SPECIAL eBULLETIN

FOR PROFESSIONAL PROVIDERS **July 1, 2021**

DELIVERING TELEHEALTH SERVICES TO HIGHMARK MEMBERS AFTER JUNE 30, 2021

While Highmark has offered telehealth services for many years, the pandemic has provided an opportunity for many of its members to try telehealth for the first time. By the end of 2020, Highmark saw an increase in utilization of telehealth services by more than 3,400 percent over 2019 and more than 3.4 million telehealth services were accessed by our members.

While some patients are returning to in-office care, the benefits of providing both members and providers with the efficiency and safety of telehealth are here to stay.

LOOKING TO THE FUTURE

Between March 13, 2020 – June 30, 2021, Highmark issued an expanded list of reimbursable telemedicine codes. **Beginning July 1, 2021, Highmark will discontinue the use of that list**.

However, that does not mean that providers will no longer be reimbursed for virtual visits.

Highmark had previously allowed the delivery of virtual visits by practitioners years before the public health emergency. Please see Highmark's Provider Manual, Chapter 2, Unit 5 for more information regarding the services that may be provided through this modality and other guidelines.

Please note that telehealth at Highmark includes:

1) Virtual Visits: Services provided by Highmark in-network providers within the scope of their license, deemed appropriate using their medical judgment, and delivered within the definition of the code billed.

2) Telemedicine: Services provided by Highmark-approved telemedicine vendors – (Amwell)™, Doctor On Demand™, and Teladoc™; as well as our partner Bright Heart Health. **In-network providers do not need to utilize these vendor services to provide telehealth services to Highmark members. These vendors are a separate option and benefit to certain members.**

HIGHMARK

REIMBURSEMENT

If a specific service is 1) eligible for separate reimbursement and 2) part of the member's benefit, reimbursement for virtual visits will continue at parity with face-to-face services if the service or procedure can be fully, safely, and effectively delivered through a virtual option and is not specifically disallowed by a Highmark medical or reimbursement policy.

The use of place of service 02 (telehealth) for 1500 claims when billing for virtual health services is still required along with the appropriate use of modifier 95 on the applicable claim lines.

PHE WAIVERS OF CERTAIN RESTRICTIONS

There are still some restrictions in which the U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) and the Office of Civil Rights (OCR) are enforcing discretion through the end of the PHE. They are as follows:

- **Alternate communication channels**, such as Skype or FaceTime, may be permissible for telehealth treatment or diagnosis purposes during the PHE.
- **Virtual visits** may be allowed by phone or audio only if the service can be reasonably delivered in that way. Visit documentation for audio-only services should follow the same level of documentation as similar E&M visit complexity.
- For Medicare Advantage, **annual wellness visits** may be delivered through a virtual visit and may be used to identify care gaps that lead to gap closures or other STAR benefits and Submit diagnoses to close risk adjustment gaps. The ability to impact STAR or risk adjustments measures through virtual visits is dependent on the type of gap and data able to be collected through this modality. See "Providing the Annual Wellness Visit Through Virtual Visits During Covid-19" for more information.

Please see more information about the above topics on **Highmark's Provider Resource Center > Covid-19 > Telemedicine and Virtual Visits**.

MEMBER COVERAGE

The waiver of Highmark member cost-sharing for in-network telehealth visits is effective for dates of service from March 13 through June 30, 2021. **Beginning July 1, 2021, regular member cost-sharing for telehealth visits will begin again.**