Updated: 04/24/20

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	

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Follow Common Direction?		**See above**	
		Use of 'CS' modifier is not applicable	
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's for COVID-19. If U07.1 is not effective or appropriate due to an initial visit, then refer to the recommended diagnosis coding from the CDC. 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'	

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		Medicaid FFS and MCOs will also reimburse for testing billed with CPT code U0002 and, as of 04/14/20, with codes U0003 & U0004. 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 in to 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 doesn't 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

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Follow Common Direction?		**See above**	
			the visit Molina will follow the same process for all programs
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 doesn't 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	

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Follow Common Direction?		**See above**	
		time of the visit. When the COVID-19 diagnosis is not available, the E&M code should be billed with one of the appropriate ICD-10 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 03/27/20	The associated E&M visit should be billed with diagnosis code U07.1. There may be additional recommended billing guidelines as we begin to receive more COVID-19 coded claims. Providers can bill with CS but it is information and does not drive payment.	
UHC - Commercial			