Health Plan Policies, Procedures and Practices

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

A) COVID Related Billing

B) Alternative Treatment Locations

C) Telehealth

D) Provider Workflow

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

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NOTE: Though CMS has approved the use of 'CS' modifier to identify those services that should not have a member cost share (per CMS https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se#_Toc37139913), some but not all commercial health plans will recognize the 'CS' modifier in their adjudication processing.</td></tr>
<tr><td>Aetna</td><td>Yes
03/30/20</td><td>Aetna COVID page</td><td>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.</td></tr>
<tr><td>Amerigroup – DSNP</td><td>Yes
04/24/20</td><td>Provider COVID FAQ

Use of 'CS' modifier is not applicable</td><td></td></tr>
<tr><td>CHPW - Medicare Advantage</td><td>Yes
03/27/20</td><td>Provider COVID FAQ</td><td>'CS' modifier will be processed for Medicare</td></tr>
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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 is 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 - Commercial	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. Copayment, coinsurance, and/or deductible cost-sharing requirements will be waived for medically necessary COVID-19 diagnostic testing and/or medical screening services.

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First Choice (TPA and PPO)	Varies by our Payers' Plans 03/27/20	COVID Provider page Modifier CS will be considered in the adjudication of COVID-19 testing services with other claim information	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 amount and the patient cannot be billed. Use of 'CS' modifier is inappropriate as cost sharing is not applicable for Medicaid/MCO covered services'	Claim coding should be consistent with the HCA FAQs posted at https://www.hca.wa.gov/information-about-novel-coronavirus-covid-19 Scroll down to 'Providers, Billers and Partners' See FFS and MCO specific pages identified below.

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<tr><td>Medicaid FFS</td><td>Yes
03/27/20</td><td>COVID resource page</td><td></td></tr>
<tr><td>Amerigroup</td><td>Yes
03/27/20</td><td>See "COVID-19 News and Resources" on provider web site (https://providers.amerigroup.com/pages/wa.aspx</td><td></td></tr>
<tr><td>CHPW</td><td>Yes
03/27/20</td><td>Provider COVID FAQ</td><td></td></tr>
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<tr><td>Molina</td><td>Yes
04/01/20</td><td>Molina COVID Resource Page</td><td>See HCA response for Medicaid.

For Medicare will follow CMS guidance.</td></tr>
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UHC Community Plan	Yes 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.
KP-NW	Yes 04/24/20	We will NOT use the CS modifier in our adjudication	Most of our health plans require use of in-network providers for non-emergency services. However, in alignment with federal guidance, we cover COVID-19 related testing and visit, without deductible or cost-sharing, regardless of the provider's network status.
KP-WA	Yes 04/24/20	We will NOT use the CS modifier in our adjudication	Most of our health plans require use of in-network providers for non-emergency services. However, in alignment with federal guidance, we cover COVID-19 related testing and visit, without deductible or cost-sharing, regardless of the provider's network status. Self-insured plan sponsors will be able to opt-out of this program at their discretion

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<tr><td>Labor & Industries</td><td>Yes
04/08/20</td><td>If due to work exposure
https://www.lni.wa.gov/agency/outreach/workers-compensation-coverage-and-coronavirus-covid-19-common-questions</td><td>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</td></tr>
<tr><td>Molina - Marketplace</td><td>Yes
04/01/20</td><td>Molina COVID Resource Page</td><td>Health plan has no Self-insured plan sponsors.

We allow modifier CS submitted with diagnosis codes per CDC guidance. 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</td></tr>
<tr><td>Pacific Source</td><td>Most
03/27/20</td><td>Provider page (link available on page to download COVID FAQ).</td><td>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.</td></tr>
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			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 accepts the CS modifier but it is optional, not required	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.

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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 04/29/20	COVID resource page Scroll down to COVID Testing Providers can bill with CS, but it is information and does not drive payment.	Regence is covering testing, the additional respiratory diagnostic panels, and the associated office visit for COVID-19 without any out-of-pocket costs for our fully insured members. Regence is also covering the cost of treatment for COVID-19 without any out-of-pocket costs for our fully insured members who are admitted through June 30, 2020. Regence is working with our self-funded employer groups to implement similar cost share arrangements when directed For additional information and current claims submission information related to COVID-19 testing and treatment, please visit the Regence provider site referenced here. This site is updated as quickly as possible when new information is available.

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**			
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UHC - Commercial	Most 03/27/20	Provider COVID resource UHC accepts the CS modifier, but it is optional, not required	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.

Consensus Direction:

Follow coding guidelines of the health plans 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
- Test code used should be consistent with Medicare Guidelines https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se#_Toc37139913. HCPS U0002 is for dates of service on or after February 4, 20200 and CPT 87635 for dates of service after March 13. HCPS U0003 and U0004 are for dates of service after April 14, 2020

As part of their adjudication process, *commercial* health plans will differentiate between the following two scenarios: 1) E&M visit is related to COVID/Diagnostic panel testing (patient cost share waived), and 2) E&M visit is related to COVID care once the testing is completed (patient cost share not waived).

NOTE: Though CMS has approved the use of 'CS' modifier to identify those services that should not have a member cost share (per CMS https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se#_Toc37139913), some but not all commercial health plans will recognize the 'CS' modifier in their adjudication processing.

Under the Emergency Order, some health plans will cover the entire cost, prior to deductible and with no patient cost share, of COVID testing (https://www.cms.gov/files/document/cms-2020-01-r.pdf), 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 Common Direction?		**See above**	
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 - DSNP	Yes 04/24/20	Provider COVID FAQ Use of 'CS' modifier is not applicable	

Under the Emergency Order, some health plans will cover the entire cost, prior to deductible and with no patient cost share, of COVID testing (https://www.cms.gov/files/document/cms-2020-01-r.pdf), 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.			
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Follow Common Direction?		**See above**	
CHPW - Medicare Advantage	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 - Commercial	Yes 03/27/20	For Apple Health - HCA COVID billing guidelines 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.	Providers should bill the appropriate E/M code with the appropriate diagnosis codes including U07.1 and those found in the link attached.
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 is 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. Modifier CS will be considered in the adjudication of COVID-19 testing services with other claim information	
HCA – Apple Health	04/08/20	All services covered at 100% of the allowed and patient cannot be billed Use of 'CS' modifier is inappropriate as cost sharing is not applicable for Medicaid/MCO covered services' Medicaid FFS and MCOs will also reimburse for testing billed with CPT code U0002 and, as of 04/14/20, with codes U0003 & U0004.	

Under the Emergency Order, some health plans will cover the entire cost, prior to deductible and with no patient cost share, of COVID testing (https://www.cms.gov/files/document/cms-2020-01-r.pdf), 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 Common Direction?		**See above**	
		Claims should be submitted consistent with the guidance provided on the FFS and MCO websites: Providers do not need to differentiate between the clinical scenarios above but instead follow the coding guidance on the FAQs found at https://www.hca.wa.gov/information-about-novel-coronavirus-covid-19	
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 into the provider's office just for the specimen collection, then the provider can bill 99211 for the service.	
Amerigroup	Yes 03/27/20	See HCA Apple Health response	
CHPW	Yes 03/27/20	We expect the CR modifier, or one of the COVID diagnosis or related diagnosis put out by CDC	
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.
Molina	Yes 04/17/20	See HCA Apple Health response Molina COVID Resource Page	Molina does not differentiate between the two scenarios. Follow coding guidance: 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

Under the Emergency Order, some health plans will cover the entire cost, prior to deductible and with no patient cost share, of COVID testing (https://www.cms.gov/files/document/cms-2020-01-r.pdf), 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 Common Direction?		**See above**	
UHC – Community Plan	Yes 04/17/20		
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. We will NOT use the CS modifier in our adjudication	
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.	
Molina - Marketplace	Yes 04/01/20	Molina COVID Resource Page 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.	Molina does not differentiate between the two scenarios. Follow coding guidance. We allow modifier CS submitted with dx codes per CDC guidance. 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
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	

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Follow Common Direction?		**See above**	
		appropriate ICD-10 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. Premera accepts the CS modifier but it is optional, not required	
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 04/28/20	The associated E&M visit should be billed with diagnosis code U07.1. When the E&M visit is billed separately, a review will be done to identify the testing related visit. There may be additional recommended billing guidelines as we begin to receive more COVID-19 coded claims. Providers can bill with CS, but it is information and does not drive payment.	
UHC - Commercial			

When do you anticipate that providers should submit claims to you for COVID testing?			
Follow Common 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 – DSNP	Yes 04/21/20		
CHPW - Medicare Advantage	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.	
Coordinated Care - Commercial	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	Now 04/11/20	See specific instructions for FFS and MCOs below	
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.	
Amerigroup	Now 03/27/20	Provider can submit claims for COVID testing 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.	
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.	
Molina	Now 04/01/20	Claims can be submitted for COVID testing retroactive to the 2/4/20 date of service	

When do you anticipate that providers should submit claims to you for COVID testing?			
Follow Common 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**	
UHC Community Plan	04/01 03/27/20	We ask that care providers hold claims for processing until April 1, 2020.	
KP-NW	Now 04/01/20	Our systems are currently configured to accept COVID testing claims	
KP-WA	Now 04/01/20	Our systems are currently configured to accept COVID testing claims	
Labor & Industries	Now 05/20/20	Now claims should be submitted as they occur	
Molina - Marketplace	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 04/28/20	Our systems are currently accepting claims. Please visit the Regence COVID resource page and scroll down to COVID Testing for the specific code effective dates.	
UHC - Commercial	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 Common 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 – DSNP	Yes 04/21/20	https://providers.amerigroup.com/pages/wa.aspx under "Provider Resources & Documents" includes instructions on submission of corrected claims.	
CHPW - Medicare Advantage	Yes 03/27/20		
Cigna	Yes 05/11/20	COVID response page – Under 'Interim Billing Guidelines' scroll to 'General billing guidance for COVID-19 related services' section.	
Coordinated Care - Commercial	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 do not 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	Yes 04/11/20	See specific instructions for FFS and MCOs below Any claim can be adjusted per the guidance on the HCA and Managed care websites	
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 Common 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)	
Amerigroup	Yes 03/27/20	https://providers.amerigroup.com/pages/wa.aspx under "Provider Resources & Documents" includes instructions on submission of corrected claims.	
CHPW	Yes 03/27/20		
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 do not feel it was processed correctly as billed.	
Molina	Yes 04/01/20	Medicare & Medicaid Providers should submit a corrected claim and include one of the following ICD-10's: B97.29, U07.1, Z03.818, Z20.828	
UHC Community Plan	Yes 04/01/20		
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	Yes 05/20/20	A corrected claim should be submitted after coordinating with the claim manager.	
Molina - Marketplace	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			

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 Common 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)	
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 04/28/20	We anticipate corrected claims may need to be submitted.	
UHC - Commercial	Yes 04/28/20		

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 Common 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	Locum Tenes 04/28/20		
Amerigroup – DSNP	Locum Tenes 05/05/20	The provider entity that employers/accepts the volunteer services of the new practitioner would bill us under its normal billing procedures, in the name of the authorizing provider (who is already credentialed with us)	
CHPW - Medicare Advantage	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	Locum Tenes 05/11/20	COVID response page – Under 'Provider Frequently Asked Question' scroll to 'Credentialing' section. Also, effective April 1, 2020, Cigna is accelerating the initial credentialing process for COVID-19 related applications. We anticipate that the majority of providers will be initially credentialed through this accelerated credentialing process to address COVID-19 related services. This accelerated initial credentialing process will be available until June 30, 2020. Providers are asked to identify that their credentialing request is a COVID-19 application upon submission.	
Coordinated Care - Commercial			
First Choice (TPA and PPO)	Locum Tenens	This is during the public health emergency.	

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 Common 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.**	
	04/24/20		
HCA-Apple Health	Locum Tenes 04/13/20	Providers registered in DOH's volunteer health practitioner system must also be enrolled with HCA as either a billing or non-billing provider in order to bill Medicaid services. DOH does not have this information posted so HCA is working on this communication pathway with DOH, but this is still pending.	
Medicaid FFS	Locum Tenes 04/13/20		
Amerigroup	Locum Tenens 04/16/20	https://providers.amerigroup.com/Reimbursement%20Policy%20Documents/ALL_RP_LocumTenensPhysicians.pdf Amerigroup allows locum tenens reimbursement for a period of 90 continuous days with at least 30 days elapsing between 90-day periods in accordance with Washington State Health Care Authority (HCA) Physician Related Services manual.	
CHPW	Locum Tenes 04/13/20	Will follow HCA Guidelines	
Coordinated Care	Locum Tenes 04/13/20		
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'	

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 Common 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.**	
UHC Community Plan	Locum Tenes 04/13/20		
KP-NW	Locum Tenes 04/24/20		
KP-WA	Locum Tenes 04/24/20		
Labor & Industries	Locum Tenes 5/21/20	L&I has also developed a process to expedite provider account applications for those healthcare providers participating in the Department of Health Emergency Volunteer Healthcare Practitioner program.	
Molina - Marketplace	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	Locum Tenes 04/20/20	https://www.premera.com/wa/provider/reference/medical-manuals/credentialing-contracting/	We allow providers to be considered a Locum Tenens if they are providing services for 90 consecutive days or less. After the 90 days, they need to be credentialed.
Providence			
Regence	Locum Tenes 04/16/20	https://www.regence.com/provider/library/whats-new/covid-19#credentialing-providers	

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 Common 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.**	
		Regence is expediting credentialing applications for providers with practices directly impacted by COVID-19. Providers should complete a credentialing application and contact provider relations to request expedited credentialing. Regence is also allowing exceptions to our locum tenens policy. The use of locum tenen provider has been expanded to 180 days during the COVID-19 emergency. Also, a locum tenen can have a valid license in a different state than the one in which they are practicing in.	
UHC - Commercial	Locum Tenes 04/28/20	Provider COVID resource See the section on "Credentialing & Contracting"	

B) **Alternative Treatment Locations**

Are ED services provided in tents and patient cars covered and if so, how should they be billed?			
Follow Common 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 – DSNP	Yes 04/21/20	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.	

Are ED services provided in tents and patient cars covered and if so, how should they be billed?			
Follow Common 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.**	
CHPW - Medicare Advantage	Yes 03/27/20		
Cigna			
Coordinated Care - Commercial	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	Yes 04/11/20	See specific instructions for FFS and MCOs below	
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.	
Amerigroup	Yes 04/23/20	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. We follow HCA guidance in this regard.	
CHPW	Yes 03/27/20		
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.	
Molina	Yes 04/01/20	Providers should bill POS 23 for hospital parking lot, POS 15 is also allowed for cars. Medicare: do not use CR modifier but POS codes are relevant.	

Are ED services provided in tents and patient cars covered and if so, how should they be billed?			
Follow Common 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.**	
UHC Community Plan	Yes 04/11/20		
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	Yes 5/20/20	Providers should bill POS 23 for hospital parking lot. Can use CR and DR modifiers for professional and facility billings, respectively.	
Molina - Marketplace	Yes 04/01/20	Providers should bill POS 23 for hospital parking lot, POS 15 is also allowed for cars	
Pacific Source	Yes 03/27/20		
Premera	Yes 03/27/20		
Providence	Yes 04/01/20		
Regence	Yes 03/27/20		
UHC - Commercial			

Are outpatient services provided in patient cars covered and if so, how should they be billed?			
Follow Common 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 - DSNP	Yes 04/21/20		
CHPW - Medicare Advantage	Yes 03/27/20		
Cigna			
Coordinated Care - Commercial	Yes 03/27/20	We follow the Medicaid FFS guidance below.	
First Choice (TPA and PPO)	Yes 03/27/20		
HCA – Apple Health	Yes 04/11/20	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. See specific instructions for FFS and MCOs below	
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:	

Are outpatient services provided in patient cars covered and if so, how should they be billed?			
Follow Common 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**	
		• 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 - 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.	
Amerigroup	Yes 04/11/20	Amerigroup will follow HCA guidance for Medicaid MCOs	
CHPW	Yes 03/27/20		
Coordinated Care	Yes 03/27/20	We follow the Medicaid FFS guidance below.	
Molina	Yes 04/01/20	POS 15 is allowed for cars, POS 99 can also be submitted Medicare: follow CMS guidelines	
UHC Community Plan	Yes		

Are outpatient services provided in patient cars covered and if so, how should they be billed?			
Follow Common 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**	
	04/11/20		
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	Yes 05/20/20	The POS code should match the situation. If hospital-owned then POS 11 with a CR modifier should be used. If hospital owned but off-campus, then POS 19 with a CR modifier should be used. If an OP visit outside of an ER occurs, then POS 23 with a CR modifier should be used. If the situation does not fit any other example (as drive up sites might) then POS 15 with a CR modifier should be used.	
Molina- Commercial	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 - Commercial	Yes		

Are outpatient services provided in patient cars covered and if so, how should they be billed?			
Follow Common 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**	
	04/28/20		

"Hospitals: CMS Flexibilities to Fight COVID-19" : https://www.cms.gov/files/document/covid-hospitals.pdf			
Are services provided by licensed hospitals 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 patients provided by licensed hospitals in non-licensed space and/or in 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 or in a large tent or temporary structure that is off the hospital's campus, all of the sponsoring hospital site of service and all policies and procedures 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 - DSNP	Yes 04/21/20	Amerigroup is following HCA and CMS guidance.	
CHPW - Medicare Advantage	Yes 03/27/20		
Cigna			
Coordinated Care - Commercial	Yes 03/27/20	CCW is following all HCA and CMS guidance, or OIC mandates.	

"Hospitals: CMS Flexibilities to Fight COVID-19" : https://www.cms.gov/files/document/covid-hospitals.pdf			
Are services provided by licensed hospitals 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 patients provided by licensed hospitals in non-licensed space and/or in 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 or in a large tent or temporary structure that is off the hospital's campus, all of the sponsoring hospital site of service and all policies and procedures would apply.**	
First Choice (TPA and PPO)	Yes 04/01/20		
HCA – Apple Health	Qualified Yes 04/13/20	HCA will cover services provider in a licensed hospital's on-campus space. Normal billing would apply Services provided off-campus would require a DOH waiver on their usual and customary licensure requirements before HCA would cover.	
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	
Amerigroup	Qualified Yes 04/13/20	Amerigroup will follow HCA guidance for Medicaid MCOs.	
CHPW	Yes 03/27/20		
Coordinated Care	Yes 03/27/20	CCW is following all HCA and CMS guidance, or OIC mandates.	
Molina	Yes 04/01/20	Molina will follow all HCA and CMS guidance, and OIC mandates.	
UHC Community Plan	Qualified Yes 04/13/20		
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.	

"Hospitals: CMS Flexibilities to Fight COVID-19" : https://www.cms.gov/files/document/covid-hospitals.pdf			
Are services provided by licensed hospitals 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 patients provided by licensed hospitals in non-licensed space and/or in 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 or in a large tent or temporary structure that is off the hospital's campus, all of the sponsoring hospital site of service and all policies and procedures would apply.**	
Labor & Industries	Yes 05/20/20	Yes. The controlling party for the services and procedures is the hospital. The hospital would bill with appropriate POS code. Billings would, however, have to be coordinated with a claim manager.	
Molina - Marketplace	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 - Commercial			

“Hospitals: CMS Flexibilities to Fight COVID-19” : https://www.cms.gov/files/document/covid-hospitals.pdf			
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 Common 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 - DSNP	Yes 04/21/20		
CHPW - Medicare Advantage	Yes 04/28/20	A physician may certify or recertify the need for continued hospitalization if the physician finds that the patient could receive proper treatment in a SNF, but no bed is available in a participating SNF. CHPW will continue to review and approve as inpatient until a SNF placement can be found.	
Cigna			
Coordinated Care - Commercial			
First Choice (TPA and PPO)	Yes 04/27/20	Include Appropriate SNF 'Type of Bill’ code"	
HCA – Apple Health	Yes 04/13/20	Hospitals should bill for occupation of these beds as an administrative bed, consistent with current Medicaid FFS and MCO policies.	They need to bill HCA FFS and the MCOS as instructed in the provide guide and the MCOs contract for an admin bed with the DR is great
Medicaid FFS	Yes 04/13/20		
Amerigroup	Yes 04/13/20		
CHPW	Yes 04/13/20		
Coordinated Care	Yes		

"Hospitals: CMS Flexibilities to Fight COVID-19" : https://www.cms.gov/files/document/covid-hospitals.pdf			
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 Common 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.**	
	04/13/20		
Molina	Yes 04/10/20	Hospitals should submit rev code 0191 for SNF level of care Medicare: follow CMS guidelines	
UHC Community Plan	Yes 04/13/20		
KP-NW **KP - WA**	Yes 4/27/2020	When billing, the Place of Service and level of service codes should align most closely with the facility, staff and/or function being performed at that care site. Include Appropriate SNF 'Type of Bill' code".	
Labor & Industries	Yes 05/20/20	Hospital has the option of reporting sub-acute care (swing bed) services in the type of billing field. Before billing, coordinate with a claim manager.	
Molina - Marketplace	Yes 04/10/20	Will follow CMS guidelines	
Pacific Source			
Premera	Yes 04/28/20		
Providence			
Regence	Yes 04/16/20		
UHC - Commercial	Yes 04/28/20	UHC will follow CMS guidance and OIC mandates.	

C) Telehealth

<table>
<tr><td colspan="4">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</td></tr>
<tr><td colspan="4">Will a telemedicine visit for a care service be paid at the same rate as an in-person visit for that same care service?</td></tr>
<tr><td colspan="2">Follow Common Direction?</td><td colspan="2">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)</td></tr>
<tr><td>Aetna</td><td>Yes
03/27/20</td><td>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.</td><td></td></tr>
<tr><td>Amerigroup - DSNP</td><td>Yes
04/21/20</td><td>Provider COVID FAQ</td><td></td></tr>
<tr><td>CHPW - Medicare Advantage</td><td>Yes
03/27/20</td><td></td><td></td></tr>
<tr><td>Cigna</td><td>Most
05/04/20</td><td>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"</td><td>Mid-level practitioners (e.g., physician assistants and nurse practitioners) can also provide services virtually using the same guidance. Reimbursement will be consistent as though they performed the service in a face-to-face setting</td></tr>
</table>

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 Common 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)**	
		• "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.	Waive customer cost-sharing for telehealth screenings for COVID-19 through May 31, 2020
Coordinated Care - Commercial	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	Medicaid FFS and the MCO have always had payment parity for telemedicine and continues that policy for its COVID responsive policies for telehealth services. Effective back to 1/1/2020	
Medicaid FFS	Yes		

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 Common 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)**	
	03/27/20		
Amerigroup	Yes 03/27/20		
CHPW	Yes 03/27/20		
Coordinated Care	Yes 03/27/20		
Molina	Yes 03/27/20	Molina Billing Policy	
UHC Community Plan	Most 03/27/20	We are also supporting self-insured employer customers who chose to implement similar actions.	
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 5/20/20	If an E&M code description allows for telephone/telehealth, telehealth visit for the E&M code is reimbursed at the same rate as the in-person version. Temporary Telehealth Policy	
Molina - Marketplace	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 Common 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 4/17/20	Providers should refer to our websites for the most current information and Virtual Care Reimbursement Policy: • Regence COVID • Asuris COVID • BridgeSpan COVID Click on "Get the latest information" then scroll down and click on "Telehealth visits"	
UHC - Commercial	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 Common 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 Scroll down to 'What code would be used if a physician performs a telehealth visit?"	
Amerigroup - DSNP	Yes 04/21/20	Provider COVID FAQ	
CHPW- Commercial	Yes 03/27/20		
Cigna	Yes 05/04/20	Cigna will not make any requirements regarding the type of technology used (i.e., phone, video, FaceTime, Skype, etc. are all appropriate to use at this time). COVID Provider page Scroll down to "Interim Billing Guidelines" and Select "Important Notes"	
Coordinated Care- Commercial	Yes 03/27/20		
First Choice (TPA and PPO)	Yes 03/27/20		
HCA – Apple Health	Yes 04/10/20	Guidance for all services and telehealth policies effective for the pandemic are posted in the form of FAQs at https://www.hca.wa.gov/information-about-novel-coronavirus-covid-19 Click on 'Providers, Billers and Partners' and View under General Information	

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 Common 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**	
		HCA also makes available free HIPAA compliant Zoom licenses. https://www.hca.wa.gov/hca-offers-limited-number-no-cost-telehealth-technology-licenses-providers	
Medicaid FFS	Yes 03/27/20		
Amerigroup	Yes 04/17/20		
CHPW	Yes 03/27/20		
Coordinated Care	Yes 03/27/20		
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)	
UHC Community Plan	Yes 04/10/20		
KP-NW **KP-WA**	Yes 03/27/20	We do not 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	No 05/20/20	L&I specifically defines telehealth as face-to-face services delivered by a qualified medical provider through a real-time,	

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 Common 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**	
		two-way, audio video connection. These services are not appropriate without a video connection.	
Molina - Marketplace	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	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.	

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 Common 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**	
Regence	Yes 04/28/20	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). Additionally, Regence has temporarily expanded medical and behavioral health telehealth services. Please visit https://www.regence.com/provider/library/whats-new/covid-19#temporary-updates-to-telehealth for details surrounding the expansion and instructions for billing these services.	
UHC - Commercial	Yes 04/28/20	Provider COVID resource See the section on "Telehealth Services"	

Per Section N, page 137 of the CMS rule (https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf) "Given our new understanding that these audio-only services are being furnished primarily as a replacement for care that would otherwise be reported as an in-person or telehealth visit using the office/outpatient E/M codes, we are establishing new RVUs for the telephone E/M services based on crosswalks to the most analogous office/outpatient E/M codes, based on the time requirements for the telephone codes and the times assumed for valuation for purposes of the office/outpatient E/M codes, Specifically, we are cross walking CPT codes 99212, 99213, and 99214 to 99441, 99442, and 99443 respectively. We are finalizing, on an interim basis and for the duration of the COVID-19 PHE the following work RVUs: 0.48 for CPT code 99441; 0.97 for CPT code 99442; and 1.50 for CPT code 99443. We are also finalizing the direct PE inputs associated with CPT code 99212 for CPT code 99441, the direct PE inputs associated with CMS-5531-IFC 140 CPT code 99213 for CPT code 99442, and the direct PE inputs associated with CPT code 99214 for CPT code 99443

In situations when audio only tele-services are provided, which one of the below applies:

A. **Following the recent CMS guidelines for RVUs when codes 99441, 99442, and 99443 are billed?**
B. **An audio only phone call with a patient will be considered telehealth and it should be billed as described on our web site or as noted below**
C. **Other (please describe)**

Answer to Question?			
Aetna			
Amerigroup - DSNP	Option A 05/06/20		
CHPW - Commercial			
Cigna			
Coordinated Care - Commercial			
First Choice (TPA and PPO)	Option B 05/18/20	For Physicians use 99441-99443 and for qualified Non-Physician health care professional use 98966-98968	
HCA – Apple Health	Option A 05/06/20		
Medicaid FFS	Option A 05/06/20		
Amerigroup	Option A 05/06/20		

In situations when audio only tele-services are provided, which one of the below applies:

A. **Following the recent CMS guidelines for RVUs when codes 99441, 99442, and 99443 are billed?**

B. **An audio only phone call with a patient will be considered telehealth and it should be billed as described on our web site or as noted below**

C. **Other (please describe)**

Answer to Question?			
CHPW	Option A 05/06/20		
Coordinated Care	Option A 05/06/20		
Molina	Option A 05/06/20	For providers contracted at % of Medicaid payment will be based on HCA's COVID-19 fee schedule. The payment based on updated RVU's will apply for providers contracted at % of Medicare. Molina Billing Policy	
UHC Community Plan	Option A 05/06/20		
KP-NW	Option A 05/15/20	Coding work will be completed by 05/18	
KP-WA	Option A & Option B 05/15/20	Option A: Medicare Option B: Commercial	
Labor & Industries	Option C 05/20/20	Telephone services are currently being paid according to our fee schedule and the established CMS RVUs for 2019.	
Molina - Commercial	Option A 05/08/20	For providers contracted at % of Medicaid payment will be based on HCA's COVID-19 fee schedule. The payment based on updated RVU's will apply for providers contracted at % of Medicare. Molina Billing Policy	
Pacific Source			

In situations when audio only tele-services are provided, which one of the below applies: A. Following the recent CMS guidelines for RVUs when codes 99441, 99442, and 99443 are billed? B. An audio only phone call with a patient will be considered telehealth and it should be billed as described on our web site or as noted below C. Other (please describe)			
Answer to Question?			
Premera	Option B 05/06/20	Premera has always interpreted these codes as telehealth services in its Telehealth Payment Policy Premera Telehealth	
Providence			
Regence	Option B 05/05/20	The use of audio only for telehealth services is allowed. Providers should refer to our websites for the most current information and Virtual Care Reimbursement Policy: · Regence COVID · Asuris COVID · BridgeSpan COVID Click on "Get the latest information" then scroll down and click on "Telehealth visits"	
UHC - Commercial			

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 - DSNP	Yes 04/21/20	Provider COVID FAQ	
CHPW - Medicare Advantage	Yes 04/21/20	We are following the HCA and CMS guidelines	

Will telehealth be a covered service for patients new to that provider?			
Cigna	Yes 03/27/20	During this crisis, Cigna will not make any requirements as it relates to these services being for a new or existing patient COVID Provider page Scroll down to "Interim Billing Guidelines" and Select "Important Notes"	
Coordinated Care - Commercial	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	Yes 04/11/20	See specific instructions for FFS and MCOs below	
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.	
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	Yes 04/21/20	We are following the HCA and CMS guidelines	
Coordinated Care	Yes 03/27/20	There are no restrictions on new versus established patients.	
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 detail)	
UCH Community Plan	Yes 04/11/20		
KP-NW	Yes	During the crisis	

Will telehealth be a covered service for patients new to that provider?			
KP-WA	03/27/20		
Labor & Industries	Yes 5/20/20	When those services are covered via telehealth. https://www.lni.wa.gov/patient-care/billing-payments/marfsdocs/2019/200309temptelehealthinitalevalspolicy.pdf	
Molina - Marketplace	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 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 - Commercial	Yes 04/28/20	Provider COVID resource See the section on "Telehealth 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			
Aetna			
Amerigroup - DSNP	Yes 04/21/20	Provider should follow CMS and HCA guidance.	
CHPW - Medicare Advantage	Yes 04/11/20	The provider is allowed to select and bill the E&M code they would have had they been in person. Provider may select an E&M code consistent with the CMS guidance document	
Cigna	Yes 05/11/20		
Coordinated Care - Commercial			
First Choice (TPA and PPO)	Both 04/07/20		
HCA – Apple Health	Both 04/11/20	The provider is allowed to select and bill the E&M code they would have had they been in person. Provider may select an E&M code consistent with the CMS guidance document	
Medicaid FFS	Both 04/11/20		
Amerigroup	Both 04/08/20	Follow HCA guidance	
CHPW	Both 04/11/20	The provider is allowed to select and bill the E&M code they would have had they been in person. Provider may select an E&M code consistent with the CMS guidance document	
Coordinated Care	Both 04/11/20		

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			
Molina	Both 04/08/20		
UHC Community Plan	Both 04/22/20	Will follow CMS & HCA Guidelines	
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," available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf
Molina - Marketplace	Both 04/08/20		

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			
Pacific Source	Both 04/08/20		
Premera	Both 04/07/20		
Providence			
Regence	Both 04/07/20		
UHC - Commercial	Both 04/22/20	Will follow CMS Guidelines	

Well child visits are not on the telehealth list from CMS. Will payers cover well child visits via telehealth. **These visits would occur where there is not an immediate need for an in person visit and where an immunization is not required, Physicians are considering these for children over a certain age or meeting other criteria.**			
Answer to Question			
Aetna			
Amerigroup - DSNP	NA 04/24/20		
CHPW - Medicare Advantage	NA 04/17/20	Not applicable for Medicare	
Cigna			
Coordinated Care - Commercial			
First Choice (TPA and PPO)	Varies by our Payers' Plans	First Choice Health is a PPO network that does not define the benefits. Please reach out to the individual Payers to confirm benefits.	

Well child visits are not on the telehealth list from CMS. Will payers cover well child visits via telehealth. These visits would occur where there is not an immediate need for an in person visit and where an immunization is not required, Physicians are considering these for children over a certain age or meeting other criteria.			
Answer to Question			
	04/23/20	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 04/17/20	https://www.hca.wa.gov/assets/billers-and-providers/Clinical-policy-and-billing-for-COVID-19-FAQ.pdf Page 6	
Medicaid FFS	Yes 04/17/20		
Amerigroup	Yes 04/17/20	Follows HCA Direction	
CHPW	Yes 04/17/20	we are recognizing/paying the service; this is zero cost	
Coordinated Care	Yes 04/17/20		
Molina	Yes 04/17/20		
UHC Community Plan	Yes 04/17/20		
KP-NW	Yes 04/20/20		
KP-WA	Yes 04/20/20		
Labor & Industries	NA 05/20/20	Non applicable to L&I.	
Molina - Marketplace	Yes 04/28/20	Providers bill as they would for in person visits. POS 02 is allowed. Modifier CR can be added to indicate it was not an in-person visit.	
Pacific Source			

Well child visits are not on the telehealth list from CMS. Will payers cover well child visits via telehealth. **These visits would occur where there is not an immediate need for an in person visit and where an immunization is not required, Physicians are considering these for children over a certain age or meeting other criteria.**			
Answer to Question			
Premera	Yes 04/20/20	CMS recommends that during the COVID-19 health crisis, providers be reimbursed for telehealth visits with patients at the same rate they would be reimbursed if they had been allowed to see their patient in person, in office. Premera is planning to follow these CMS guidelines and will reimburse for telehealth visits with providers who typically see patients in person, in office this way for the duration of the COVID-19 health crisis. Claim costs will be no more than what would have been paid had the member been able to see their providers in person. Only claims for telehealth visits from providers who members normally see in-person, in-office will be processed in this manner." This policy includes Well Child Care	
Providence			
Regence	Yes 04/21/20	The provider would need to assess that the services in a well child visit can be delivered via telehealth based on the criteria provided on our alert. The information can be found by visiting this website: https://www.regence.com/provider/library/whats-new/covid-19#temporary-updates-to-telehealth	
UHC - Commercial			

Per CMS guidelines (https://www.cms.gov/files/document/covid-hospitals.pdf 1st bullet point) – "During the COVID-19 PHE, if the beneficiary's home or temporary expansion site is considered to be a provider-based department of the hospital, and the beneficiary is registered as an outpatient of the hospital for purposes of receiving telehealth services billed by the physician or practitioner, the hospital may bill under the Physician Fee Schedule ("PFS") for the originating site facility fee associated with the telehealth service."			
Under these circumstances will your health plan follow the CMS Guideline and allow the hospital to bill under the PFS for the originating site facility fee associated with the telehealth service as well as for the professional fee?			
Follow Consensus Direction?		**Description.**	
Aetna			
Amerigroup - DSNP	Yes 05/29/20	Will pay Medicare allowable and if the member is enrolled in the State's Medicaid program, the cost-share (example 20% coinsurance) would be paid under Medicaid.	
CHPW – Medicare Advantage			
Cigna			
Coordinated Care - Commercial	Yes 05/28/20		
First Choice (TPA and PPO)			
HCA Apple Health	No 05/27/20	The originating site fee will not be paid if the provider providing the service and the site receiving the service is in the same facility. (Approved originating sites are defined in WAC 182-531-1730.) The originating site fee MIGHT be paid if the temporary expansion sites were an approved facility for payment & off site of the main hospital campus. (HCA is developing rules for approve expansion sites)	Refer to FAQs (https://www.hca.wa.gov/information-about-novel-coronavirus-covid-19) for updates on this issue as required to respond to changes in the delivery of care under this pandemic
Medicaid FFS	No 05/27/20	Refer to HCA – Apple Heath Response	
Amerigroup	No 05/27/20	Refer to HCA – Apple Heath Response	
CHPW	No 05/27/20	Refer to HCA – Apple Heath Response	

Per CMS guidelines (https://www.cms.gov/files/document/covid-hospitals.pdf 1st bullet point) – "During the COVID-19 PHE, if the beneficiary's home or temporary expansion site is considered to be a provider-based department of the hospital, and the beneficiary is registered as an outpatient of the hospital for purposes of receiving telehealth services billed by the physician or practitioner, the hospital may bill under the Physician Fee Schedule ("PFS") for the originating site facility fee associated with the telehealth service."

Under these circumstances will your health plan follow the CMS Guideline and allow the hospital to bill under the PFS for the originating site facility fee associated with the telehealth service as well as for the professional fee?

Follow Consensus Direction?		**Description.**	
Coordinated Care	No 05/27/20	Refer to HCA – Apple Heath Response	
Molina	No 05/27/20	Refer to HCA – Apple Heath Response	
UHC Community Plan	No 05/27/20	Refer to HCA – Apple Heath Response	
KP-NW			
KP-WA			
Labor & Industries	Depends 05/27/20	**Yes**, if the hospital • is not an Outpatient Prospective Payment System (OPPS) hospital and is not a Critical Access Hospital (CAH). • is a children's, military, veterans, or specialty hospital (they are paid 100% of charges so they could list the professional fee schedule amount) **No**, if the hospital • is an OPPS hospital • is a CAH hospital (L&I, has its own payment methodology)	
Molina - Marketplace			
Pacific Source	Yes 05/26/20		
Premera	Yes 05/26/20		

Per CMS guidelines (https://www.cms.gov/files/document/covid-hospitals.pdf 1st bullet point) – "During the COVID-19 PHE, if the beneficiary's home or temporary expansion site is considered to be a provider-based department of the hospital, and the beneficiary is registered as an outpatient of the hospital for purposes of receiving telehealth services billed by the physician or practitioner, the hospital may bill under the Physician Fee Schedule ("PFS") for the originating site facility fee associated with the telehealth service."			
Under these circumstances will your health plan follow the CMS Guideline and allow the hospital to bill under the PFS for the originating site facility fee associated with the telehealth service as well as for the professional fee?			
Follow Consensus Direction?		**Description.**	
Providence			
Regence	Yes 5/29/2020	Regence allows the provider to bill the professional service and get paid at the lower facility rate (excluding hospital-based overhead) and also bill Q3014 – telehealth facility fee – for the fee associated with the telehealth service itself.	
UHC - Commercial	Yes 05/26/20	UHC interprets this item as allowing providers to bill the professional service and get paid at the lower facility rate (excluding hospital-based overhead), but also bill Q3014 (Telehealth facility fee) for the fee associated with the telehealth service itself.	

D) <u>Provider Workflow</u>

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:

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:			
			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
Amerigroup - DSNP	Yes 04/21/20	Extending the length of time a prior authorization is in effect for elective inpatient and outpatient procedures to 90 days. Amerigroup auth update	
CHPW - Medicare Advantage	Yes 04/21/20	CHPW is extending all 2020 authorizations to 12/31/2020.	
Cigna	Yes 05/04/20	Effective March 25, 2020 and forward, for all requests received for all Cigna lines of business, we are temporarily increasing the authorization window for all elective outpatient services from three months to six months and will continue until at least May 31, 2020. Elective outpatient prior authorization decisions made between January 1, 2020 and March 24, 2020 will be assessed when the claim is received and will go payable as long as it is within six months of the original authorization.	Cigna waives preauthorization requirement for medications until June

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:			
Coordinated Care - Commercial	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	See Medicaid FFS and MCO responses below		
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.	
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	Yes 04/21/20	CHPW is extending all 2020 authorizations to 12/31/2020.	
Molina	Yes 03/30/20	Prior authorization has been extended to 09/01/20	
Coordinated Care	TBD 03/27/20	We are still researching this question.	
UHC Community Plan			
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	

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:			
		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 already setup on a continuing 12-month cycle based on member's birthday.	
KP-WA	Yes 04/24/20	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 5/20/20	As a general rule L&I would add 30 days unless there is a specific date for which the provider is asking. L&I will extend the dates, but we always have a specific time as it would depend on the claim. If there were significant changes in the IWs condition or claims issues it would be have to be considered on a case by case basis.	
Molina - Marketplace	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 04/28/20	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	

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:			
		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 or outpatient elective services. Providers need to contact us to request an extension to their expiring pre-authorization request. AIM Specialty Health (AIM) and eviCore healthcare (eviCore) are extending authorizations for six months. Any emergency room visit that results in an in-patient admission, directly related to COVID-19, does not require a pre-authorization All pharmacy pre-authorizations that are due to expire between March 23, 2020 and June 30, 2020 will be extended six months from the date of the current expiration date to alleviate work by providers' offices. https://www.regence.com/provider/library/whats-new/covid-19#care-management	
UHC - Commercial	Varies 04/28/20	UHC will provide a 90-day extension, based on original authorization date, of open and approved prior authorizations with an end date or date of service between March 24, 2020 and May 31, 2020, for services at any care provider setting.	

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 Common 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 - DSNP	Yes 04/21/20	Amerigroup auth update	
CHPW - Medicare Advantage	Yes 3/20/20	Effective 3/20/2020 CHPW has temporarily waived the prior auth requirements for Home Health, ventilators, CPAP/BiPAP services. Prior Authorization is not required for any respiratory DME or supplies currently. In addition, CHPW is approving all DME needed for discharge from an inpatient setting without prior authorization. We are requesting notification, but it can be sent after discharge of the services provided. CHPW is waiving the prior authorization requirement for admissions to post-acute facilities (SNF, LTAC, and Inpatient Rehab). In addition, no prior authorization is currently needed for any lateral transfer from one inpatient facility to the next.	
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 - Commercial			

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 Common 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.**	
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	N.A. 04/13/20	The Department of Social and Health Services has issued guidance to hospitals re: SNF placements when DSHS is the payer. See MCOs responses.	
Medicaid FFS	N.A. 04/13/20	DSHS is responsible for managing Skilled care for Medicare clients and FFS clients	
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,	

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 Common 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.**	
		along with the requirement for authorization to exceed quantity limits on gloves and masks. Amerigroup is not waiving DME authorizations at this time for non-COVID19 diagnoses.	
CHPW	Yes 3/20/20	Effective 3/20/2020 CHPW has temporarily waived the prior auth requirements for Home Health, ventilators, CPAP/BiPAP services. Prior Authorization is not required for any respiratory DME or supplies currently. In addition, CHPW is approving all DME needed for discharge from an inpatient setting without prior authorization. We are requesting notification, but it can be sent after discharge of the services provided. CHPW is waiving the prior authorization requirement for admissions to post-acute facilities (SNF, LTAC, and Inpatient Rehab). In addition, no prior authorization is currently needed for any lateral transfer from one inpatient facility to the next.	
Coordinated Care			
Molina	Yes 04/17/20	Molina waives (for participating and non-participating) prior authorization for admissions to SNFs, IP rehab, and long-term acute care hospitals. We are requesting voluntary notification, and we negotiate a rate with non-participating providers. We currently allow home health visits (evaluation + 6 visits) without prior authorization in order to facilitate discharge.	

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 Common 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.**	
UHP Community Plan			
KP-NW	Yes 04/03/20	Expedited authorization for DME would apply and in certain circumstances authorization for DME may be waived.	
KP-WA	Yes 04/03/20	Expedited authorization for DME would apply and in certain circumstances authorization for DME may be waived.	Self-insured plan sponsors will be able to opt-in to this program at their discretion.
Labor & Industries	No 05/20/20	Long term care placements and/or nursing home placements are authorized by L&I Occupational Nurse Consultants.	
Molina - Marketplace	Yes 04/17/20	Molina waives (for participating and non-participating) prior authorization for admissions to SNFs, IP rehab, and long-term acute care hospitals. We are requesting voluntary notification, and we negotiate a rate with non-participating providers. We currently allow home health visits (evaluation + 6 visits) without prior authorization in order to facilitate discharge.	
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 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	Self-insured plan sponsors will be able to opt-in to this program at their discretion.

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 Common 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.**	
		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.	
UHC - Commercial	Most 04/28/20	Prior authorization requirements for admissions to a post-acute care setting are suspended from March 24, 2020 through May 31, 2020.	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 Common 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 - DSNP	Yes 05/04/20		
CHPW - Medicare Advantage	Yes 04/21/20	Following the HCA and the CMS guidance to allow this.	
Cigna			

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Coordinated Care - Commercial	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	Yes 04/13/20	HCA website has info about informed consent. https://www.hca.wa.gov/health-care-services-supports/program-administration/authorized-representatives A new telemedicine telehealth document will be posted soon on this website to provide guidance as well	
Medicaid FFS	Yes 04/13/20		
Amerigroup	Yes 03/27/20	If/when this conflicts with HCA guidelines, will follow HCA guidelines	
CHPW	Yes 04/21/20	Following the HCA and the CMS guidance to allow this.	
Coordinated Care	Yes 04/13/20	CCW would defer to HCA guidance on this point. Providers should document all verbal interactions and agreements in the medical records.	

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Molina	Yes 04/17/20	We will follow HCA guidance. Providers should document verbal consent in the medical records. Medicare: We will follow CMS guidelines	
UHC – Community Plan	Yes 04/13/20		
KP-NW **KP-WA**	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, 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).	
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,	

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		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.	
Molina - Marketplace	Yes 04/17/20	We will follow HCA guidance. Providers should document verbal consent in the medical records.	
Pacific Source			
Premera	Yes 03/27/20		
Providence	Yes 04/01/20		
Regence	Yes 03/27/20		
UHC - Commercial	TBD 04/28/20	UHC currently offers no guidance on this issue.	