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GARY D. ANDERSON
COMMISSIONER OF INSURANCE

BULLETIN 2021-04

To: Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc.,
and Health Maintenance Organizations

From: Gary D. Anderson, Commissioner of Insurance 

Date: April 9, 2021

Re: Managed Care Practices and Continued Access to Telehealth Services

The Division of Insurance (“Division”) issues this Bulletin to supplement and in some instances supersede the provisions of Bulletin 2020-04 (“*Emergency Measures to Address and Stop the Spread of COVID-19 (Coronavirus)*”), and to provide information to Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations (“Carriers”) regarding the implementation of Chapter 260 of the Acts of 2020, “An Act Promoting a Resilient Health Care System that Puts Patients First” (“Chapter 260”). Among the features of Chapter 260, Sections 47, 49, 51, 53, and 54 created: M.G.L. c. 175, §47MM; M.G.L. c. 176A, §38; M.G.L. c. 176B, §25; M.G.L. c. 176G, §33; and M.G.L. c. 176I, §13, which require coverage for telehealth services within insured health plans issued or renewed in Massachusetts. This Bulletin outlines the Division’s expectations regarding steps Carriers are expected to take as they implement certain managed care features outlined in those laws.

Governor’s COVID-19 Order #4

On March 15, 2020, Governor Baker issued an “Order Expanding Access to Telehealth Services and to Protect Health Care Providers” (“Emergency Order”) that became effective as of March 16, 2020. The Emergency Order and the Division’s Bulletin 2020-04 established standards for the expansion of the use of telehealth by in-network providers to treat medically necessary health conditions for all covered health services to reduce the need for in-person treatment and stop the spread of COVID-19.

On January 21, 2021, Governor Baker rescinded the Emergency Order. However, with the passage of Chapter 260, Massachusetts has established new statutory provisions that also require insured health plans issued or renewed in the Commonwealth to provide access to clinically appropriate, medically necessary telehealth services through in-network providers, including a requirement for

telehealth reimbursement parity until at least 90 days¹ after the termination of the state of emergency declared by Governor Baker on March 10, 2020, which remains in effect until further notice. To ensure a smooth transition to Chapter 260, Carriers are required to remain in compliance with this Bulletin relative to the statutory standards for telehealth enacted with Chapter 260. The Division plans to issue future regulatory guidance that will further specify standards for access to telehealth services within insured managed care plans in Massachusetts.

Appropriate Guidelines to Deliver Medically Necessary Health Services via Telehealth

In Bulletin 2020-04, the Division noted that Carriers may establish reasonable requirements for telehealth services, but they are not permitted to impose any specific requirements on the technologies used to deliver telehealth services (including any limitations on audio-only or live video technologies). With the passage of Chapter 260, the Division expects Carriers to continue to provide access to services in a comparable manner until the Division provides guidance to identify acceptable telehealth standards.

Until the Division provides further guidance regarding acceptable provisions for telehealth services, when delivering services via telehealth, providers must comply with all applicable state and federal statutes and regulations governing medication management and prescribing services. If providers are delivering prescribing services via telehealth, they must: (1) maintain policies for providing patients with timely and accurate prescriptions by use of mail, phone, e-prescribing, and/or fax; and (2) document prescriptions in the patient's medical record consistent with in-person care.

The Division also noted in Bulletin 2020-04 that each Carrier should instruct its in-network providers to follow the following standards when delivering medically necessary care via telehealth:

- For an initial appointment with a new patient, the provider must review the patient's relevant medical history and any relevant medical records with the patient before initiating the delivery of any service;
- For existing provider-patient relationships, the provider must review the patient's medical history and any available medical records with the patient during the service;
- Prior to each patient appointment, the provider must ensure that the provider is able to deliver the services to the same standard as in-person care and in compliance with the provider's licensure regulations and requirements, programmatic regulations, and performance specifications related to the service (e.g., accessibility and communication access);
- If the provider cannot meet appropriate standard of care or other requirements for providing requested care via telehealth, then the provider must make this determination prior to the delivery of treatment, notify the patient of this, and advise the patient to instead seek appropriate in-person care;
- To the extent feasible, providers must ensure patients the same rights to confidentiality and security as provided in face-to-face services, and providers must inform patients of any relevant privacy considerations prior to providing services via telehealth;

¹ Primary care services and chronic care services, whether provided in-person or via telehealth, are to be reimbursed at the same level for two years following the passage of Chapter 260. Behavioral health services, whether provided in-person or via telehealth, are required to be reimbursed at the same level in perpetuity.

- Providers must follow consent and patient information protocols consistent with the protocols followed during in-person visits;
- Providers must inform patients of the location of the provider rendering services via telehealth (i.e., distant site) and obtain the location of the patient (i.e., originating site);
- Providers must inform the patient how to see a clinician in-person in the event of an emergency or otherwise.

These provisions will continue to apply until the Division issues further guidance.

In Bulletin 2020-04, it was also noted that Carriers were not to impose any prior authorization barriers to obtaining medically necessary health services via telehealth that would not apply to receipt of those same services on an in-person basis. Within Chapter 260, it is noted instead that a Carrier “may undertake utilization review, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service; provided, however, that the determination shall be made in the same manner as if the service was delivered in person.” In order to manage the implementation of any rules that Carriers may apply “to determine the appropriateness of telehealth as a means of delivering a health care service,” the Division expects that Carriers will not implement any such changes for telehealth prior to providing the Division with an implementation plan as described below. The Division requests Carriers to submit the following information by May 17, 2021 for the Division’s review regarding Carriers’ plans for changes to policies currently in place:

- Proposed plans for Carriers to provide information to members about accessing telehealth services through in-network primary care providers, specialty care providers, behavioral health providers, and those providers who treat chronic conditions; and
- Proposed plans for Carriers to develop telehealth utilization review guidelines, to define coding for reimbursement, and to hold informational meetings to educate contracting providers about telehealth implementation, including any utilization review procedures relevant to telehealth services that are developed in accordance with M.G.L. c. 176O, §16(b).

Reimbursement for Health Service Provided via Telehealth

As noted in Bulletin 2020-04, Carriers are expected to provide clear communication materials to in-network providers to explain how to submit claims of reimbursement for services provided via telehealth. Carriers may require in-network providers to follow the same claim submission documentation guidelines to explain the patient history, chief complaint, and exams for office and outpatient visits. Carriers may continue to evaluate specific CPT code documentation and review that the documented reason for the visit medically supports the extent of the exam, the discussion time noted, and the complexity of the visit and assessment. Carriers may require providers to present claim documentation in order for the provider-patient encounter to qualify for reimbursement. Carriers may review to determine whether claims are billed at an appropriate E/M service code based on the level of service warranted.

Carriers must reimburse providers for services delivered via telehealth at least at the rate of reimbursement that is defined in Chapter 260. Where Carriers have specific agreements with a provider regarding reimbursement for services delivered via telehealth that are inconsistent with the reimbursement arrangements defined within Chapter 260 or other relevant regulations or guidance,

Carriers are to take steps necessary to reimburse providers at a rate that is no less than the reimbursement required in Chapter 260.

As noted in Bulletin 2020-04, for purposes of recording the number of health services that are being provided via telehealth, Carriers may request that providers include a specific telehealth code (place of service code or telehealth modifier) when providers submit claims for reimbursement.

If you have any questions about this Bulletin, please contact Kevin Beagan, Deputy Commissioner for the Health Care Access Bureau, at (617) 521-7323.