Atlantic Health System

COVID-19
Insurance Updates
AHS Managed Care Dept

Information current as of: **4/27/2020**

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Disclaimer

Please note that the following policies and guidance apply to each carrier's fully insured business lines. The carriers have taken the position that these policies will apply to their self-insured clients, unless the clients specifically elect to opt-out.

The contents of this presentation are based upon publicly available information put forth by each of the carriers and is subject to change.

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COVID-19 Visit & Testing Policies

All testing for COVID-19 is being administered with a $0 copay per federal legislation.

All carriers have adopted a uniform position on whether the associated COVID-19 visit (ER, Urgent Care, Office, Virtual) will be administered with $0 cost sharing.

	Medicare	Aetna	AmeriHealth	Cigna	Horizon BCBS	United/Oxford
Waived Cost sharing for associated visit for in network providers	Yes	Yes	Yes	Yes	Yes	Yes

Additionally, all commercial carriers are covering the treatment of COVID-19 without any cost-sharing:

	Medicare	Aetna	AmeriHealth	Cigna	Horizon BCBS	United/Oxford
Waived Cost sharing for associated visit for in network providers	No	Yes	Yes	Yes	Yes	Yes

COVID-19 Visit & Testing Policies – Medicare Guidance

- The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients for COVID-19 testing-related services. These services are medical visits for the HCPCS evaluation and management categories described below when an outpatient provider, physician, or other providers and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635.

- Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE); that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following categories of HCPCS evaluation and management codes:

    - Office and other outpatient services
    - Hospital observation services
    - Emergency department services
    - Nursing facility services
    - Domiciliary, rest home, or custodial care services
    - Home services
    - Online digital evaluation and management services

- For services furnished on March 18, 2020, and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing wavier for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

- Providers who did not initially submit claims with the CS modifier must notify their Medicare Administrative Contractor (MAC) and request to resubmit applicable claims with dates of service on or after 3/18/2020 with the CS modifier to get 100% payment.

COVID-19 Visit & Testing Coding Guidance

ICD-10 Reporting Codes

Exposure to COVID-19

The below diagnosis codes are required on visits to receive the cost sharing waivers from the carriers:

Code U07.1, 2019-nCoV acute respiratory disease, will be implemented into ICD-10-CM with the update effective April 1, 2020. Until then, providers must use available ICD-10 codes and guidance.

Z03.818 (Encounter for observation for suspected exposure to other biological agents ruled out). 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). Used for cases where there is an actual exposure to someone who is confirmed to have COVID-19.

For other signs and symptoms the following codes apply:

For patients presenting with any signs/symptoms (such as fever, etc.) and where a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:

- R05 (Cough)
- R06.02 (Shortness of breath)
- R50.9 (Fever, unspecified)

Pneumonia

For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes:

- J12.89 (Other viral pneumonia)
- B97.29 (Other coronavirus as the cause of diseases classified elsewhere)

COVID-19 Visit & Testing Coding Guidance – Continued

ICD-10 Reporting Codes

Bronchitis

Acute bronchitis confirmed as due to COVID-19, assign codes:

- J20.8 (Acute bronchitis)
- B97.29 (Other coronavirus as the cause of diseases classified elsewhere)

Bronchitis not otherwise specified (NOS) due to the COVID-19 should be coded using codes:

- J40 (Bronchitis, not specified as acute or chronic)
- B97.29 (Other coronavirus as the cause of diseases classified elsewhere)

Lower Respiratory Infection

Assign the following codes if the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS:

- J22 (Unspecified acute lower respiratory infection)
- B97.29 (Other coronavirus as the cause of diseases classified elsewhere)

Assign the following codes if the COVID-19 is documented as being associated with a respiratory infection, NOS:

- J98.8 (Other specified respiratory disorders)
- B97.29 (Other coronavirus as the cause of diseases classified elsewhere)

ARDS

ARDS due to COVID-19 should be assigned the codes:

- J80 (Acute respiratory distress syndrome)
- B97.29 (Other coronavirus as the cause of diseases classified elsewhere)

Diagnosis code B34.2 (Coronavirus infection, unspecified) would in general not be appropriate for the COVID-19, because the cases have universally been respiratory in nature, so the site would not be “unspecified.”
If the provider documents “suspected”, “possible” or “probable” COVID-19, do not assign code B97.29. Assign a code(s) explaining the reason for encounter (such as fever, or Z20.828).

COVID-19 Visit & Testing Coding Guidance – Continued

Section 1135 and Section 1812(f) Waivers As a result of this PHE, apply the following to claims for which Medicare payment is based on a “formal waiver” including, but not limited to, Section 1135 or Section 1812(f) of the Act:

1. The “DR” (disaster related) condition code for institutional billing, i.e., claims submitted using the ASC X12 837 institutional claims format or paper Form CMS-1450.
2. 2. The “CR” (catastrophe/disaster related) modifier for Part B billing, both institutional and non-institutional, i.e., claims submitted using the ASC X12 837 professional claim format or paper Form CMS-1500 or, for pharmacies, in the NCPDP format.
3. Medicare FFS Questions & Answers (FAQs) available on the Waivers and Flexibilities webpage apply to items and services for Medicare beneficiaries in the current emergency.

CMS is not requiring the CR modifier on telehealth services

COVID-19 Telemedicine Policies

To open access to all patients, Medicare has significantly loosened existing requirements on the provisions of telemedicine services. Many of the commercial carriers are following their lead.

- The following describes the waivers as they apply to Medicare FFS. It is up to other carriers' discretion to align with these policies.
- Medicare's changes are not limited to COVID-19 related encounters. It is an alternative to be used for all encounters in order to promote social distancing when feasible.
- Telemedicine visits can be provided by physicians and most other licensed practitioners, including mental health professionals.
- Normally, all of the following services are provided through Medicare Part B and require a 20 percent beneficiary co-pay. CMS is waiving the requirement for copay collection if a provider elects not to collect the full or partial amount.
- Each of the following Medicare policies remain in place until the Public Health Emergency ends.

COVID-19 Telemedicine Policies - Waivers

- Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.

- Effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.

- The Medicare coinsurance and deductible would generally apply to these services. However, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

- HHS will not conduct audits to ensure that a prior relationship required under traditional rules existed for claims submitted during this public health emergency.

- Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies. This is applicable to all carriers.

COVID-19 Telemedicine Policies – Covered Services

Members have access to three types of virtual services:

- Medicare Telehealth Visits
- Virtual Check-Ins & Telephonic Services
- E-Visits

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COVID-19 Telemedicine Policies – Medicare Telehealth Visits

What is the Service?	HCPCS/CPT Code	Patient Relationship with Provider
A visit with a provider that uses live interactive audio and visual telecommunication systems between a provider and a patient. **It must be provided through an interactive audio and video telecommunications system. Per guidance during this emergency that could include telephones utilizing Skype or Facetime.**	Common telehealth services include: • 99201-99215 (office or other outpatient visits) • G0425-G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals of SNFs) • CMS also expanded the code list on **March 30th** to include additional services including but not limited to Radiation tx management, Emergency visits, and group psychotherapy For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes Payment is at the same rate as an in-person visit. As such, visits should reflect the same level of care a patient would receive in-person. **For CMS, use POS 11 and modifier 95, which indicates a telehealth place of service.** For commercial carriers, GT or 95 modifiers should be used in addition to POS 02 or POS 11.	For new* or established patients *To the extent the 1135 waiver requires an established relationship , HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency

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COVID-19 Telemedicine Policies – Virtual Check-Ins & Telephonic Services

What is the Service?	HCPCS/CPT Code	Patient Relationship with Provider
A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office or other service is needed. A remote evaluation of recorded video/or images submitted by an established patient.	G2010 - Remote evaluation of recorded video and or/images submitted by an established patient (e.g., store-and-forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available) G2012 - Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion **99441-99443 – On March 30th, CMS announced that E&M telephone services would be covered using the codes 99441-99443.** NNJ CMS 2020 Reimbursement: 99441 - $15.70 99442 - $30.45 99443 - $44.51 G2010 - $13.57 G2012- $16.13 No modifier is required for these codes.	For established patients

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COVID-19 Telemedicine Policies – E Visits

What is the Service?	HCPCS/CPT Code	Patient Relationship with Provider
A communication between a patient and their provider through an online patient portal **<u>This type of encounter is limited to provision through an online patient portal.</u>**	**99421** - Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes **99422** - Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes **99423** - Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes. **G2061** - Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes **G2062** - Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes **G2063** - Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes. 2020 NNJ Medicare Reimbursement: • **99421** – Non-Facility: $16.98 Facility: $14.41 • **99422** – Non-Facility: $33.88 Facility: $29.59 • **99423** – Non-Facility: $54.81 Facility: $47.08 • **G2061** - $13.21 • **G2062** - $23.29 • **G2063** - $36.07 No modifier is required for these codes.	For established patients

COVID-19 Telemedicine Policies – United/Oxford

Overview:
United/Oxford has closely followed Medicare's lead on telehealth reimbursement.

Through June 18th, United/Oxford has waived the originating site requirement. All services that are currently reimbursable by CMS are currently reimbursed by United/Oxford for both **in network** and **out of network** providers.

Phone Calls:
All visits including E&M visits (99201-99215) can be completed using both audio and visual technology or **audio only technology**. G2012 is also reimbursable for check ins. PT/OT/ST are the exception to this rule.

Preventive Medicine Services:
UHC/Oxford is reimbursing for preventive medicine visits for both children and adults.

Place of Service and Modifiers for E&Ms :
UHC is now recommending POS 11, 20, 22, or 23 rather than POS 02 with modifier 95.

Cost Sharing:
Cost-sharing is waived for in-network telehealth visits from March 31 until June 18.

All other components of United/Oxford's payment policy still apply:

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Telehealth-and-Telemedicine-Policy.pdf

COVID-19 Telemedicine Policies – Aetna

Overview:
Aetna has adopted modified telemedicine policies effective March 6, 2020 for 90 days through June 4, 2020 for **in network** providers.

In general, Aetna has closely followed the CMS policies.

Phone Calls:
Aetna is allowing for the reimbursement of codes 99441-99443, which are for telephone evaluation and management services.

Preventive Medicine Services:
Aetna is not currently reimbursing for preventive medicine services.

Place of Service and Modifiers for E&Ms:
Aetna uses POS 02 for telehealth claims with either modifier GT or 95.

Cost Sharing:
Copays for all telemedicine visits have been waived for all in network providers including non-COVID related visits.

Aetna's full policy is available via Availity or NaviNet. Their behavioral health telemedicine policy is available publicly:

https://www.aetna.com/content/dam/aetna/pdfs/health-care-professionals/bh-televideo-service-codes-covid-19.pdf

COVID-19 Telemedicine Policies – Cigna

Overview:
Cigna has adopted modified telemedicine policies effective March 2 through May 31, 2020 for **in network** providers. Claims systems will be ready to process the changes effective April 6, 2020.

Phone Calls:
All visits including E&M visits (99201-99215) can be completed using both audio and visual technology or **audio only technology**. G2012 is also reimbursable for check ins. PT/OT/ST are the exception to this rule.

New/Established Patients:
Cigna is currently reimbursing for preventive medicine services.

Place of Service and Modifiers for E&Ms:
Cigna is requiring the use of POS 11 and modifier GQ, GT, or 95 for telemedicine claims.

Cost Sharing:
For all other non-COVID-19 related in-office and virtual visits, the standard cost share, reimbursement, and payment policies remain in effect.

COVID-19 Telemedicine Policies – Horizon

Overview:
Effective March 13th for a 90 day period, Horizon has waived cost sharing for all telemedicine visits performed by an **in-network** provider.

In general, Horizon has closely followed the CMS policies.

Phone Calls:
Horizon is allowing for the reimbursement of codes 99441-99443, which are for telephone evaluation and management services.

Preventive Medicine Services:
Horizon is currently reimbursing for preventive medicine services.

Place of Service and Modifiers for E&Ms:
Horizon is requiring the use of POS 11 or 02 and modifier GT or 95 for telemedicine claims. Medicare Advantage requires POS 02.

Cost Sharing:
Horizon has waived cost sharing for all members except their ASO book of business (i.e. self-insured plans).

COVID-19 Telemedicine Policies – AmeriHealth

Overview:
Effective March 6 through June 4, 2020, in addition to the current telemedicine service coverage, telemedicine services for evaluation and management of a new or established patient are eligible for reimbursement consideration by AmeriHealth when provided through the AmeriHealth network of professional providers (i.e., primary care providers and specialist providers).

Phone Calls:
AmeriHealth is allowing for the reimbursement of codes 99441-99443, which are for telephone evaluation and management services.

Preventive Medicine Services:
AmeriHealth is currently reimbursing for preventive medicine services. Guidance is that the telehealth based well visit must ultimately be followed by a in office visit for the physical examination that is not considered separately reimbursable.

Place of Service and Modifiers for E&Ms:
AmeriHealth uses POS 02 for telehealth claims with either modifier GT or 95.

Cost Sharing:
Copays for all telemedicine visits have been waived for all in network providers including non-COVID related visits.

Additional COVID-19 Related Policies

Utilization Management:

Post Acute Prior Authorizations:
Each of the major carriers has waived post-acute facility inpatient authorization requirements for admissions to Skilled Nursing, Subacute Physical Rehab, and Inpatient Physical Rehab. Notification of admission is still required.

Inpatient Prior Authorizations:

Aetna: Has waived prior authorization requirements for all inpatient admissions.

Cigna: Prior authorizations for existing scheduled surgeries and admissions have been extended six months. For new services, they are still required.

Horizon: Has waived prior authorization requirements for all inpatient admissions through April 30th.

United: Prior authorizations for existing inpatient admissions will be extended 90 days. They are still required. Site of service reviews have been suspended.

AmeriHealth: Has waived prior authorizations for members with a COVID-19 diagnosis through April 30th and for transfers for any diagnosis.

Credentialing:

Aetna: Aetna is implementing operational changes to accelerate its existing credentialing process.

Cigna: Cigna is relaxing its initial credential process through June 30th in order to accelerate credentialing. Providers are asked to identify that their credentialing request is related to COVID-19 upon submission.

United/Oxford: UHC/Oxford has implemented a provisional credentialing process to accelerate participation of out of network providers in its network. The full credentialing process will be completed within 180 days following acceptance of the provisional credentialing.

Additional COVID-19 Related Policies Continued

PT/OT/ST Hospital Telemedicine Billing:
Cigna, Horizon, United, and Aetna have acknowledged that PT/OT/ST services can be billed via a UB form for hospital-based providers.

Behavioral Health Hospital Telemedicine Billing:
Cigna, Optum, Aetna and Horizon have allowed for IOP and PH Behavioral Health services to be billed via a UB form by an outpatient department.

Referral Policies:
Effective March 30th, Horizon NJ Health waived its requirements for referrals.
Cigna has waived all referral requirements for specialist office visits for individual and family plans.

Timely Filing Extension:
Aetna: No change to date

Cigna: Yes, timely filing requirements have been relaxed by an additional 90 days.

Horizon: No change to date

United/Oxford: Waived timely filing deadlines for all claims submitted between 1/1/2020 – 6/30/20

AmeriHealth: No change to date.

COVID-19 PAYER WEBSITE LINKS

- **Aetna**
  - https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html#acc_link_content_section_responsivegrid_copy__responsivegrid_accordion_9
- **Horizon BCBS**
  - https://www.horizonblue.com/coronavirus-2019
- **Cigna**
  - https://www.cigna.com/individuals-families/health-wellness/topic-disaster-resource-center/coronavirus-public-resources
- **United/Oxford**
  - https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19.html
- **AmeriHealth**
  - https://www.amerihealthnj.com/html/custom/announcements/coronavirus.html
- **Medicare**
  - https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00224506
- **OCR**
  - https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html
- **HHS portal to apply for the additional $20B**
  - https://covid19.linkhealth.com/#/step/1

Questions

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