COVID-19 MEDICARE ADVANTAGE BILLING & AUTHORIZATION GUIDELINES

Contents

These guidelines apply to Medicare Advantage and Medicare-Medicaid members. Using these recommended billing guidelines and codes will facilitate proper payment and help avoid errors and reimbursement delays.

References made throughout this document in regards to referrals and cost-share are only applicable if required by the member's benefit plan.

Updated July 24, 2020- *Highlighted text indicates update*

Background Information

In December 2019, a new kind of coronavirus was identified as the cause of various cases of pneumonia in China. In February 2020, the World Health Organization designated the disease COVID-19. The virus that causes COVID-19 is designated severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

CMS has released several memorandums, provider toolkits and guidance around COVID-19, and the changes to the healthcare environment. The most recent Clinician letter was posted by CMS on 4/7/2020 which summarizes recent changes: https://www.cms.gov/files/document/covid-dear-clinician-letter.pdf.

(REVISED 7/24/2020) The current Public Health Emergency (PHE) period has been extended to end on **10/22/2020**.

To keep up to date with the important work CMS is doing in response to COVID-19, visit the https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page website.

Increasing Available Care

(REVISED 7/24/2020) We recognize these are times of high demand for quality healthcare. In order to support the healthcare needs of our members and help alleviate pressure to our existing network providers, we have implemented an accelerated initial credentialing process for providers performing critical COVID-19 related services. This process will help to ensure we are able to meet our members' needs by onboarding critically needed providers into the network quicker.

This accelerated initial credentialing process will be ***available until 10/31/2020***. It is requested that providers identify their application as COVID-19 related upon submission. Standard credentialing and onboarding requirements for plan participation apply.

CMS has also established a free hotline for providers to enroll and receive temporary Medicare billing privileges. Reference the CMS Medicare Provider Enrollment Hotline FAQ for details: https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

Referral Requirements

(REVISED 7/24/2020)

In-network Providers. Referral requirements (if required by member's benefit plan) are waived for ***in-network*** provider services ***until 10/22/2020***.

Utilization Management Guidelines

(REVISED 6/22/2020)

Authorization Requirements

We require authorization of certain services, medications, procedures, and/or equipment prior to performing or providing the service to prevent unnecessary utilization while safeguarding beneficiary access to the most appropriate medically necessary care.

Authorization ***requirements apply for services provided by in and out of network providers*** *according to plan rules as listed in the online provider manual (https://www.lmchealthplans.com/English/Documents/Provider_Manual.pdf).*

Exceptions: No authorizations are required for in or out of network providers for the following:

- SARS-CoV-2 testing
- Treatment services with a COVID-19 diagnosis

Locate the **2020 Plan Authorization Guidelines** here: https://www.lmchealthplans.com/English/Documents/Provider%20Prior%20Authorization%20List.pdf

Clinical Review/DME Requests and Routine Procedures

(REVISED 7/24/2020)

We have made the modifications below to the initial clinical reviews, DME and routine procedure requests. These modifications apply to both in and out of network providers:

- Initial Clinical Review: Initial clinical review is waived for the services listed below ***until 7/31/2020*.** Note that authorization requirements and admission notification still apply in order for us to concurrently review and provide discharge/transition of care planning support.
    - Home Health Requests
    - SNF Admissions
    - LTAC Admissions
    - Inpatient Rehab Admissions

- Elective Surgeries and Procedures (Outpatient and Inpatient): As more healthcare providers are increasingly being asked to assist with the COVID-19 response, we ask that you consider whether non-essential surgeries and procedures can be delayed so that personal protective equipment (PPE), beds, and ventilators can be preserved. In order to assist providers with this request, routine procedure requests will be extended to six (6) months to allow for rescheduling of needed tests. Eligibility should be confirmed prior to scheduling. Also note that medical necessity review is still required.

- DME. Documentation of face to face, physician order, and medical necessity is not required to obtain replacements of DME that is lost, destroyed, irreparably damaged or rendered unusable. All other authorization requirements for contracted providers apply unless specifically outlined in the Additional Authorization Guidelines Outside of PHE section below. ***The face to face waiver applies until 10/22/2020.***

1135 Waiver Information

(POSTED 4/24/2020)

Hospitals without Walls

On March 30th, CMS announced additional waivers and temporary rule changes in an effort to increase hospital capacity to manage patient surges due to COVID-19. Under these temporary rule changes, hospital systems are permitted to perform services outside their hospital buildings and transfer patients to other facilities (e.g. ambulatory surgical centers, inpatient rehabilitations hospitals, hotels and dormitories) while continuing to receive payment for hospital services from Medicare. This is otherwise known as known as "*Hospitals without Walls*".

Hospitals must continue to exercise the necessary control and responsibility over the use of hospital resources in treating patients regardless of whether the treatment occurs in a hospital setting or outside of a hospital setting.

To ensure proper coverage and reimbursement, a facility providing care outside of a normal hospital setting should bill for the level of care provided, rather than the setting. For example, if the level or care is intensive, regardless of the setting (tent, convention center, etc.) the services should be billed as if they occurred in an ICU under the contracted facility address, Tax ID and NPI.

Emergency Room and Transport

To allow greater flexibility in providing emergency services, the following rule changes are retroactive effective 3/1/2020 through the duration of the PHE.

Emergency Departments. EDs may test and screen patients for COVID-19 at drive through and other off-campus testing sites.

Ambulances. May transport patients to a wider range of locations when other transportation is not medically appropriate. Locations may include:

- Critical Access Hospitals
- Skilled Nursing Facilities
- Community Health Centers
- Federally Qualitied Health Centers
- Physician offices
- Urgent care centers
- Ambulatory surgical centers
- Dialysis Centers
- Patients home (beneficiary's home)

Coronavirus Aid, Relief, and Economic Security Act (CARES Act)

(POSTED 4/24/2020)

As the number of COVID-19 cases in the U.S. continues to grow, the CARES Act, passed on March 27, 2020, makes a number of changes to support the ability of the health care system to respond to the crisis over the coming months. In addition, health care provisions are principally designed to offer financial support and flexibilities to providers as they care for patients during the public health emergency.

Sequestration

(POSTED 4/24/2020)

Sequestration is the automatic reduction of certain federal spending as mandated by the federal budget control legislation. As a result of Sequestration, since April 1, 2013, CMS has been making a 2% payment adjustment (reduction) on Original Fee-for-Service (FFS) Medicare provider payments in addition to the premium amounts paid to Medicare Advantage Organizations like Leon Medical Centers Health Plans.

The CARES Act, temporarily suspends Sequestration on Medicare programs for the period beginning May, 1, 2020 and ending December 31, 2020.

Accordingly, we are modifying payment for services rendered to our Medicare and Medicare-Medicaid patients.

Contracted Providers

- Fee-for-Service. We will continue to follow the terms of our provider contracts. Therefore, for providers that are reimbursed as a percent of Original FFS Medicare and for whom we have been applying a two percent (2%) Sequestration related payment adjustment, we will **not apply** Sequestration on claims with DOS or discharge between 5/1/2020 – 12/31/2020.
- Other Reimbursement Type. For providers whose contracts utilize a different reimbursement methodology (e.g., capitation, per diem, case rate, value based, etc.) there will be no change **unless** the contract specifically calls for application of Sequestration (in which case we will suspend application of Sequestration between May 1, 2020 – and December 31, 2020).

Non-Contracted Providers

We will not apply Sequestration on claims with DOS or discharge dates of May 1, 2020 – December 31, 2020.

Inpatient Prospective Payment System (IPPS) Hospitals- DRG Payment Increase

(POSTED 4/24/2020)

Effective 1/27/2020, we will increase the weighting factor of the assigned Medicare DRG by 20% for members hospitalized with a COVID-19 diagnosis and discharged during the COVID-19 Public Health Emergency (PHE) period. Discharges of an individual diagnosed with COVID-19 will be identified by the presence of the following ICD-10 diagnosis codes:

- B97.29- (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after January 27, 2020, and on or before March 31, 2020.
- U07.1- (2019-nCoV acute respiratory disease) for discharges occurring on or after April 1, 2020, through the duration of the COVID-19 public health emergency period.

We will reprocess claims submitted for discharges occurring 1/27/2020 or after that have the applicable COVID-19 diagnosis codes listed. This increase will apply to contracted and non-contracted facilities.

Screening Guidelines

Note that state and federal mandates may supersede these guidelines.

Per the CDC, as well as state and local public health departments, it is recommended that patients first be screened virtually (i.e., by phone or video) by a clinician for potential COVID-19 symptoms. If the clinician determines SARS-CoV-2 testing is needed, the patient should be referred to a physician's office or a specimen collection center for specimen collection.

Testing

(REVISED 6/1/2020)

Testing Site Locator

(REVISED 5/4/2020). If a patient needs to be tested for SARS-CoV-2 and your office is not able to conduct the test, refer the patient to Leon Medical Centers or reference the Testing Site Locator at http://cigna.com/covidtesting. The testing site locator is a searchable tool for members and providers to find local sites that can test individuals for SARS-CoV-2. The tool does not include antibody testing sites.

Note: The Testing Site Locator is not plan specific, therefore, non-COVID-19 related services or testing obtained by patients at the location may not be covered and will incur cost-share (if applicable depending on the benefit plan) if the location is not contracted with us.

Any physician, nurse practitioner, or physician assistant who has an FDA approved testing kit can collect the specimen.

If the physician's office is not CLIA certified, the specimen must be sent to an approved CLIA certified laboratory.

Testing Reimbursement

(POSTED 6/1/2020)

Testing will be reimbursed according to the CMS pricing outlined here: https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf

Reference the CPT and Diagnosis Codes table for acceptable testing codes.

Testing Coverage

(REVISED 6/22/2020)

To help remove any barriers to receive testing, we are committed to covering the laboratory tests for COVID-19.

Member cost-share (*if applicable depending on the member's benefit plan*) ***is waived until 12/31/2020*** for members when the FDA-approved test is performed by a laboratory that is CLIA certified and bills consistently with CMS guidelines. No prior authorization is required for testing.

(POSTED 4/14/2020) Home test kits that are not FDA approved or administered by a CLIA certified lab are not covered.

Antibody Testing

(POSTED 4/24/2020)

Antibody testing for SARS-CoV-2 is now available. A Coronavirus antibody test could become a key element in fighting the pandemic by providing a more accurate measure of how many people have been infected. It is not yet clear that the presence of antibodies provides immunity against re-infection.

NOTE: Antibody tests are just now showing up in the market and we expect that more and more companies will develop antibody tests over the next several months. There is no current guidance from the CDC or FDA on how this test can be utilized in the treatment or evaluation of COVID-19. In addition, there are at least 4 other types of Coronaviruses that can cause a common cold and some antibody tests may have overlap of antibodies between those Coronaviruses and the SARS-CoV-2 Coronavirus. We will continue to monitor and follow the guidance from the CDC in making recommendations on the utility of antibody testing.

Antibody Test Coverage

(REVISED 6/1/2020)

We cover FDA approved antibody tests. Member cost-share (*if applicable depending on the member's benefit plan*) for FDA approved antibody tests ***is waived until 12/31/2020***.

Treatment of Confirmed COVID-19 Cases

(REVISED 6/22/2020)

In order to ensure patients have the care they need, member cost-share (*if applicable depending on the member's benefit plan*) for COVID-19 treatment (inpatient and outpatient) for in-network and out-of-network providers ***is waived until 12/31/2020.*** In addition, no prior authorization is required for treatment services with a COVID-19 diagnosis.

This applies to treatment with dates of service (DOS) after 2/3/2020. Covered treatment includes all services covered under Medicare and applicable state regulations for the management of a COVID-19 diagnosis. Unless otherwise noted in this document:

- In-network providers will be reimbursed consistent with their fee schedules for services rendered.

- Out-of-network providers will be reimbursed 100% of Medicare or Medicaid allowable depending on the member's benefit plan.

When COVID-19 is confirmed, the applicable ICD-10 codes should be used for treatment. Reference the CPT and Diagnosis Codes table for applicable codes to use.

Non COVID-19 Related PCP & Specialist Services

(POSTED 6/1/2020)

COVID-19 has affected all age groups, physically, financially and emotionally. At Leon Medical Centers Health Plans, we want everyone to focus on getting and staying well, including those that have not been diagnosed with the virus, and not worrying about how they will access or afford the care and services they need.

That is why, as of 6/1/2020, we are waiving member cost-share for non COVID-19 related services performed ***by in-network physicians until 12/31/2020***. We hope that this additional coverage will encourage members to engage with their physicians.

This includes face to face or telehealth services received from contracted:

- Primary Care Providers
- Specialist Physicians, inclusive of:
    - Nurse Practitioners
    - Chiropractors
    - Mental Health/Behavioral Health professionals
    - Podiatrists
    - Therapists: Physical, Speech & Occupational
    - Wound Care Specialists

Applicable member ***cost-share applies*** for non COVID-19 related services received from ***out-of-network providers or received prior to 6/1/2020***.

Telehealth

(REVISED 4/24/2020)

Telehealth generally refers to the exchange of medical information from one site to another through electronic communication to improve a patient's health. There are several types of telehealth services physicians can provide to Medicare and Medicare-Medicaid (MMP) beneficiaries.

- Telehealth Visits (audio & video)
- Audio Only Telehealth visits
- Virtual Check-Ins
- E-Visits (patient to provider via online portal)
- eConsults (provider to provider) also known as Interprofessional Consults

Reference the CPT and Diagnosis Codes table for technology requirements, details and acceptable telehealth codes.

COVID-19 Telehealth Services

(REVISED 6/1/2020)

In and out-of-network providers can be reimbursed for telehealth services related to COVID-19. Member cost-share (if applicable depending on the member's benefit plan) ***is waived for these visits until 12/31/2020.***

Non COVID-19 Telehealth Services

(REVISED 6/1/2020)

For those concerned about face-to-face encounters, we are also waiving member cost-share for non COVID-19 related telehealth services as outlined below. This allows members not only multiple modalities to engage with their physicians but also free access to their physicians from the safety of their homes.

In-network Providers. As of 6/1/2020, we are waiving member cost-share for non-COVID-19 related telehealth services when the service is performed by a contracted provider. This waiver further supports our members and the medical community as we work together to prevent the spread of COVID-19. Member-cost share ***is waived until 12/31/2020***. ***Member cost-share applies for non COVID-19 related telehealth services received prior to 6/1/2020.***

Out-of-network Providers. Member cost-share ***applies for non COVID-19 related telehealth services performed by out-of-network providers***.

Billing for Telehealth Services

(POSTED 4/14/2020)

In order to allow for proper payment of telehealth services, providers should only use CPT codes allowed via telehealth by CMS. Reference the CPT and Diagnosis Codes table for accepted telehealth codes. In addition, note the following:

- Place of Service. Physicians and practitioners who bill for Medicare telehealth services should report the POS code that would have been reported had the service been furnished in person.
- Modifier. During the Public Health Emergency Period, the CPT Telehealth modifier, modifier 95, should be applied to claim lines that describe services furnished via telehealth.

CMS has published the following documents to outline telehealth services:

- *(POSTED 5/12/2020)* List of covered telehealth services: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- Medicare Telehealth Frequently Asked Questions released by CMS on March 17, 2020 by visiting for details: https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf
- Medicare Telemedicine Health Care Provider Fact Sheet located at: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- *(POSTED 5/12/2020)* Reference the Emergency Declarations Blanket Waivers for Health Care Providers at: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf. This document outlines all practitioners that are able to furnish telehealth services.
- *(POSTED 61/2020)* View CMS's recently published Medicare Coverage and Payment of Virtual Services video that answers common questions about the expanded Medicare telehealth services benefit during the COVID-19 PHE. New information includes how CMS adds services to the list of telehealth services, additional practitioners that can provide telehealth services, and the distant site services that Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) can provide. Further, the video includes information about audio-only telehealth services, telehealth services that hospitals, nursing homes and home health agencies can provide, along with how to correctly bill for telehealth services. See the video here: https://www.youtube.com/watch?v=Bsp5tIFnYHk&feature=youtu.be

Audio Only Telehealth (CPT Codes 99441-99443)

(REVISED 5/4/2020)

CMS recognizes there are members who may not have the financial means to access the equipment needed for telehealth visits requiring two-way audio and video interaction. In order to assist both providers and members in getting the clinical care they need when video technology is absent or challenging for our members, CMS has established separate payment for CPT codes 99441-99443 during the PHE for the COVID-19 pandemic. These new codes allow providers to perform services which typically require an office visit over the phone. Reference CMS's Interim Final Rule with Comment for further details: https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

Electronic Consultations (eConsults) *aka* Interprofessional Consultations

(REVISED 6/1/2020)

Electronic Consultations (eConsults), *aka* Interprofessional Consultations, differ from E-visits. *E-visits* are patient to health care provider telecommunications. *eConsults* are health care provider to health care provider communications. eConsults can help reduce patient and physician COVID-19 exposure by allowing providers to share information in writing, online, telephonically or virtually without bringing the patient into an office setting. In order to facilitate consultation between providers during the COVID-19 pandemic, we will reimburse the treating provider and the consulting provider for eConsults.

- COVID-19 eConsults. Member cost-share is ***waived*** for eConsults with a COVID-19 diagnosis received by in and out-of-network providers ***until 12/31/2020***.

- Non COVID-19 eConsults.
    - **In-network Providers.** Member cost-share is ***waived*** for eConsults without a COVID-19 diagnosis performed by in-network providers ***from 6/1/2020 through 12/31/2020***. Member cost-share applies for services prior to 6/1/2020.

    - **Out-of-network Providers.** Patient cost-share ***applies*** for eConsults without a COVID-19 diagnosis performed by out-of-network providers.

Reference the CPT and Diagnosis Codes table for COVID-19 related diagnosis codes.

CPT and Diagnosis Codes List

(REVISED 6/1/2020)

COVID-19 Related Services:

Member Cost-share (if applicable depending on member's benefit plan) is waived for the COVID-19 listed services when the applicable codes are used. This applies to services received by in and out of network providers until 12/31/2020.

Non COVID-19 Services:

- *In-network Providers.* Member cost-share (if applicable depending on member's benefit plan) is waived when the face to face or telehealth service is received by a contracted physician with DOS 6/1 through 12/31/2020. Cost-share applies for services received prior to 6/1/2020.

- *Out of network Providers.* Member cost-share applies for non COVID-19 related face to face or telehealth services received by out-of-network physician.

Reimbursement: Providers will be reimbursed at their contracted rate or the CMS fee schedule if there is no pre-negotiated rate. Non-contracted labs will be reimbursed at their billed rate.

DIAGNOSIS CODES FOR SCREENING & TREATMENT		
Note: Append GQ, GT, or 95 modifier if done virtually		
Code Type	Code	Description and Reimbursement
SCREENING	Z03.818	Encounter for observation for suspected exposure to other biological agents ruled out. To be used for cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation.
	Z20.828	Contact with and (suspected) exposure to other viral communicable diseases. Should be used for cases where there is an actual exposure to someone who is confirmed to have COVID-19.
	Z11.59	Encounter for screening for other viral diseases.
TREATMENT	U07.1	2019-nCoV acute respiratory disease.
	B34.2	Coronavirus infection, unspecified
	B97.2	Coronavirus as the cause of diseases classified elsewhere
	B97.29	Other coronavirus as the cause of diseases classified elsewhere.
	B97.21	SARS-associated coronavirus as the cause of diseases classified elsewhere
	J12.81	Pneumonia due to SARS-associated coronavirus

TESTING & SPECIMEN COLLECTION CODES		
Reference the MAC COVID-19 Test Pricing at: https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf		
Code Type	Code	Description and Reimbursement
SPECIMEN COLLECTION	G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source
	G2024	Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source
	C9803 *(POSTED 5/4/2020)*	Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source)
	99211 *(POSTED 5/12/2020)*	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

SARS-CoV-2/ 2019-nCoV TESTING	U0001	This HCPC code is used for the tests developed by the Center of Disease Control and Prevention (CDC). 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel.
	U0002	This HCPC code is used by laboratories performing non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). 2019-nCoV Coronavirus, SARS COV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets).
	U0003 *(REVISED 6/1/2020)*	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R.
	U0004 *(REVISED 6/1/2020)*	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R.
	87635	This new CPT code became available on March 13, 2020. Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique.

ANTIBODY TESTING CODES		
These codes will be reimbursed according to the CMS fee schedule.		
(REVISED 6/1/2020) Codes will be accepted with DOS 4/10/2020 and after. These codes will be reimbursed according to the CMS pricing: https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf		
Code Type	**Code**	**Description and Reimbursement**
ANTIBODY TESTING *(POSTED 4/24/2020)*	86318	Immunoassay for infectious agent antibody(ies), qualitative or semi quantitative, single step method (eg, reagent strip).
	86328	severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
	86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])

TELEHEALTH SERVICES		
Service Type	**Code**	**Description and Reimbursement**
E-VISITS *(Established Patients Only)*	• 99241 • 99422 • 99423 • G2061 • G2062 • G2063	A communication between a patient and their provider through an online patient portal. Requirement: Patient portal
VIRTUAL CHECK-IN (*New or Established Patients*)	• G2012 • G2010	A brief (5-10) minute check-in conversation between member and provider to determine whether an office visit or other service is needed. Requirement: Audio only
MEDICARE TELEHEALTH VISITS (*New or Established Patients*) *(REVISED 5/12/2020)*	We will accept CMS covered telehealth codes for COVID-19 and Non-COVID-19 related services as listed here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	A visit with a provider that uses telecommunication systems between a provider and patient. Requirement: Video and audio *(note exception below)* Exception: CMS has recently waived the video requirement for certain telephone evaluation and management services and has added them to the list of Medicare telehealth services. As a result, Medicare beneficiaries will be able to use an audio-only telephone to get certain telehealth services.

		Reference the Interim Final Rule with Comment for further details: https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf.

ELECTORONIC CONSULTATIONS (eConsults) *aka* INTERPROFESSIONAL SERVICES		
Service Type	**Code**	**Description and Reimbursement**
eCONSULT *(Provider to Provider)* *(POSTED 4/24/2020)*	• 99446 *(5-10 min)* • 99447 *(11-20 min)* • 99448 *(21-30 min)* • 99449 *(31+ min)*	Interprofessional telephone/Internet/electronic health assessment and management service provided by a consultative physician, ***including a verbal and written report*** to the patient's treating/requesting physician or other qualified health care professional. Number of minutes for medical consultative discussion and review indicated next to code.
	• 99451 *(5+ min)*	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, ***including a written report*** to the patient's treating/requesting physician or other qualified healthcare professional, 5 minutes or more of medical consultative time. Note that no verbal interaction between providers must occur, this can be accomplished with a written report only.
	• 99452 *(30 min)*	Interprofessional telephone/internet/electronic health ***record referral service(s) provided by a treating/requesting physician*** or other qualified healthcare professional, 30 minutes. This code is for use of the treating physician, NP or PA.

Frequently Asked Questions

Utilization Guidelines

Initially, you stated that no authorizations were required for any services for non-contracted providers until the end of the PHE 10/22/2020, what changed? *(REVISED 7/24/2020)*

We require authorization of certain services, medications, procedures, and/or equipment prior to performing or providing the service to prevent unnecessary utilization while safeguarding beneficiary access to the most appropriate medically necessary care. At the beginning of the COVID-19 epidemic, it was our understanding that we could not require authorizations during the PHE for non-contracted providers. Since then, we have received clarification from CMS that authorization requirements can continue according to plan rules during the PHE period. Therefore, as of 6/22/2020, we re-implemented authorization requirements as stated in the Online Provider Manual (https://www.lmchealthplans.com/English/Documents/Provider_Manual.pdf).

Do authorization requirements now apply to non-contracted provider services with DOS 6/22 or after? *(REVISED 6/22/2020)*

Yes. Any claim received from a non-contracted provider for a service listed on the 2020 authorization grid as requiring an authorization with a DOS of 6/22/2020 or after that does not have an authorization on file will be denied. Providers will need to follow the standard appeal process as necessary.

Where are the Authorization Requirements listed? *(REVISED 6/22/2020)*

The 2020 authorization requirements can be located here:
https://www.lmchealthplans.com/English/Documents/Provider%20Prior%20Authorization%20List.pdf
Note that these requirements may change, reference our provider website for the latest information. (https://www.lmchealthplans.com)

Are there any exceptions to the authorization requirements because of COVID-19? *(REVISED 6/22/2020)*

Yes. Given the COVID-19 circumstances, we are not requiring authorizations for treatment services with a COVID-19 diagnosis code or SARS-CoV-2 testing.

Are authorizations still required for Home Health, SNF, LTAC and Inpatient Rehab? *(REVISED 7/24/2020)*

Yes. Authorization requirements still apply for these services. However, the initial clinical review for these services is waived until 7/31/2020. On 8/1/2020 or after, initial clinical reviews will commence for these services.

SARS-CoV-2 TESTING

Will the SARS-CoV-2 laboratory test be covered? *(REVISED 6/1/2020)*

Yes. SARS-CoV-2 testing will be **covered** for both **in-network** and **out-of-network** labs, and applicable member cost-share is waived ***until 12/31/2020***. Note that home test kits that are not FDA approved or administered by a CLIA certified lab are not covered.

Will the office visits for SARS-CoV-2 test be covered? *(REVISED 6/1/2020)*

Yes. Member cost-share (*if applicable depending on the member's benefit plan*) for physician visits for testing (both in-network and out-of-network) is waived **until 12/31/2020**.

How does a laboratory submit a claim for testing?

CMS has created Healthcare Common Procedure Coding System codes specifically for testing SARS-CoV-2, the virus that causes novel coronavirus (COVID-19). (https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-02-20#_Toc32923423). Laboratories performing the test can bill Medicare and other health insurers for services that occurred after **February 4, 2020**, using the HCPCS codes outlined in the billing guidelines document attached.

How much will providers be reimbursed for SARS-CoV-2 testing performed by commercial labs, such as LabCorp and Quest?

CMS has released a fee schedule to determine pricing for SARS-CoV-2 testing which varies by state. (https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf)

Are there any prior authorizations required for SARS-CoV-2 lab testing?

No. Prior authorization is not required for SARS-CoV-2 lab testing.

Will cost-sharing be waived for diagnostic testing with a Respiratory Viral Profile (RVP) prior to a provider ordering a SARS-CoV-2 testing?

No. Cost-share (*if applicable depending on the member's benefit plan*) is only waived for the commercial laboratory testing of SARS-CoV-2. Cost-share is not waived for other laboratory testing at this time.

What if I need to test a patient for SARS-CoV-2, will I get paid for collecting the specimen? *(POSTED 5/12/2020)*

If you are a provider that can bill for an E/M service, the testing is part of the E/M service. If the patient goes in to the provider's office just for the specimen collection, then you can bill code 99211 for the service.

Is a physician's order still required for SARS-CoV-2 testing? *(REVISED 6/1/2020)*

To help ensure that Medicare beneficiaries have broad access to testing related to COVID-19, a written physician's order is no longer required for the COVID-19 test for Medicare payment purposes. It is important that providers and members check local state requirements as some states will not allow testing centers to test member's without a physician's order. Reference the CMS Laboratory Tests Requirements notice (https://www.cms.gov/files/document/covid-ifc-2-flu-rsv-codes.pdf) which outlines which lab codes do not require a physician's order.

How should claims with no ordering physician be submitted? *(POSTED 6/1/2020)*

- If an order is not written, you do not need to provide the National Provider Identifier (NPI) of the ordering or referring professional on the claim.

- If an order is written, include the NPI of the ordering or referring professional, consistent with current billing guidelines.

COVID-19 MEDICAL TREATMENT

Will cost-sharing be waived for members with costs related to COVID-19 treatment? *(REVISED 6/1/2020)*

Yes. Treatment of COVID-19 is covered according to the benefit plans and provider contracts as appropriate. Depending on the member's benefit plan, applicable deductibles and cost-sharing related to treatment for COVID-19 is waived until **12/31/2020.**

What is considered COVID treatment? *(POSTED 3/31/2020)*

Treatment is any care given at any location (hospital, doctor's office, urgent care, virtual care, skilled nursing facility, etc.) that contains a COVID-19 diagnosis code as listed in the Billing Guidelines.

Are any medications covered under treatment of COVID-19? *(POSTED 3/31/2020)*

Currently there are no medications covered under Medicare Part D for the treatment of COVID-19. However, this is a fluid situation and the Medicare rules may change as the circumstances necessitate. If and when notice is received from CMS that certain drugs are covered, the medications will be covered under the member's Part D benefit.

What happens if a member is diagnosed with COVID-19 on a date of service after December 31, 2020? *(REVISED 6/1/2020)*

After 12/31/2020, regular member benefits apply, however, as the COVID-19 pandemic situation continues to evolve, we are monitoring new developments. At this time, we are not able to predict what the situation will be as of 12/31/2020. Currently, the member cost-share (*if applicable to the member's benefit plan*) is waived until 12/31/2020. If this changes, this document will be updated accordingly.

What will providers be reimbursed for providing services related to COVID-19 screening and treatment?

In-network providers will be reimbursed consistent with their fee schedules for services rendered. Out-of-network providers will be reimbursed 100% of Medicare or Medicaid allowable depending on the member's benefit plan.

Will providers who cannot submit claims or request authorizations on time because of staffing shortages be penalized?

Every effort will be made to accommodate facilities and provider groups who are adversely affected by COVID-19. We may request to review the care that was provided for medical necessity post-service.

COVID-19 Telehealth Policy

In lieu of having an office visit, can providers get reimbursed for telehealth services? *(REVISED 4/3/2020)*

Yes. Physicians who bill for a telehealth visit for the duration of the COVID-19 Public Health Emergency will be reimbursed according to their contracted rate if in-network or Medicare allowable if out-of-network.

What codes should providers use for billing telehealth services? *(REVISED 4/3/2020)*

Providers should reference the CMS telehealth codes on the following website: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

Can providers resubmit telehealth claims that were previously submitted using POS 02 instead of the in person POS code? *(POSTED 4/24/2020)*

Yes. Providers can submit corrected claims for reprocessing. The adjusted POS code should be included along with modifier 95 to indicate the service occurred via telehealth.

Why should providers not bill with POS 02 for telehealth services? *(POSTED 4/24/2020)*

Consistent with CMS guidance, billing a face-to-face place of service will ensure providers receive the same reimbursement as they typically get for a face-to-face visit.

Is using the in person POS code instead of POS 02 fraudulent since the service was not performed in person but providers are being asked to bill as if it was a face to face visit? *(POSTED 4/24/2020)*

CMS has implemented this coding and billing guidance as a temporary measure. CMS guidance is to append modifier 95 to the claim indicating the service was performed via telehealth. As long as providers are following CMS guidance and billing appropriately, we do not consider this fraudulent.

Will providers be reimbursed for providing non-COVID-19 related services via telehealth? *(POSTED 4/24/2020)*

Yes. Providers will be reimbursed for COVID-19 and non-COVID-19 related telehealth services.

Who are the eligible practitioners that can perform services via telehealth? *(POSTED 5/12/2020)*

CMS has expanded the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services. Reference the Emergency Declarations Blanket Waivers for Health Care Providers at: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

PHARMACY

Are prescription refill limits/requirements being lifted?

Our focus is to help members stay on track with their medication. As part of our normal business practice, retail pharmacists can enter a submission clarification code to allow early refills using their professional judgement. Cigna/Express Scripts communicated a reminder of the process to pharmacies in light of COVID-19.

Are there any drug shortages? *(POSTED 4/6/2020)*

Our Express Scripts pharmacy network team has been keeping in close daily contact with pharmacies to monitor volumes and supply. Due to a national shortage, patients utilizing albuterol inhalers on a chronic basis may need to switch to albuterol solution via a nebulizer until supplies can be replenished. As there may be a risk of spreading virus laden droplets to other household members, an albuterol inhaler, if available, might still be a more appropriate choice for patients infected with COVID-19 illness.

What if a pharmacy asks me about early refill overrides, signature pad or other related questions? *(POSTED 3/31/2020)*

Please direct pharmacies to the Express Scripts Pharmacist Resource Center at https://PRC.Express-Scripts.com or dial 1-800-922-1557 for further assistance.

CMS Advanced Payments

What type of financial assistance is available for providers? *(REVISED 5/4/2020)*

In order to increase cash flow to providers of services and suppliers impacted by the 2019 Novel Coronavirus (COVID-19) pandemic, the Centers for Medicare & Medicaid Services (CMS) has expanded their Accelerated and Advance Payment Program. The expansion of this program is only for the duration of the public health emergency. Details on eligibility, the request process and listing by state are outlined here:
https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf
https://www.cms.gov/files/document/covid-accelerated-and-advance-payments-state.pdf

Additional Provider Resources

What additional resources are available for providers? *(REVISED 5/12/2020)*

Providers should reference the CMS Current Emergencies site for additional information on COVID-19. The site can be accessed here: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page

Cigna Behavioral Health has also created the following resources to help providers cope with COVID-19 related challenges they may be facing.

- Health care workers: Self-care in stressful times webcast
- Relaxing Techniques
- Fatigue Awareness
- Self- Care Checklist
- Understanding Grief