraph (2)(B)), as determined appropriate by the Secretary. (D) REPORTS.— (i) INTERIM REPORT.—Not later than October 1, 2024, the Secretary shall submit to the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives an interim report on the study conducted under subparagraph (A). (ii) FINAL REPORT.—Not later than April 1, 2026, the Secretary shall submit to the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a final report on the study conducted under subparagraph (A). (2) DEFINITIONS.—In this subsection: (A) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services. (B) STANDARD PROGRAM INTEGRITY REVIEW.—The term "standard program integrity review" refers to the review of any claim that requires a review of the associated medical record by the Secretary to determine the medical necessity of the services furnished or to identify potential fraud. H. R. 2617—1443 (C) TELEHEALTH SERVICE.—The term "telehealth service" has the meaning given that term in section 1834(m)(4)(F) of the Social Security Act (42 U.S.C. 1395(m)(4)(F)). (3) FUNDING.—In addition to amounts otherwise available, there is appropriated to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2023, out of any amounts in the Treasury not otherwise

appropriated, $10,000,000, to remain available until expended, for purposes of carrying out this subsection.
(h) PROGRAM INSTRUCTION AUTHORITY.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of, including amendment.

V. DEFINITIONS :

A. Chief Medical Officer (CMO): The Plan's executive responsible for overseeing health services, quality, and other applicable functions.

B. Covered Benefits: Those medically necessary services and supplies that Members are entitled to receive under an agreement and which are described in the Member Handbook.

C. Healthcare Effectiveness Data and Information Set (HEDIS): A widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance.

D. Health Care Provider: Any of the following:

1. A person who is licensed under Section 2290.5 of the Business and Professions Code.

2. An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3.

3. A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 1374.73 of the Health and Safety Code and Section 10144.51 of the Insurance Code.

E. Member: An individual who has enrolled in the Plan and for whom applicable Premiums have been paid.

F. Member Handbook: Sharp Health Plan's Combined Evidence of Coverage and Disclosure Form.

G. Plan Medical Group (PMG): Plan Medical Group. A group of physicians, organized as or contracted through a legal entity, which has met the Plan's criteria for participation in the Plan's Provider network and has entered into an agreement with the Plan to provide Professional Services.

H. Promotion or Coordination of Service: Advertising of a Third-party Corporate Telehealth Provider service or communications that recommends a Member receive care from a Third-party Corporate Telehealth Provider.

I. Provider: Contracted providers including physicians, individually contracted telehealth providers, Third-party Corporate Telehealth Providers, and Plan Medical Groups (PMGs).

J. Protected Health Information: Individually identifiable health information that is transmitted or maintained by electronic media, or any other form or medium.

K. Telehealth: The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

L. Third-party Corporate Telehealth Provider: A corporation directly contracted with the Plan that provides health care services exclusively through a telehealth technology platform and has no physical location at which a patient can receive services.

VI. POLICY: It is the policy of Sharp Health Plan (Plan) to ensure that Telehealth services are offered to Sharp Health Plan Members in a manner consistent with appropriate clinical practice and applicable state and federal laws. Telehealth services are covered by Sharp Health Plan as a means of improving the quality, access, equity, and efficiency of Covered Benefits.

A. Telehealth services may be offered for any Covered Benefit where clinically appropriate.

B. Telehealth services are provided to Sharp Health Plan Members by contracted Providers such as physicians, individually contracted telehealth providers, Third-party Corporate Telehealth Providers, and Plan Medical Groups (PMGs).

- Providers are not required to offer Telehealth services but must notify the Plan in advance if the Provider proposes to offer Telehealth services. (Does not apply to Third-party Corporate Telehealth Providers).

C. Temporary Medicare Changes-Post Public Health Emergency (PHE) Expiring 12/31/2024

- Beneficiaries can receive telehealth services authorized in the CY 2023 in their home (expanded list of 240+ service codes covered under Medicare FFS (Can be provided by all eligible Medicare providers).
- No geographic restrictions for originating site for non-Behavior Health /Mental Health (BH/MH) telehealth services.
- Telehealth services can be provided by a Physical therapist (PT), Occupational therapist (OT), speech language pathologist (SLP) or audiologist.
- Federal Qualified Health Centers (FQHC)/ Rural Health Clinics (RHC) can serve as a distant site provider for non BH/MH telehealth services.
- An in-person visit within 6 months of an initial BH/MH telehealth service, and annually thereafter, is not required.

D. Permanent Medicare Telehealth Post PHE

- Beneficiaries can receive telehealth services for BH/MH in their home with no geographic restrictions for originating site.
- FQHCs/RHCs can serve as distant site provider for BH/MH telehealth services.
- BH/MH telehealth services can be delivered using audio-only communications platforms.
- Rural hospital emergency (REH) department are accepted as an originating site.
- Telehealth services may be used for monthly end-stage renal disease-related visits for home dialysis members in a hospital based or critical access hospital based renal dialysis center, renal dialysis facility or the member's home.
- Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location.
- Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if:
  You are not a new patient and
  The check in isn't related to an office visit in the past 7 days and
  The check in doesn't lead to an office visit within 24 hours or the soonest available appointment.
- Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
  You have an in-person visit within 6 months prior to your first telehealth visit

You have an in-person visit every 12 months while receiving telehealth services
Exceptions can be made to the above for certain circumstances.

- Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location.

E. The Provider is responsible for ensuring the following Plan's requirements for Telehealth services are met. The Provider or their office, as appropriate, is responsible for notifying Members when telehealth services are available and responsible for explaining the process to be used to schedule a telehealth visit. (Does not apply to third party corporate Telehealth providers.)

1. Telehealth services are utilized for clinically appropriate conditions, symptoms, and services, as determined by the Provider.
2. Telehealth services are voluntary for members, i.e., Members have the option of scheduling an in-person visit or a Telehealth visit for any condition, symptom or service that is a Covered Benefit, as determined clinically appropriate by the Provider.
3. Members are notified at the time of scheduling about any cost- sharing associated with a Telehealth visit.
4. Telehealth services are available to all Members, regardless of Member status or where the Member lives.
5. Coverage is not extended for devices that may be provided to members to assist in interactive communication, including, but not limited to, robotic devices, laptop computers, desktop computers, personal assistive devices, tablets, and smartphones.
6. Telehealth services are rendered in a secure manner to ensure the privacy of Protected Health Information.
7. Telehealth services are tracked in the appointment scheduling system and documented in the Member's medical record. (Does not apply to Third party corporate Telehealth providers.)
8. Telehealth services are billed as a claim or submitted to the Plan as encounter data using industry accepted procedure codes (CPT), place of service (POS), modifiers and billing practices. Plan. For commercial telehealth, the DMHC APL for the Public Health Emergency states that any service that can be performed via telehealth is covered and can be billed with the appropriate POS and required modifier. Only providers outlined in the CS modifier guideline below can bill using the modifier CS.
    a) Place of Service Code = 02, 10
    b) Modifiers:
        i) 93 - Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System (effective 1/1/22)
        ii) 95 – Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
        iii) CS - Cost Sharing Waiver
    c) Modifier CS guideline: Cost-sharing waived for specified COVID-19 testing-related services that result in an order for, or administration of, a COVID-19 test and/or used for cost-sharing waived preventive services furnished via telehealth in Rural Health

Clinics and Federally Qualified Health Centers during the COVID-19 public health emergency.

9. Telehealth services may supplement but may not replace in-person visits required by industry standards (e.g., HEDIS).
10. Provider is responsible for notifying Plan of any Member grievances related to Telehealth services, in accordance with the agreement between the Plan and Provider.

F. The Member's cost-share for Telehealth services shall not exceed the applicable office visit copayment/coinsurance (primary care or specialist). Deductibles may also apply, depending upon the plan design. Sharp Health Plan is responsible for determining the Telehealth cost-share for each applicable benefit plan.

G. Neither Plan nor Provider shall require that in-person contact occur between a health care provider and a Member before payment is made for the covered services appropriately provided through Telehealth, subject to the terms and conditions of the contract entered into between the Member and the Plan, between the Plan and its providers.

H. Neither the Plan nor the Provider shall limit the type of setting where services are provided for the Member or by the Health Care Provider before payment is made for the covered services appropriately provided through Telehealth, subject to the terms and conditions of the contract entered into between the Member and the Plan, between the Plan and its Providers.

I. All contracts with Providers will specify that the Plan will reimburse covered telehealth services on the same basis and to the same extent the Plan reimburses the same covered services delivered in-person.

J. The Third-Party Corporate Telehealth Provider (if delegated) is responsible for ensuring the following requirements for Telehealth services are met .

1. Third-party Corporate Telehealth Providers will ensure the Member consents to the service via telehealth consistent with Section 2290.5 of the Business and Professions Code.
2. If Member is currently receiving specialty telehealth services for a mental or behavioral health condition, the Member will be given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility.
3. The Third-party Corporate Telehealth Provider will notify Member of their right to access their medical records.
4. The Third-party Corporate Telehealth Provider will notify the Member that their medical records shall be shared with their primary care provider unless the Member objects.
5. The Third-party Corporate Telehealth Provider will ensure that the records are entered into a patient record system shared with the Member's primary care provider or are otherwise provided to the Member's primary care provider unless the Member objects .
6. The Third-party Corporate Telehealth Provider will notify the Member that all services received through the Third-party Corporate Telehealth Provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.
7. The Third-party Corporate Telehealth Provider will provide to the Plan the reporting data specified in Health and Safety Code Section 1374.141(d).
8. The Third-party Corporate Telehealth Provider will comply with the requirements under, Health and Safety Code Section 1374.141.

9. The Third-party Corporate Telehealth Provider will provide to a person licensed or certified in the healing arts, including physicians, nurses, osteopathic physician, chiropractors, emergency medical personnel, or a clinic, health dispensary, or health facility, information regarding how to find data breaches reported pursuant to Section 1798.82 on the internet website of the Attorney General.

K. The Plan is responsible for ensuring the following requirements for Telehealth services are met:

1. In any promotion or coordination of a telehealth health care service through a Third-party Corporate Telehealth Provider, the Plan will disclose the availability of receiving the service on an in-person basis or via telehealth, if available, from the Member's primary care provider, treating specialist, or from another contracting individual health professional, contracting clinic, or contracting health facility.
2. The Plan will also disclose the cost-sharing obligation for out-of-network benefits compared to in-network benefits and balance billing protections for services received from contracted Providers.
3. The Plan covers all Telehealth services offered through Plan Medical Groups (PMGs). Cost sharing equal to in-person visit.)
4. The Plan Provider Directory will notate providers who offer services exclusively via telehealth, and also include/identify the providers linguistic capabilities. All of the overall telehealth regulatory requirements are streamlined whether the provider offers telehealth and in person services, or just telehealth only. The key is that if telehealth is the only service that a member would know what languages they speak

VII. PROCEDURE:

A. When a delegated PMG has developed a Telehealth program that meets the requirements outlined in the Policy above, the PMG's designated representative notifies the Chief Medical Officer (or delegate) and Plan Contracting Manager (or delegate).

1. The CMO or delegate reviews the PMG policies, procedures, guidelines and/or program descriptions to determine if the requirements listed in the Policy above have been addressed.

   a) If the requirements are sufficiently addressed, the CMO notifies the Contracting Manager.

   b) If the requirements are not sufficiently addressed, the CMO notifies the PMG representative of the gaps in documentation and provides the PMG with an opportunity to submit revised documents.

2. Once the PMG policies and procedures are approved by the CMO, the Plan Contracting Manager (or delegate) works with the PMG representative to amend the PMG agreement as appropriate.

B. The assigned Systems Analyst loads the Telehealth cost-sharing information in the Prime Butterfly, as approved by the Benefits Committee for each applicable benefit plan.

C. The assigned representative of the Benefits Committee updates all applicable Benefit Plan Documents with the Telehealth cost-sharing information approved by the Benefits

Committee.

D. The Manager of Legislative and Regulatory Affairs or delegate updates the content of the Member Handbook to provide information about Telehealth services, as approved by the Department of Managed Health Care.

E. The Plan Appeals & Grievance Coordinator handles any complaints about Telehealth visits through the appropriate Member Appeals or Grievance process.

F. At the discretion of the CMO, the designated Health Services representative conducts an audit of Telehealth services conducted by the PMG to ensure that the requirements outlined in the Policy above are being met.

VIII. PROCESS / ATTACHMENTS:

A. Requests for the Telehealth services are to be reviewed by the delegated Plan Medical Group (PMG) or by the Plan through their regular and appropriate utilization management process and administered consistent with Plan benefit.

B. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this guideline. This Policy provides assistance in determining coverage under the member's benefit plan.

C. All requests for Telehealth Services will be reviewed by the delegated PMG or the Plan according to its regular and appropriate utilization management process and administered consistent with the Plan benefit. The terms of a member's benefit plan summary defined in the evidence of coverage document may differ from the standard benefit plans upon which this guideline is based. In the event of a conflict, the member's specific benefit document supersedes these guidelines.

D. The terms of a member's benefit plan summary defined in the evidence of coverage document may differ from the standard benefit plans upon which this guideline is based. In the event of a conflict, the member's specific benefit document supersedes these guidelines.

IX. REFERENCES:

A. Consolidated Appropriations Act 2023

B. Telehealth.HHS.gov

C. Code of Federal Regulations:42 CFR § 414.65

D. Medicare Managed 'Care Manual Chapter 4 Telemonitoring Services

E. Public Health Institute/ Center for Connected Health Policy: Billing for Telehealth encounters- an Introductory Guide on Medicare Fee for Service, July 2023

X. REVISION HISTORY:

Date	Modification (Reviewed and/or Revised)
9/27/23	Original