Health Plan Policies, Procedures and Practices

New **Updated.** **Blank cell – Awaiting health plan response.**

A) COVID Related Billing

Page 3	For all patients that meet the CDC criteria, plans will cover 100% of the cost of COVID testing, Diagnostic Test Panels and testing related outpatient or emergency department visit without patient deductible or cost share?
Page 8	In situations where the testing is billed by the lab and the E&M visit is billed by the provider, how should providers submit the claim with the E&M visit -- so that it is clear that E&M visit is to be covered under the Emergency Order (since the testing will be billed by the lab)?
Page 12	When do you anticipate that providers should submit claims to you for COVID testing?
Page 14	If a claim was billed for COVID testing after the order (March 5th) and it was billed with an incorrect code, how should it be rebilled so that it is adjudicated under the order?
Page 17	As provider organizations that do not have delegated credentialing bring on new providers to address the COVID demands, are there policies/practices under which the new provider can bill the health plan sooner rather than later

B) Alternative Treatment Locations

Page 18	Are ED services provided in tents and patient cars covered and if so, how should they be billed?
Page 19	Are outpatient services provided in patient cars covered and if so, how should they be billed?
Page 22	Are services provided in non-licensed space and/or non-licensed beds covered and if so, how should they be billed?
Page 23	Is SNF care provided in a licensed hospital to COVID patients in non-licensed beds covered and if so, how should they be billed?

C) Telehealth

Page 25	Will a telemedicine visit for a care service be paid at the same rate as an in-person visit for that same care service?
Page 28	Are you following the HHS guidelines for the methods that will be considered telehealth (e.g. SKYPE, Facetime, etc.)? How should they be billed?
Page 30	Will a phone call with a patient be considered telehealth if there is no video feed; i.e. just voice interaction over the phone? If so, how should it be billed?
Page 33	Will telehealth be a covered service for patients new to that provider?
Page 35	For telehealth services during this interim period, will your plans allow the provider to select E&M code level based just on MDM OR on either MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter?

D) Provider Workflow

Page 37	Will the outpatient pre-authorizations and pre-authorizations for scheduled elective admissions be extended longer than 90 days? If so, by how much?
Page 41	Will health plans ease authorization requirements for key components of after-hospital care, such as admission to SNFs or rehab, providing home health visits, during this COVID period?
Page 43	Can any patient signature requirements be waived for COVID patients, e.g. Medicare MOON?

A) <u>Billing under the Emergency Orders 20-01, 20-02</u>

For all patients that meet the CDC criteria, plans will cover 100% of the cost, without patient deductible or cost share, of • **COVID test** • **Diagnostic test panels for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV), when any of this testing is determined medically necessary by the enrollee's health care provider** • **Testing related visit in the outpatient or Emergency Department setting**			
Follow Consensus Direction?		**Health plans provide 100% coverage, as outlined in the OIC Emergency Order above, except where self-funded groups opt out of that coverage. Coding should be consistent with** https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf	
Aetna	Yes 03/30/20	Aetna COVID page	Aetna is waiving member cost-sharing for diagnostic testing related to COVID-19. This policy covers the cost of a physician-ordered test and the office, clinic or emergency room visit that results in the administration of or order of a COVID-19 test. The test can be done by any approved laboratory. This member cost-sharing waiver applies to all Commercial, Medicare and Medicaid lines of business. The policy aligns with new Families First legislation requiring all health plans to provider COVID-19 testing without cost share. The requirement also applies to self-insured plans.
Amerigroup	Yes 03/27/20	Provider COVID FAQ	Health plan has no Self-insured plan sponsors.
CHPW	Yes 03/27/20	Provider COVID FAQ	Health plan has no Self-insured plan sponsors.
Cigna	Most 04/01/20	COVID Provider page Scroll down to "Provider Frequently Asked Questions" and Select "COVID-19 Medical Treatment"	Cigna will waive customers' out-of-pocket costs for COVID-19 testing-related visits with in-network providers, whether at a doctor's office, urgent care clinic, emergency room or via telehealth, through May 31, 2020. Cigna also eliminated patient out-of-pocket costs for the diagnostic testing, when it's recommended by a physician. This expanded coverage includes customers in the United States who are enrolled in Cigna's employer/union sponsored group insurance plans, globally-mobile plans, Medicare Advantage, Medicaid and the Individual & Family plans. Employers and other entities that sponsor self-insured plans administered by Cigna will be given the opportunity to adopt a similar coverage policy.
Coordinated Care	Yes 03/27/20	COVID Provider page	When medically necessary diagnostic testing or medical screening services are ordered and/or referred by a licensed health care provider, we will cover the cost of medically necessary COVID-19 tests and the associated physician visit.

For all patients that meet the CDC criteria, plans will cover 100% of the cost, without patient deductible or cost share, of • **COVID test** • **Diagnostic test panels for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV), when any of this testing is determined medically necessary by the enrollee's health care provider** • **Testing related visit in the outpatient or Emergency Department setting**			
Follow Consensus Direction?		**Health plans provide 100% coverage, as outlined in the OIC Emergency Order above, except where self-funded groups opt out of that coverage. Coding should be consistent with** https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf	
			Copayment, coinsurance and/or deductible cost-sharing requirements will be waived for medically necessary COVID-19 diagnostic testing and/or medical screening services.
First Choice (TPA and PPO)	Varies by our Payers' Plans 03/27/20	COVID Provider page	First Choice Health is a PPO network that does not define the benefits. Please reach out to the individual Payers to confirm benefits. As an administrator for our self-funded health Plans, we are complying with the Families First Coronavirus Act, specifically the "Health Provisions". FCH is encouraging all FCH payors to waive patient responsibility for COVID-19 diagnostics, including testing services, performed in accordance with the Families First Coronavirus Response Act.
HCA – Apple Health	Yes 04/08/20	Tests and E&M visit covered at 100% of the allowed and patient. cannot be balance billed	
KP-NW	Yes 04/03/20		Most of our health plans require use of in-network providers for non-emergency services, and the COVID-19 testing and visit would be covered without deductible or cost-sharing. If a health plan covers services from out-of-network providers, then the COVID-19 testing and visit would be covered from those providers without deductible or cost-sharing. We monitor access to in-network providers, and if members cannot access care from an in-network provider, we will assist members in accessing care from out-of-network providers, and in such circumstances the COVID-19 testing and visit will be covered without deductible or cost-sharing.

For all patients that meet the CDC criteria, plans will cover 100% of the cost, without patient deductible or cost share, of • **COVID test** • **Diagnostic test panels for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV), when any of this testing is determined medically necessary by the enrollee's health care provider** • **Testing related visit in the outpatient or Emergency Department setting**			
Follow Consensus Direction?		**Health plans provide 100% coverage, as outlined in the OIC Emergency Order above, except where self-funded groups opt out of that coverage. Coding should be consistent with** https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf	
KP-WA	Most 03/27/20		Most of our health plans require use of in-network providers for non-emergency services, and the COVID-19 testing and visit would be covered without deductible or cost-sharing. If a health plan covers services from out-of-network providers, then the COVID-19 testing and visit would be covered from those providers without deductible or cost-sharing. We monitor access to in-network providers, and if members cannot access care from an in-network provider, we will assist members in accessing care from out-of-network providers, and in such circumstances the COVID-19 testing and visit will be covered without deductible or cost-sharing. Self-insured plan sponsors will be able to opt-out of this program at their discretion
Labor & Industries	Yes 04/08/20	If due to work exposure https://www.lni.wa.gov/agency/outreach/workers-compensation-coverage-and-coronavirus-covid-19-common-questions	Recommend worker file claim (Report of Accident or Occupational Disease) online before going for test, then take L&I claim # to provider giving test. https://secure.lni.wa.gov/home/default.aspx?rfs=PleaseSign%20In
Medicaid FFS	Yes 03/27/20	COVID resource page	Covers any medically necessary lab tests. Medicaid does not have copays or deductible. Covered at 100%.

For all patients that meet the CDC criteria, plans will cover 100% of the cost, without patient deductible or cost share, of • COVID test • Diagnostic test panels for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV), when any of this testing is determined medically necessary by the enrollee's health care provider • Testing related visit in the outpatient or Emergency Department setting			
Follow Consensus Direction?		**Health plans provide 100% coverage, as outlined in the OIC Emergency Order above, except where self-funded groups opt out of that coverage. Coding should be consistent with** https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf	
Molina	Yes 04/01/20	Molina COVID Resource Page	Health plan has no Self-insured plan sponsors.
Pacific Source	Most 03/27/20	Provider page (link available on page to download COVID FAQ).	PacificSource is also covering all outpatient, urgent care and emergency room visits, testing and radiology (applicable chest x-rays) at 100%, if billed with a COVID-19 DX (B342, B9729, U071, Z03818, Z20828). If the patient is admitted to the hospital, regular member benefits apply. Self-insured plan sponsors will be able to opt-in to this program at their discretion.
Premera	Most 03/27/20	COVID Provider page	Premera will cover 100% of the cost of the COVID-19 lab and other diagnostic test panels and the associated visit resulting in no cost share for the fully insured members. Premera and LifeWise Health Plan of Washington customers will pay nothing out of pocket for treatment of COVID-19 or health complications associated with COVID-19, including in-patient and out-patient hospital admissions, urgent care and emergency room visits, medical transport when needed, and FDA-approved in-patient medications for both in and out of network providers. The company previously announced that it would waive cost shares for COVID-19 testing. Self-funded employer groups will apply this approach but may opt out of this arrangement.
Providence	Most 04/01/20		Most - We are supporting self-insured plan sponsors who choose to implement the same or similar coverage, however, self-insured plan sponsors are able to opt-out of this coverage at their discretion.
Regence	Most	COVID resource page	

For all patients that meet the CDC criteria, plans will cover 100% of the cost, without patient deductible or cost share, of • **COVID test** • **Diagnostic test panels for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV), when any of this testing is determined medically necessary by the enrollee's health care provider** • **Testing related visit in the outpatient or Emergency Department setting**			
Follow Consensus Direction?		**Health plans provide 100% coverage, as outlined in the OIC Emergency Order above, except where self-funded groups opt out of that coverage. Coding should be consistent with** https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf	
	03/27/20	Scroll down to COVID Testing	
UHC	Most 03/27/20		UnitedHealthcare is waiving member costs for COVID-19 testing provided at approved locations in accordance with the U.S. Centers for Disease Control and Prevention (CDC) guidelines. This coverage applies to Medicare and Medicaid members as well as our commercial insured members. We are also supporting self-insured employer customers who chose to implement similar actions.

Under the Emergency Order, some health plans will cover the entire cost, prior to deductible and with no patient cost share, of HCPS U0002 (COVID testing), CPT 87635 (COVID testing), Diagnostic test panels for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV) and, in the outpatient setting, the associated E&M visit			
In situations where the testing is billed by the lab and the E&M visit is billed by the provider, how should providers submit the claim with the E&M visit -- so that it is clear that E&M visit is to be covered under the Emergency Order (since the testing will be billed by the lab)?			
Follow Consensus Direction?		**Follow coding guidelines of the health plan and submit the claim with the appropriate diagnosis after the testing has come back** • **Diagnosis Code used should be consistent with** https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf • **HCPS U0002 is for dates of service on or after February 4, 20200 and CPT 87635 for dates of service after March 13.** **When coding a COVID-covered claim, providers are not able to differentiate between the following two scenarios: 1) E&M visit is related to COVID/Diagnostic panel testing, and 2) E&M visit is related to COVID care once the testing is completed. The health plan will need to make this determination. Some health plans may pend these claims for manual processing so that they can determine which claim is paid under the order and which is paid under the patient's standard benefits.**	
Aetna	Yes 03/27/20	Aetna COVID page Scroll down to • 'What CPT, HCPS, ICD-10 and other codes should I be aware of related to COVID-19?" & to • "What Common Procedural Technology (CPT) codes should be used for COVID-19 testing?	
Amerigroup	Yes 03/27/20	Medicaid MCO members have no cost sharing or copays so no cost sharing or copays would be deducted from the amount reimbursed to the provider	
CHPW	Yes 03/27/20	We expect the CR modifier, or one of the COVID diagnosis or related diagnosis put out by CDC	
Cigna	Yes 03/27/20	COVID response page – Under 'Interim Billing Guidelines' scroll to 'General billing guidance for COVID-19 related services' section.	
Coordinated Care	Yes 03/27/20	For Apple Health - HCA COVID billing guidelines	Providers should bill the appropriate E/M code with the appropriate diagnosis codes including U07.1 and those found in the link attached.

Under the Emergency Order, some health plans will cover the entire cost, prior to deductible and with no patient cost share, of HCPS U0002 (COVID testing), CPT 87635 (COVID testing), Diagnostic test panels for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV) and, in the outpatient setting, the associated E&M visit			
In situations where the testing is billed by the lab and the E&M visit is billed by the provider, how should providers submit the claim with the E&M visit -- so that it is clear that E&M visit is to be covered under the Emergency Order (since the testing will be billed by the lab)?			
Follow Consensus Direction?		**Follow coding guidelines of the health plan and submit the claim with the appropriate diagnosis after the testing has come back** • **Diagnosis Code used should be consistent with** https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf • **HCPS U0002 is for dates of service on or after February 4, 20200 and CPT 87635 for dates of service after March 13.** **When coding a COVID-covered claim, providers are not able to differentiate between the following two scenarios: 1) E&M visit is related to COVID/Diagnostic panel testing, and 2) E&M visit is related to COVID care once the testing is completed. The health plan will need to make this determination. Some health plans may pend these claims for manual processing so that they can determine which claim is paid under the order and which is paid under the patient's standard benefits.**	
		For Marketplace plan, for claim billed without the COVID-19 lab tests, screening related claims with diagnosis codes Z20.828 and Z03.818 will be covered with $0 member liability.	
First Choice (TPA and PPO)	Yes 03/27/20	When COVID-19 diagnosis code U07.1 is appropriately coded with an E&M code, this will indicate it's for COVID-19. If U07.1 is not effective or appropriate due to an initial visit, then refer to the recommended diagnosis coding from the CDC.	
HCA – Apple Health	N.A. 04/08/20	All services covered at 100% of the allowed and patient cannot be balance billed.	
KP-NW **KP-WA**	Yes 04/01/20	The provider should bill with the appropriate screening diagnosis associated with COVID-19 to include relevant ICD-10 infection codes. Additionally, we have established provider reconsideration processes if a provider believes the claim was paid incorrectly.	
Labor & Industries	N.A. 04/08/20	If due to work exposure, all services are covered regardless of the order in which they are submitted.	

Under the Emergency Order, some health plans will cover the entire cost, prior to deductible and with no patient cost share, of HCPS U0002 (COVID testing), CPT 87635 (COVID testing), Diagnostic test panels for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV) and, in the outpatient setting, the associated E&M visit			
In situations where the testing is billed by the lab and the E&M visit is billed by the provider, how should providers submit the claim with the E&M visit -- so that it is clear that E&M visit is to be covered under the Emergency Order (since the testing will be billed by the lab)?			
Follow Consensus Direction?		**Follow coding guidelines of the health plan and submit the claim with the appropriate diagnosis after the testing has come back** • **Diagnosis Code used should be consistent with** https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf • **HCPS U0002 is for dates of service on or after February 4, 20200 and CPT 87635 for dates of service after March 13.** **When coding a COVID-covered claim, providers are not able to differentiate between the following two scenarios: 1) E&M visit is related to COVID/Diagnostic panel testing, and 2) E&M visit is related to COVID care once the testing is completed. The health plan will need to make this determination. Some health plans may pend these claims for manual processing so that they can determine which claim is paid under the order and which is paid under the patient's standard benefits.**	
Medicaid FFS	Yes 03/27/20	For providers that can bill for an E/M service, the testing is part of the E/M service. If the client comes in to the provider's office just for the specimen collection, then the provider can bill 99211 for the service.	
Molina	Yes 04/01/20	Molina COVID Resource Page	Providers should include the appropriate ICD-10 diagnosis code (B97.29, U07.1, Z03.818, Z20.828) with the E&M code for the visit Molina will follow the same process for all programs
Pacific Source	Yes 03/27/20		
Premera	Yes 03/27/20	When the provider can provide a diagnosis of COVID-19, U07.1, the diagnosis should be billed on the claims for the E&M visit. However, since the initial visit is to diagnose the patient, the COVID-19 is not expected to be available at the time of the visit. When the COVID-19 diagnosis is not available, the E&M code should be billed with one of the appropriate ICD-10	

Under the Emergency Order, some health plans will cover the entire cost, prior to deductible and with no patient cost share, of HCPS U0002 (COVID testing), CPT 87635 (COVID testing), Diagnostic test panels for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV) and, in the outpatient setting, the associated E&M visit			
In situations where the testing is billed by the lab and the E&M visit is billed by the provider, how should providers submit the claim with the E&M visit -- so that it is clear that E&M visit is to be covered under the Emergency Order (since the testing will be billed by the lab)?			
Follow Consensus Direction?		**Follow coding guidelines of the health plan and submit the claim with the appropriate diagnosis after the testing has come back** • **Diagnosis Code used should be consistent with** https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf • **HCPS U0002 is for dates of service on or after February 4, 20200 and CPT 87635 for dates of service after March 13.** **When coding a COVID-covered claim, providers are not able to differentiate between the following two scenarios: 1) E&M visit is related to COVID/Diagnostic panel testing, and 2) E&M visit is related to COVID care once the testing is completed. The health plan will need to make this determination. Some health plans may pend these claims for manual processing so that they can determine which claim is paid under the order and which is paid under the patient's standard benefits.**	
		diagnosis codes related to possible COVID-19 exposure as defined by the CDC. Premera will waive the cost share associated with the initial E&M visit when the visit is billed on the same claim as the COVID-19 lab testing. When the E&M visit is billed separately, a review will be done to identify the testing related visit. When the related visit is not identified, the E&M claim will be adjusted as identified by the provider or the member.	
Providence	Yes 04/01/20	No cost share for E&M visits associated with testing billed with HPCS codes U0001, U0002 or CPT code 87365, regardless of dx code.	
Regence	Yes 03/27/20	The associated E&M visit should be billed with diagnosis code U07.1. There may be additional recommended billing guidelines as we begin to receive more COVID-19 coded claims.	

Under the Emergency Order, some health plans will cover the entire cost, prior to deductible and with no patient cost share, of HCPS U0002 (COVID testing), CPT 87635 (COVID testing), Diagnostic test panels for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV) and, in the outpatient setting, the associated E&M visit			
In situations where the testing is billed by the lab and the E&M visit is billed by the provider, how should providers submit the claim with the E&M visit -- so that it is clear that E&M visit is to be covered under the Emergency Order (since the testing will be billed by the lab)?			
Follow Consensus Direction?		**Follow coding guidelines of the health plan and submit the claim with the appropriate diagnosis after the testing has come back** • **Diagnosis Code used should be consistent with** https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf • **HCPS U0002 is for dates of service on or after February 4, 20200 and CPT 87635 for dates of service after March 13.** **When coding a COVID-covered claim, providers are not able to differentiate between the following two scenarios: 1) E&M visit is related to COVID/Diagnostic panel testing, and 2) E&M visit is related to COVID care once the testing is completed. The health plan will need to make this determination. Some health plans may pend these claims for manual processing so that they can determine which claim is paid under the order and which is paid under the patient's standard benefits.**	
UHC			

When do you anticipate that providers should submit claims to you for COVID testing?			
Follow Consensus Direction?		**Claims can be submitted now, in some cases, the health plan will hold claims until the systems are configured (with pricing) to process the claims accurately**	
Aetna	Now 03/27/20	For Coding Guidelines, see Aetna's Response to the previous question.	
Amerigroup	Now 03/27/20	Provider can submit claims for COVID testing (retroactive to 2/4/20 dates of service) at any time. Amerigroup will hold claims until our systems are configured to process the claims accurately.	
CHPW	Now 03/27/20	Provider can bill for dates of service 02/01/2020 and forward.	
Cigna	04/01 03/27/20	Laboratories are asked to hold any claims for COVID-19 using code this until April 1, 2020 to ensure proper reimbursement.	

When do you anticipate that providers should submit claims to you for COVID testing?			
Follow Consensus Direction?		**Claims can be submitted now, in some cases, the health plan will hold claims until the systems are configured (with pricing) to process the claims accurately**	
Coordinated Care	Now 03/27/20	The new codes are loaded in our system and will be processed accordingly. If you submitted claims previously that rejected, please resubmit your claim.	
First Choice (TPA and PPO)	Now 03/27/20	Codes are loaded. Claims may be processed manually until system set up is complete.	
HCA – Apple Health			
KP-NW	Now 04/01/20	Our systems are currently configured to accept COVID testing claims	
KP-WA	Now 04/01	Our systems are currently configured to accept COVID testing claims	
Labor & Industries			
Medicaid FFS	Now 03/27/20	Provider can submit claims for COVID testing (retroactive to 2/4/20 dates of service) at any time. Some claims may need to be resubmitted for dual eligible clients.	
Molina	Now 04/01/20	Claims can be submitted for COVID testing retroactive to the 2/4/20 date of service	
Pacific Source	Now 03/27/20	Submit claims using the correct CPT codes; claims that are denied should be resubmitted with the correct codes.	
Premera	Now 03/27/20		
Providence	Now 04/01/20	Our systems are currently configured to accept COVID testing claims	
Regence	Now 03/27/20	Our systems are currently accepting claims.	
UHC	04/01 03/27/20	We ask that care providers hold claims for processing until April 1, 2020.	

If a claim was billed for COVID testing after the order (March 5th) and it was billed with an incorrect code how should it be rebilled so that it is adjudicated under the order?			
Follow Consensus Direction?		**To the extent a claim was submitted with incorrect coding, it should be rebilled following the standard rebilling process with the corrected diagnosis and procedure codes.** (CDC COVID-19 coding guidelines)	
Aetna	Yes 03/27/20	To the extent a claim was submitted with incorrect coding and reimbursement was not received in accordance with the OIC's COVID19 Emergency Order, please submit a corrected claim. For Coding Guidelines, see Aetna's Response to the previous question.	
Amerigroup	Yes 03/27/20	Amerigroup Provider Page under "Provider Resources & Documents" includes instructions on submission of corrected claims.	
CHPW	Yes 03/27/20		
Cigna			
Coordinated Care	Yes 03/27/20	If the provider feels the claim was not adjudicated probably based on evolving guidance, they can submit a corrected claim within the timeframes specified in their contract or in our Provider Handbook for reprocessing. They may also call our Customer Service Center to ask us to review their claim if they don't feel it was processed correctly as billed.	
First Choice (TPA and PPO)	Yes 04/01/20	Please follow the corrected claim process and submit a corrected claim with the appropriate coding.	
HCA – Apple Health			
KP-NW **KP-WA**	Yes 03/27/20	If a claim was coded incorrectly and does not have the expected adjudication aligning with the COVID-19 emergency order, please follow the normal process to submit a revised claim for re-adjudication or to follow the provider reconsideration process, as appropriate.	
Labor & Industries			
Medicaid FFS	Yes 03/27/20	The addition of the CR modifier to the claim will allow the claim to pay.	

If a claim was billed for COVID testing after the order (March 5th) and it was billed with an incorrect code how should it be rebilled so that it is adjudicated under the order?			
Follow Consensus Direction?		**To the extent a claim was submitted with incorrect coding, it should be rebilled following the standard rebilling process with the corrected diagnosis and procedure codes.** (CDC COVID-19 coding guidelines)	
Molina	Yes 04/01/20	Providers should submit a corrected claim and include one of the following ICD-10's: B97.29, U07.1, Z03.818, Z20.828	
Pacific Source			
Premera	Yes 03/27/20	This Probably depends on whether the claim was paid or denied or something else. More than likely the diagnosis and lab test codes were not established for some of the prior submissions so if the claim was paid, I am not sure they need total resubmit. If the claim was denied, I think the reason for the denial would determine whether to rebill or not. If the "rebill" reason is to remove member cost share, then the provider should be coding the claim correctly. If services were performed after the date of the order (3/5/2020 WA, 3/3/2020 AK), then the provider could rebill using the new COVID-19 lab testing codes U0001, U0002. If the services were performed prior to the date of the order, there would be no adjustment needed as the cost shares are being waived if services are performed as of the date of the order.	
Providence	Yes 04/01/20		
Regence	Yes 03/27/20	Providers must bill as directed by the CDC interim guidelines (https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf) or with the new ICD-10 code (U07.1). We expect anticipate corrected claims may need to be submitted.	
UHC			

Consensus Direction

New providers that are Washington Licensed/DOH approved or are registered in DOH's volunteer health practitioner system can bill for services under one of the following policies/practices. Health Plans will indicate which of the below policies/practices they adopt – RC, LT, or Both.

1) Retro-Credentialing (RC): Once a provider is credentialed, services that they provided on or after the date of completion of credentialing application can be billed

   - Expedited Credentialing: Health Plans will expedite the credentialing process for providers that are filling positions to meet the demand of the current COVID crisis. Providers should complete the standard credentialing application and contact the health plan's provider relations team to request expedited credentialing
   - Effective Billing Date: Upon successful completion of the credentialing process, the provider's effective date for the purpose of billing will be the same as the date that their application was received by the health plan as complete.

     Claims for services rendered by providers being credentialed should be submitted not earlier than 30 days past the credentialing approval date to allow the health plan system to be set up.

     Any claims submitted for services rendered by provider being credentialed prior to this timeframe will be paid as out of network, something else:

AND/OR

2) Locum Tenens (LT): The provider will fall under locum tenens and their services can be billed.

   A provider can identify and authorize care for his or her patients by another provider for at least 90 days, and ideally 180 day, while the authorizing provider continues to treat patients at the organization. During the period, the provider organization can bill for locum tenes provider services and the locum tenens provider can be going through expedited credentialing.

   Locum Tenens applies to all provider organizations whether or not they have delegated credentialing.

As provider organizations that do not have delegated credentialing bring on new providers to address the COVID demands, are there policies/practices under which the new provider can bill the health plan sooner rather than later?			
Follow Consensus Direction?		**New providers that are Washington Licensed/DOH approved or are registered in DOH's volunteer health practitioner system can bill for services under one of the following policies/practices. Health Plans will indicate which of the policies/practices they adopt – Retro-Credentialing, Locum Tenes or Both.**	
Aetna			
Amerigroup			
CHPW	Locum Tenes 04/02/20	• Paying providers who are qualified – locums and not necessarily locums. • We are paying non-credentialed but qualified providers during this crisis. • Additionally, we have expedited credentialing.	
Cigna			
Coordinated Care			
First Choice (TPA and PPO)			
HCA-Apple Health			
KP-NW			
KP-WA			
Labor & Industries			
Medicaid FFS			
Molina	Locum Tenes 04/10/20	This will include temporary providers joining contracted and non-contracted provider groups/facilities. Molina COVID Resource Page Scroll down to 'Provider Credentialing'	
Pacific Source			
Premera			
Providence			
Regence			
UHC			

B) Alternative Treatment Locations

Are ED services provided in tents and patient cars covered and if so, how should they be billed?			
Follow Consensus Direction?		**Tents and/or patient cars located in close proximity to the ED in which ED staff provide COVID care or non-COVID care will be considered extensions of the ED. Claims for that care should use Place of Service Code – 23 Emergency Room – Hospital, with Modifier CR for professional billing and Condition Code DR for institutional billing.**	
Aetna	Yes 03/27/20		
Amerigroup	Yes 04/01/20	If services are provided in a tent located in close proximity to the ED and the ED staff provides COVID care or non-COVID care, it will be considered extensions of the ED- POS 23. Professional services use CR modifier. For facility fee use modifier DR.	
CHPW	Yes 03/27/20		
Cigna			
Coordinated Care	Yes 03/27/20	Tents and cars in proximity to the facility will be considered an extension of the facility and paid accordingly. We follow all HCA and CMS guidance in this regard.	
First Choice (TPA and PPO)	Yes 03/27/20		
HCA – Apple Health			
KP-NW	Yes 03/27/20	When billing, the Place of Service codes should align most closely with the facility, staff and/or function being performed at that care site.	
KP-WA			
Labor & Industries			
Medicaid FFS	Yes 03/27/20	If services are provided in a tent or in a patient car that is located in proximity to, or as an extension of the emergency room, use POS 23 and the CR modifier for all professional services and use the DR modifier for the facility fee.	
Molina	Yes 04/01/20	Providers should bill POS 23 for hospital parking lot, POS 15 is also allowed for cars	

Are ED services provided in tents and patient cars covered and if so, how should they be billed?			
Follow Consensus Direction?		**Tents and/or patient cars located in close proximity to the ED in which ED staff provide COVID care or non-COVID care will be considered extensions of the ED. Claims for that care should use Place of Service Code – 23 Emergency Room – Hospital, with Modifier CR for professional billing and Condition Code DR for institutional billing.**	
Pacific Source	Yes 03/27/20		
Premera	Yes 03/27/20		
Providence	Yes 04/01/20		
Regence	Yes 03/27/20		
UHC			

Are outpatient services provided in patient cars covered and if so, how should they be billed?			
Follow Consensus Direction?		Patient cars located in the parking lot of a clinic in which clinic staff provide COVID care or non-COVID care will be considered extensions of the clinic. Claims for that care should use Place of Service Code as follows: • 15 – Mobile: If the car is used as a drive up COVID testing site where a specimen is taken • 11 – Office: If the clinic is not hospital owned • 19 – Off Campus – Outpatient Hospital: If the clinic is hospital owned but not on the hospital campus	
Aetna	Yes 03/27/20	Aetna recognizes place of service codes: 11 (physician office), 15 (mobile unit), 17 (Walk-in retail health clinic), 19 (off campus outpatient hospital), 20 (urgent care facility), 22 (on campus outpatient hospital), 23 (emergency room hospital, and 81 (independent laboratory).	
Amerigroup	??? 03/24/20	Amerigroup will follow HCA guidance for Medicaid MCOs and is consulting with HCA on this question.	

Are outpatient services provided in patient cars covered and if so, how should they be billed?			
Follow Consensus Direction?		Patient cars located in the parking lot of a clinic in which clinic staff provide COVID care or non-COVID care will be considered extensions of the clinic. Claims for that care should use Place of Service Code as follows: • 15 – Mobile: If the car is used as a drive up COVID testing site where a specimen is taken • 11 – Office: If the clinic is not hospital owned • 19 – Off Campus – Outpatient Hospital: If the clinic is hospital owned but not on the hospital campus	
CHPW	Yes 03/27/20		
Cigna			
Coordinated Care	Yes 03/27/20	We follow the Medicaid FFS guidance below.	
First Choice (TPA and PPO)	Yes 03/27/20		
HCA – Apple Health			
KP-NW **KP-WA**	Yes 03/27/20	When billing, the Place of Service codes should align most closely with the facility, staff and/or function being performed at that care site.	
Labor & Industries			
Medicaid FFS	Yes 03/27/20	Patient cars located in the parking lot of a clinic in which clinic staff provide COVID care or non-COVID care will be considered extensions of the clinic. Claims for that care should use Place of Service Code as follows: • When collecting specimens to test for COVID-19 that is not associated with an E/M visit HCA is allowing CPT code 99001 to be billed. • Bill with the POS that is most relevant for the situation (typically the POS you currently bill with): - For provider clinics that are not hospital owned, use POS 11 with CR modifier	

Are outpatient services provided in patient cars covered and if so, how should they be billed?			
Follow Consensus Direction?		Patient cars located in the parking lot of a clinic in which clinic staff provide COVID care or non-COVID care will be considered extensions of the clinic. Claims for that care should use Place of Service Code as follows: • 15 – Mobile: If the car is used as a drive up COVID testing site where a specimen is taken • 11 – Office: If the clinic is not hospital owned • 19 – Off Campus – Outpatient Hospital: If the clinic is hospital owned but not on the hospital campus	
		- For hospital owned/associated and off campus, use POS 19 and the CR modifier - For visits outside of emergency rooms, use POS 23 and the CR modifier For visits in drive up sites that do not fit in the examples above, use the POS 15 and the CR modifier.	
Molina	Yes 04/01/20	POS 15 is allowed for cars, POS 99 can also be submitted	
Pacific Source	Yes 03/27/20		
Premera	Yes 03/27/20		
Providence	Yes 04/01/20		
Regence	Yes 03/27/20		
UHC			

Are services provided in non-licensed space and/or non-licensed beds covered and if so, how should they be billed?			
Follow Consensus Direction?		**Claims for services to COVID and non-COVID patient provided in non-licensed space and/or non-licensed beds should be submitted with the Place of Service Code most closely associated with the staff/function being performed in that space/bed as if the space/bed was licensed.** **If the additional space is on hospital grounds, then the sponsoring hospital site of service and all policies and procedures would apply. If the additional space were off a hospital campus such as a naval ship or large tented or other temporary structure then the policies and procedures of the sponsoring organization would apply.**	
Aetna	Yes 03/27/20	Aetna recognizes place of service codes: 11 (physician office), 15 (mobile unit), 17 (Walk-in retail health clinic), 19 (off campus outpatient hospital), 20 (urgent care facility), 22 (on campus outpatient hospital), 23 (emergency room hospital, and 81 (independent laboratory).	
Amerigroup	??? 03/24/20	Amerigroup will follow HCA guidance for Medicaid MCOs and is consulting with HCA on this question.	
CHPW	Yes 03/27/20		
Cigna			
Coordinated Care	Yes 03/27/20	CCW is following all HCA and CMS guidance, or OIC mandates.	
First Choice (TPA and PPO)	Yes 04/01/20		
HCA – Apple Health			
KP-NW **KP-WA**	Yes 03/27/20	When billing, the Place of Service codes should align most closely with the facility, staff and/or function being performed at that care site.	
Labor & Industries			
Medicaid FFS	Varies 03/27/20	Medicaid is currently determining how these will be covered and billed. It would be based on services being rendered in those beds/spaces	

Are services provided in non-licensed space and/or non-licensed beds covered and if so, how should they be billed?			
Follow Consensus Direction?		**Claims for services to COVID and non-COVID patient provided in non-licensed space and/or non-licensed beds should be submitted with the Place of Service Code most closely associated with the staff/function being performed in that space/bed as if the space/bed was licensed.** **If the additional space is on hospital grounds, then the sponsoring hospital site of service and all policies and procedures would apply. If the additional space were off a hospital campus such as a naval ship or large tented or other temporary structure then the policies and procedures of the sponsoring organization would apply.**	
Molina	Yes 04/01/20	Molina will follow all HCA and CMS guidance, and OIC mandates.	
Pacific Source	Yes 03/27/20		
Premera	Yes 03/27/20		
Providence	Yes 04/01/20		
Regence	Yes 03/27/20		
UHC			

Is SNF care provided in a licensed hospital to COVID patients in non-licensed beds covered and if so, how should they be billed?			
Follow Consensus Direction?		**Claims for services to COVID patients where the SNF level care is being delivered to patients in a licensed hospital in non-licensed/uncertified beds should be submitted with the most appropriate bed type that represents the level of care of service. Optionally, condition code DR would be reported in field 18 of the UB form. Coverage is dependent up a patient have a SNF Benefit.** **The sponsoring hospital site of service and all policies and procedures would apply.**	
Aetna			
Amerigroup			
CHPW			

Is SNF care provided in a licensed hospital to COVID patients in non-licensed beds covered and if so, how should they be billed?			
Follow Consensus Direction?		**Claims for services to COVID patients where the SNF level care is being delivered to patients in a licensed hospital in non-licensed/uncertified beds should be submitted with the most appropriate bed type that represents the level of care of service. Optionally, condition code DR would be reported in field 18 of the UB form. Coverage is dependent up a patient have a SNF Benefit.** **The sponsoring hospital site of service and all policies and procedures would apply.**	
Cigna			
Coordinated Care			
First Choice (TPA and PPO)			
HCA – Apple Health			
KP-NW			
KP-WA			
Labor & Industries			
Medicaid FFS			
Molina	Yes 04/10/20	Hospitals should submit rev code 0191 for SNF level of care	
Pacific Source			
Premera			
Providence			
Regence			
UHC			

C) Telehealth

For Plans that are regulated by the Office of the Insurance Commissioner, e.g. Commercial fully insured plans

"From March 26 until April 24, in network providers will be paid at the same rate when providing services via telemedicine as they are paid for providing the same services in-person (payment parity)"

- Proclamation. Telemedicine Proc
- See Section 1 of ESSB Bill 5385 for patients and services that qualify: Telemedicine Bill

Will a telemedicine visit for a care service be paid at the same rate as an in-person visit for that same care service?

Follow Consensus Direction?		**In-network providers will be paid at the same rate when providing services via telemedicine as they are paid for providing the same services in-person (payment parity)**	
Aetna	Yes 03/27/20	In-network providers will be paid for a health care service provided through telemedicine at the same rate as if the health care service was provided in person by a provider in accordance with Gov. Proclamation 20-29. Aetna's telemedicine policy is available to providers on the NaviNet and Availity portals.	
Amerigroup	Yes 03/27/20		
CHPW	Yes 03/27/20		
Cigna	Most 03/27/20	Allow providers to bill any code on their existing fee schedule virtually and be reimbursed at face-to-face rates. COVID Provider page Scroll down to "Interim Billing Guidelines" and Select • "Virtual Care Guidelines" • "General Billing Guidance for both COVID and Non-COVID care Self-insured plan sponsors will be able to opt-out of this program at their discretion.	

For Plans that are regulated by the Office of the Insurance Commissioner, e.g. Commercial fully insured plans

"From March 26 until April 24, in network providers will be paid at the same rate when providing services via telemedicine as they are paid for providing the same services in-person (payment parity)"

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- See Section 1 of ESSB Bill 5385 for patients and services that qualify: Telemedicine Bill

Will a telemedicine visit for a care service be paid at the same rate as an in-person visit for that same care service?

Follow Consensus Direction?		**In-network providers will be paid at the same rate when providing services via telemedicine as they are paid for providing the same services in-person (payment parity)**	
Coordinated Care	Yes 03/27/20		
First Choice (TPA and PPO)	Varies by our Payers' Plans 03/27/20	First Choice Health is a PPO network that does not define the benefits. Please reach out to the individual Payers to confirm benefits. As an administrator for our self-funded health Plans, we are complying with the Families First Coronavirus Act, specifically the "Health Provisions".	
HCA – Apple Health	Yes 03/27/20		
KP-NW	Yes 03/27/20		
KP-WA	Most 03/27/20	Self-insured plan sponsors will be able to opt-out of this program at their discretion.	
Labor & Industries	Yes 03/27/20	If an E&M code allows for telephone/telehealth, telehealth visit for the E&M code is reimbursed at the same rate as the in-person version. And it is coded with POS = 2.	
Medicaid FFS	Yes 03/27/20		
Molina	Yes 03/27/20	Molina Billing Policy	
Pacific Source	Most 03/27/20	Self-insured plan sponsors will be able to opt-out of this program at their discretion.	

For Plans that are regulated by the Office of the Insurance Commissioner, e.g. Commercial fully insured plans "From March 26 until April 24, in network providers will be paid at the same rate when providing services via telemedicine as they are paid for providing the same services in-person (payment parity)" • Proclamation. Telemedicine Proc • See Section 1 of ESSB Bill 5385 for patients and services that qualify: Telemedicine Bill			
Will a telemedicine visit for a care service be paid at the same rate as an in-person visit for that same care service?			
Follow Consensus Direction?		**In-network providers will be paid at the same rate when providing services via telemedicine as they are paid for providing the same services in-person (payment parity)**	
Premera	Most 03/27/20	-funded employer groups will apply this approach but may opt out of this arrangement.	
Providence	Most 03/27/20	We are supporting self-insured plan sponsors who choose to implement the same or similar coverage, however, self-insured plan sponsors are able to opt-out of this coverage at their discretion.	
Regence	Most 03/27/20	Providers should refer to our websites for the most current information and Virtual Care Reimbursement Policy: • Regence COVID • Asuris COVID • BridgeSpan COVID	Regence is temporarily expanding the services that can be offered by in-network providers via telehealth. The visits are considered the same as in-person visits and are paid consistently with in-person visits. Under this expansion for claims to process correctly, claims must be submitted with POS 11 or IOP and the GT modifier. (Note: To receive reimbursement consistent with an in-office visit, the POS must be either 11 or IOP. The GT modifier will indicate that the services were rendered via telehealth.)

For Plans that are regulated by the Office of the Insurance Commissioner, e.g. Commercial fully insured plans "From March 26 until April 24, in network providers will be paid at the same rate when providing services via telemedicine as they are paid for providing the same services in-person (payment parity)" • Proclamation. Telemedicine Proc • See Section 1 of ESSB Bill 5385 for patients and services that qualify: Telemedicine Bill			
Will a telemedicine visit for a care service be paid at the same rate as an in-person visit for that same care service?			
Follow Consensus Direction?		**In-network providers will be paid at the same rate when providing services via telemedicine as they are paid for providing the same services in-person (payment parity)**	
			We will continue to cover the medical and behavioral health codes, as outlined in our Virtual Care Reimbursement Policy. However, providers should submit the codes in the policy with POS 11 or IOP and the GT modifier to be reimbursed consistent with an in-person visit.
UHC	Most 03/27/20	We are also supporting self-insured employer customers who chose to implement similar actions.	

Per HHS announcement re telehealth: www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html			
Are you following the HHS guidelines for the methods that will be considered telehealth (e.g. SKYPE, Facetime, etc.)? How should they be billed?			
Follow Consensus Direction?		**Methods of interactions between providers and COVID & non-COVID patient outlined in the announcement (e.g. SKYPE, Facetime, etc.) would be considered telehealth and should be billed appropriately in accordance with CMS guidelines**	
Aetna	Yes 03/30/20	Aetna COVID page	

Per HHS announcement re telehealth: www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html			
Are you following the HHS guidelines for the methods that will be considered telehealth (e.g. SKYPE, Facetime, etc.)? How should they be billed?			
Follow Consensus Direction?		**Methods of interactions between providers and COVID & non-COVID patient outlined in the announcement (e.g. SKYPE, Facetime, etc.) would be considered telehealth and should be billed appropriately in accordance with CMS guidelines**	
		Scroll down to 'What code would be used if a physician performs a telehealth visit?"	
Amerigroup			
CHPW	Yes 03/27/20		
Cigna			
Coordinated Care	Yes 03/27/20		
First Choice (TPA and PPO)	Yes 03/27/20		
HCA – Apple Health			
KP-NW **KP-WA**	Yes 03/27/20	We don't place restrictions on the platforms used by our contracted providers to deliver telemedicine services, however, providers must bill in accordance with CMS telehealth billing guidelines.	
Labor & Industries			
Medicaid FFS	Some 03/27/20	Zoom https://www.hca.wa.gov/hca-offers-limited-number-no-cost-telehealth-technology-licenses-providers.	
Molina	Yes 03/27/20	See Molina COVID Resource Page Scroll down to Molina's detailed COVID-19 Telehealth Billing Policy & follow link for additional details by program (Medicaid, Marketplace, Medicare)	

Per HHS announcement re telehealth: www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html			
Are you following the HHS guidelines for the methods that will be considered telehealth (e.g. SKYPE, Facetime, etc.)? How should they be billed?			
Follow Consensus Direction?		**Methods of interactions between providers and COVID & non-COVID patient outlined in the announcement (e.g. SKYPE, Facetime, etc.) would be considered telehealth and should be billed appropriately in accordance with CMS guidelines**	
Pacific Source	Yes 03/27/20		
Premera	Yes 03/27/20	Premera Telehealth	The 2020 CPT code book contains significant new guidance on telehealth services as well and should be a standard reference.
Providence	Yes 03/27/20	Effective March 6, 2020 Providence Health Plan has enacted a temporary emergency policy to reimburse contracted providers for telehealth services without requiring an originating site. Providers may be paid for services performed by two-way video connections where the patient is calling from a personal device. No contract amendments or provider attestations will be required for reimbursement under this emergency policy. Our contracted providers may access this emergency policy to learn more by visiting the ProvLink provider portal at Providence Login.	
Regence	Yes 03/27/20	We are following the U.S. Department of Health and Human Services' guidance with respect to HIPAA compliant platform requirements (e.g. SKYPE, Facetime, etc. are allowed).	
UHC			

Will a phone call with a patient be considered telehealth if there is no video feed, i.e. just voice interaction over the phone? If so, how should it be billed?			
Answer to Question:			
Aetna	Yes 03/30/20	Aetna allows in-network Washington providers to use non-HIPAA compliant communication platforms to provide patient care in accordance with Emergency Order 20-02. The use of audio-only telephone as telemedicine is permitted at this time.	
Amerigroup	Yes 03/24/20	Amerigroup will follow HCA guidance for Medicaid MCOs. Billing guidance for Medicaid providers are in the HCA FAQ. This includes temporary coverage of codes for telephone evaluation and management when extraordinary circumstances, as defined by HCA, are involved.	
CHPW	Yes 03/27/20	CHPW is allowing telephone services based on HCA and the CMS guidelines. We are also paying these services at the E&M level of care, versus the lower telephone rate.	
Cigna			
Coordinated Care	Yes 03/27/20	CCW reimburses for telephone calls using codes 99441-99423 following HCA policy.	
First Choice (TPA and PPO)	Yes 03/27/20	In order for services to be considered as telehealth, they must be billed with either telehealth modifier 95 for CPT codes in appendix P of the AMA CPT Book, or modifier GQ/GT for HCPA codes in the CMS Telehealth Code List for 2020, or Place of Service 02. See the links below for these resources. AMA Tele Guide AMA CPT Reporting CMS Tele Services	
HCA – Apple Health			
KP-NW **KP-WA**	In Some Cases 03/27/20	Depending on how the communication occurs (e.g., Skype audio vs. traditional telephone) the service could be billed via CMS telemedicine billing guidelines or CMS billing guidelines for telephone services (99441-99443). KP will also follow all OIC mandates.	
Labor & Industries	No 04/12/20		

<table>
<tr><th colspan="4">Will a phone call with a patient be considered telehealth if there is no video feed, i.e. just voice interaction over the phone? If so, how should it be billed?</th></tr>
<tr><th colspan="4">Answer to Question:</th></tr>
<tr><td>Medicaid FFS</td><td>In Some Cases 03/27/20</td><td>The following codes are to be used when current practice for providing services is not an option (face to face, telemedicine) and there are extraordinary circumstances involved.

<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>99441</td><td>Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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</td></tr>
<tr><td>99442</td><td>Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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; 11-20 minutes of medical discussion</td></tr>
<tr><td>99443</td><td>Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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; 21-30 minutes of medical discussion</td></tr>
<tr><td>99421</td><td>Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes</td></tr>
</table></td><td></td></tr>
</table>

Will a phone call with a patient be considered telehealth if there is no video feed, i.e. just voice interaction over the phone? If so, how should it be billed?			
Answer to Question:			
		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	
Molina	Yes 03/27/20	See Molina COVID Resource Page Scroll down to Molina's detailed COVID-19 Telehealth Billing Policy & follow link for additional details by program (Medicaid, Marketplace, Medicare)	
Pacific Source	TBD 03/27/20	Currently evaluating phone-only services.	
Premera	Yes 03/27/20	Premera Telehealth	The 2020 CPT code book contains significant new guidance on telehealth services as well and should be a standard reference.
Providence	Yes 04/01/20	PHP will reimburse contracted providers for telephone calls based on guidelines in Payment Policy 92.0 on ProvLink. For the duration of the Covid-19 crisis, these services may be billed for both new and established patients. Contracted providers may access our telehealth policies by visiting the ProvLink provider portal at Providence Login.	
Regence	Yes 03/27/20	For claims to process correctly, claims must be submitted with POS 11 or IOP and the GT modifier. (Note: To receive reimbursement consistent with an in-office visit,	

Will a phone call with a patient be considered telehealth if there is no video feed, i.e. just voice interaction over the phone? If so, how should it be billed?			
Answer to Question:			
		the POS must be either 11 or IOP. The GT modifier will indicate that the services were rendered via telehealth.)	
UHC			

Will telehealth be a covered service for patients new to that provider?			
Answer to Question:			
Aetna	Yes 03/27/20	A prior face-to-face visit is not required for a provider to provide telemedicine services.	
Amerigroup	Yes 03/24/20	HCA is allowing use of codes 99441-99443, 99421-99423 for new or established patients during this crisis and is applying this guidance to Medicaid MCOs.	
CHPW			
Cigna	Yes 03/27/20	During this crisis.	
Coordinated Care	Yes 03/27/20	There are no restrictions on new versus established patients.	
First Choice (TPA and PPO)	Yes 03/27/20	First Choice Health is following the CMS expanded coverage guidelines for new and established patients.	
HCA – Apple Health			
KP-NW	Yes 03/27/20	During the crisis.	
KP-WA			
Labor & Industries	Yes 04/11/20	https://www.lni.wa.gov/patient-care/billing-payments/marfsdocs/2019/200309temptelehealthinitalevalspolicy.pdf	
Medicaid FFS	Yes 03/27/20	Telemedicine services for established and non-established patients will be covered. For telephone and online digital E and M, which are typically covered for non-established patients, Medicaid is allowing use of codes 99441-99443, 99421-99423 for both new or established patients, accompanied by the CR modifier, and billed at the line level.	
Molina	Yes	See Molina COVID Resource Page.	

Will telehealth be a covered service for patients new to that provider?			
	03/27/20	Scroll down to Molina's detailed COVID-19 Telehealth Billing Policy & follow link for additional details by program (Medicaid, Marketplace, Medicare detail).	
Pacific Source	Yes 03/27/20	We are following CMS expanded coverage guidelines, which does allow telehealth visits for both new and established patients.	
Premera	Yes 03/27/20	A new patient may be provided with telehealth services.	
Providence	Yes 04/01/20	PHP will reimburse contracted providers for telehealth visits provided to new and established patients during the emergency. Contracted providers may reference Payment Policies 92.0 and 53.0 on our provider portal for more information. Providence Login	
Regence	Yes 03/27/20	A new patient may be provided with telehealth services.	
UHC			

During this interim period, CMS Guidelines allow providers to select E&M (Evaluation & Management) code level for telehealth service base upon Time or Medical Decision making. https://www.cms.gov/files/document/covid-final-ifc.pdf (page 136 from start of page to the end of the 1st full paragraph)			
For telehealth services during this interim period, will your plans allow the provider to select E&M code level based just on MDM OR on either MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter?			
Answer to Question			
Aetna			
Amerigroup - Commercial			
CHPW - Commercial			
Cigna			
Coordinated Care - Commercial			
First Choice (TPA and PPO)	Both		

During this interim period, CMS Guidelines allow providers to select E&M (Evaluation & Management) code level for telehealth service base upon Time or Medical Decision making. https://www.cms.gov/files/document/covid-final-ifc.pdf (page 136 from start of page to the end of the 1st full paragraph)			
For telehealth services during this interim period, will your plans allow the provider to select E&M code level based just on MDM OR on either MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter?			
Answer to Question			
	04/07/20		
HCA – Apple Health			
Medicaid FFS			
Amerigroup	04/08/20	Follow HCA guidance	
CHPW			
Coordinated Care			
Molina	Both 04/08/20		
UHC Community Plan			
KP-NW	Both 04/07/20		
KP-WA	Both 04/07/20		
Labor & Industries	Both 04/08/20	L&I will pay for E&M codes 99201 – 99203 delivered via telehealth based on time or medical decision making. E&M codes 99204 and 99205 are not payable when delivered via telehealth.	To determine the appropriate level of service, providers must use one of the following guidelines in conjunction with Evaluation and Management (E/M) Services Guidelines noted in CPT®: • The "1995 Documentation Guidelines for Evaluation & Management Services," available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf OR • The "1997 Documentation Guidelines for Evaluation and Management Services,"

During this interim period, CMS Guidelines allow providers to select E&M (Evaluation & Management) code level for telehealth service base upon Time or Medical Decision making. https://www.cms.gov/files/document/covid-final-ifc.pdf (page 136 from start of page to the end of the 1st full paragraph)			
For telehealth services during this interim period, will your plans allow the provider to select E&M code level based just on MDM OR on either MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter?			
Answer to Question			
			available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf
Molina - Commercial	Both 04/08/20		
Pacific Source	Both 04/08/20		
Premera	Both 04/07/20		
Providence			
Regence	Both 04/07/20		
UHC - Commercial			

D) Provider Workflow

Will the outpatient pre-authorizations and pre-authorizations for scheduled elective admissions be extended longer than 90 days? If so, by how much?			
Answer to Question:			
Aetna	Varies 03/30/20	Prior authorization approvals are valid for at least 45 calendar days from the date of approval. However, authorization approval for most elective medical/surgical procedures are valid for 6 months.	Aetna has published "Temporary Changes in Prior Authorization/ Precertification and Admissions Protocols" for COVID19 here: https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/prior-authorization-notification.pdf Additionally, when an enrollee is determined to be ready for discharge from a hospital and insufficient time exists for prior approval of long term care or home health care, we will deem this to be an extenuating circumstance. Please refer to our extenuating circumstance policy located here: http://www.aetna.com/healthcare-professionals/documents-forms/washington-extenuating-circumstances-policy.pdf

Will the outpatient pre-authorizations and pre-authorizations for scheduled elective admissions be extended longer than 90 days? If so, by how much?			
Answer to Question:			
Amerigroup	May 03/24/20	Amerigroup is extending the length of time a prior authorization is in effect for elective inpatient and outpatient procedures to 90 days. Longer extensions will be considered on a case-by-case basis.	
CHPW			
Cigna	No 03/27/20		Cigna waives preauthorization requirement for medications until June
Coordinated Care	TBD 03/27/20	We are still researching this question.	
First Choice (TPA and PPO)	TBD 03/27/20	Extensions will be considered on a case by case basis.	
HCA – Apple Health			
KP-NW	Yes 3/31/20	• Standard process is to review initial and extension requests based on eligibility and medical necessity. • Authorizations will have an immediate start date, and an extended expiration date of 12.31.20 (extended from the typical 3-6 months), WITH the following language included with the authorization: "Due to the COVID-19 pandemic, please be aware that all elective, routine, non-urgent care may be delayed in accordance with emergency orders issued. The authorization expiration date has been extended to allow adequate time for routine care to be provided once emergency orders have been lifted." • All current, open authorizations, will be revised to extend the expiration date to 12.31.20. Exceptions include those authorizations in which all visits have been exhausted, inpatient and residential which are based on days, and dialysis which is	
KP-WA			

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Answer to Question:			
		already setup on a continuing 12-month cycle based on member's birthday.	
Labor & Industries			
Medicaid FFS	Yes 03/27/20	Most authorization are 6 months/ 12 months depending on the services. If by chance, the authorization is less than 6/12 months the provider can request an extension.	
Molina	Yes 03/30/20	Prior authorization has been extended to 09/01/20.	
Pacific Source			
Premera	Yes 03/31/20	Extended the effective date out to 6 months from the initial approval date.	
Providence	TBD 04/01/20	PHP is currently evaluating	
Regence	Yes 03/31/20	Effective immediately, if hospitals need to transfer a patient quickly due to the COVID-19 impact and do not have time to secure pre-authorization for post-acute care settings or home-based care (i.e., skilled nursing facilities, long-term acute care hospitals and inpatient rehabilitation), we will waive the pre-authorization requirements. If a patient has services that are delayed, we will extend pre-authorizations for elective inpatient admissions. Providers need to contact us to request an extension to their elective inpatient admission pre-authorization request. AIM Specialty Health (AIM) and eviCore healthcare (eviCore) are extending authorizations for six months. All pharmacy pre-authorizations that are due to expire between March 23, 2020 and June 30, 2020 will be extended six months from	

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Answer to Question:			
		the date of the current expiration date to alleviate work by providers' offices.	
UHC			

Will health plans ease authorization requirements for key components of after-hospital care, such as admission to SNFs or rehab, providing home health visits, during this COVID period?			
Follow Consensus Direction?		**Pre-authorization will be waived when a patient is ready for discharge from a hospital, and insufficient time exists for long-term care facility or home health services that will follow discharge to receive approval prior to delivery of care.**	
Aetna	Most 04/03/20	Aetna has published "Temporary Changes in Prior Authorization/ Precertification and Admissions Protocols" for COVID19 here: https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/prior-authorization-notification.pdf	Self-insured plan sponsors will be able to opt-in to this program at their discretion.
Amerigroup	Yes 04/08/20	We are waiving (for in and out of network regardless of diagnosis) prior authorization for admissions to SNFs, IP rehab, and long term acute care hospitals. Though we are requesting voluntary notification. We are also waiving prior auth for home health related to patient transfers. As it relates to DME **for COVID-19 diagnoses**, prior auth requirements are suspended for DME effective March 26, including oxygen supplies, respiratory devices and continuous positive airway pressure (CPAP) devices for patients diagnosed with COVID-19, along with the requirement for authorization to exceed quantity limits on gloves and masks.	

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		Amerigroup is not waiving DME authorizations at this time for non-COVID19 diagnoses.	
CHPW			
Cigna	Most 04/01/20	Cigna waives prior authorizations for the transfer of its non-COVID-19 customers from acute inpatient hospitals to in-network long term acute care hospitals.	Self-insured plan sponsors will be able to opt-in to this program at their discretion.
Coordinated Care			
First Choice (TPA and PPO)	Varies by our Payers' Plans 03/27/20	COVID Provider page	First Choice Health is a PPO network that does not define the benefits. Please reach out to the individual Payers to confirm benefits. As an administrator for our self-funded health Plans, we are complying with the Families First Coronavirus Act, specifically the "Health Provisions". FCH is encouraging all FCH payors to waive patient responsibility for COVID-19 diagnostics, including testing services, performed in accordance with the Families First Coronavirus Response Act.
HCA – Apple Health			
KP-NW	Yes 04/03/20	Expedited authorization for DME would apply and in certain circumstances authorization for DME may be waived.	
KP-WA			Self-insured plan sponsors will be able to opt-in to this program at their discretion.
Labor & Industries			
Medicaid FFS			

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Molina			
Pacific Source	Most 04/03/20		Self-insured plan sponsors will be able to opt-in to this program at their discretion.
Premera	Most 04/03/20	COVID Provider page	Self-insured plan sponsors will be able to opt-in to this program at their discretion.
Providence	Most 04/03/20		Self-insured plan sponsors will be able to opt-in to this program at their discretion.
Regence	Most 04/07/20	We are not necessarily across the board waiving prior authorization for DME. We are however committed to removing barriers in order to quickly discharge our members to alternate settings to accommodate care needs of critical members. We are available to support discharge needs and providers should contact our care management team if they are encountering any discharge barriers at 1 (866) 543-5765 from 7 a.m. to 5 p.m. Monday through Friday.	Self-insured plan sponsors will be able to opt-in to this program at their discretion.
UHC	Most 04/03/20		Self-insured plan sponsors will be able to opt-in to this program at their discretion.

As providers begin to treat suspected and actual COVID patients, they are trying to get paperless in the room (less contamination). As such, providers would like to not have to get the patient to sign any forms.			
Can any patient signature requirements be waived for COVID patients, e.g. Medicare MOON?			
Follow Consensus Direction?		**A paperless environment with COVID patients is endorsed and strongly supported. Payers are not aware of any group contractual requirement and believe that the only signatures needed are Consent to Treat and HIPAA Notice Receipt. For these documents, HIPAA Notice Receipt and Consent to Treat, signatures are possibly required by the provider to protect themselves – and not the payer. The HIPAA notice provided by the provider to the member is not a Payer Privacy requirement but rather a Provider obligation as the covered entity. Please let the payer know if there is a specific document on which they are requiring a patient signature.**	
Aetna	TBD 03/20/20	This is under consideration.	
Amerigroup	Yes 03/27/20	If/when this conflicts with HCA guidelines, will follow HCA guidelines	
CHPW			
Cigna			
Coordinated Care	TBD 3/31/20	CCW would defer to HCA guidance on this point. Providers should document all verbal interactions and agreements in the medical records.	
First Choice (TPA and PPO)	Yes 03/27/20		
HCA – Apple Health			
KP-NW	Yes 03/27/20	From a health plan perspective, HIPAA allows claims submission from the provider to the carrier without a form signed by the patient. However, the forms that are signed in a care delivery setting are often for the purposes of the patient agreeing to financial liability if the service is not covered by a health plan and informed consent. These forms are not required by an insurance company, but the actual hospital or facility may require providers to obtain signatures. In some lines of business, such as Medicare and Medicaid, in order for the provider or hospital to be paid,	

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		the patient must sign the form. Because of this, CMS and the Health Care Authority may need to loosen requirements during the COVID-19 outbreak for all services (not just flexibility for COVID-19).	
KP-WA	Yes 03/31/20	At this time, for prior authorizations expiring between 3/15/20 and 4/30/20, these authorizations will be extended for 3 additional months, subject to some exclusions. Current plan quantity limits are still applicable.	
Labor & Industries	Yes 04/01/20	For COVID patients, they may file their portion of the Report of Accident online through FileFast which does not require an electronic signature. It there was a medical visit, providers should complete the provider portion of the ROA. We have not been waiting for the provider documents to get claims allowed and benefits paid as appropriate.	
Medicaid FFS			
Molina	TBD 3/31/20	This is under consideration	
Pacific Source			
Premera	Yes 03/27/20		
Providence	Yes 04/01/20		

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Regence	Yes 03/27/20		
UHC			