# COVID-19 Authorization, Coding and Billing: What the "Office" Needs to Know

*As of 06.23.2020*

Due to the rapidly changing laws and rules affecting health plans and healthcare professionals, the information below can become outdated or incorrect at any time. For the most current information, please use the live links provided throughout the document to access the payor websites and policies. Matters of the Louisiana State Board of Medical Examiners or Arkansas State Medical Board are not addressed in this resource.

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# HIPAA

The HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against healthcare providers that serve patients in good faith through everyday communication technologies, such as FaceTime or Skype, during the COVID-19 public health emergency [Link].

# Payor Changes for COVID-19

*Most* of the third-party payors are implementing the following to facilitate access to care for patients with or suspicious of coronavirus infection.

- Waiver of prior authorizations for diagnostic tests and for covered services that are medically necessary for the diagnosis of the virus (e.g., lab)
- Diagnostic services (as defined and approved by the CDC) covered at 100% without a patient copay, deductible or cost share
- Telehealth services without patient cost share.
- Increasing refill limits on 30-day prescription maintenance medications (consistent with member's benefit plan) and/or encouraging members to use 90-day mail order benefit
- Encouraging telehealth and remote services

Refer to the Practice solutions Payor Policy Modification and Expiration Dates resource [Link]

# Authorizations and Pre-certifications

| Payor | Notes |
|---|---|
| **Aetna** [Link] | • Prior authorization requests for commercial members are now being approved for 9 months instead of standard 6 months. [Link] |
| **Blue Cross (LA)** [Link] | • For dates of service on and after June 1, 2020, Blue Cross' standard authorization processes will apply |
| **Blue Cross (AR)** [Link] | • Stopping prior authorizations and pre-certifications for hospital inpatient, outpatient and ambulatory surgery centers for our fully insured members through July 25, 2020<br>• This change does not apply to prior authorizations for prescription and specialty medication, high-tech radiology services or long-term acute-care hospitals. |

| Payor | Notes |
|---|---|
| **Cigna** [Link] | • 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 inpatient** and outpatient services from three months to six months and will continue until at least July 31, 2020.<br>• **Elective inpatient and 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.<br>• Cigna continues to require prior authorization reviews for **routine advanced imaging**.<br>• Cigna has not lifted precertification requirements for **scheduled surgeries**. |
| **Humana** [Link] | • Suspend all medical authorizations and referrals for COVID-related diagnoses for both in network/participating and out-of-network/non-participating provide |
| **Medicaid (LA)** [Link] | • All existing prior authorizations for other services are extended through July 31, 2020. |
| **Medicaid (AR)** [Link] [Link2] | • Physician and hospital visits related to the treatment of COVID-19 will not count in the twelve (12) visit annual limit |
| **United Healthcare** [Link] | • Summary of COVID-19 Dates by Program [Link] |

# Diagnosis Coding

Effective April 1, 2020-

- U07.1 *COVID-19, virus identified'* is assigned to a disease diagnosis of COVID-19 documented by the provider, documentation of a positive COVID-19 test result, or a presumptive positive COVID-19 test result. NOTE: Presumptive positive COVID-19 test results should be coded as confirmed
- If the provider documents "suspected," "possible," "probable," or “inconclusive” COVID19, do not assign code U07.1. Assign a code(s) explaining the reason for encounter

For all dates of service prior to April 1st, use B97.29 *Other coronavirus* as the cause of diseases, with any respiratory condition listed as primary.

- Z03.818 possible exposure to COVID-19, but the disease is ruled out
- Z20.828 actual exposure to someone who is confirmed to have COVID-19

Diagnosis code B34.2, *Coronavirus infection, unspecified*, should not be used for the COVID-19, because the cases have universally been a respiratory infection, so the site would not be classified as "unspecified" as represented by code B34.2.

Other codes for conditions unrelated to coronavirus may also be required in order to code services. For more ICD-10 coding guidelines, see the CDC ICD-10 Official Coding Guidelines Supplement [Link].

# Coding for Services

## Testing

There are no specific CPT codes for diagnosing patients for COVID-19.

If you prepare a specimen and send it to an outside lab to test for the virus, the specimen collection code is **99000**. However, CPT code 99000 is designated as status B code (bundled and never separately reimbursed) on the Physician Fee Schedule RBRVU file [Link].

In the April 30, press release, CMS will pay hospitals and practitioners to assess beneficiaries and collect laboratory samples for COVID-19 testing, and make separate payment when that is the only service the patient receives [Link]. Physician offices should code the specimen collection using CPT code 99211. *Guidance!* This code can be used for COVID-19 specimen collection on new or established patients.

Here are several reminders related to billing for COVID-19 symptom and exposure assessment and specimen collection performed on and after March 1, 2020:

- Use CPT code 99211 to bill for assessment and collection provided by clinical staff (such as pharmacists) incident to your services, unless you are reporting another Evaluation and Management (E/M) code for concurrent services.
- This applies to all patients, not just established patients.
- Submit the CS modifier with 99211 (or other E/M code for assessment and collection) to waive cost sharing.
- If you did not include the CS modifier when you submitted 99211 file for a claim correction (For Novitas solutions: use Novitasphere or the Reopening Gateway

CMS will automatically reprocess claims billed for 99211 that they denied due to *place of service* editing. [Link]

Specimen collection services are included in the all-inclusive rate for RHCs and the prospective payment system for FQHCs and are not paid separately, including a specimen collection for COVID-19 testing. [Link]

## Phone calls

Routine phone calls using the Telephone Services codes (99441-99443) are not usually covered by Medicare, Medicaid or most payors. However, effective for dates of service on or after March 13, 2020 and through May 31, 2020 Louisiana Medicaid reimbursed telephone evaluation and management services for patients who were actively experiencing symptoms consistent with COVID-19. Claims for audio-only interactions must be coded using the appropriate procedure codes describing the service, for example evaluation and management services, with the telehealth modifier and place of service appended.

In the 3.30.2020 Press Release, CMS approved the use (and payment) of audio only technology for phone evaluation and management codes for physicians (99441-99442) and other non-physician providers (98966-98968) treating Medicare patients.[Link].

With a retro-active effective date of March 1, CMS has increased the reimbursement for telephone visits to match payments for similar office and outpatient visits. This would increase payments for these services from a range of about $14-$41 to about $46-$110. At the same time, CMS also added these codes to the approved telehealth code list so they can also be billed as telehealth services.

Other payors are following the lead of CMS and are also now covering telephone calls and/or audio only telehealth. Consult the LAMMICO Matrix for payor specific details [Link].

## Telehealth

Telehealth (TH) services substitute for an in-person encounter using interactive audio and video telecommunication systems between a patient and provider. There are payor specific requirements for reimbursement.

1. Medicare [Link]
    - No specific CPT codes or diagnosis codes for telehealth, but Medicare only reimburses for certain services under telehealth [Link].
    - In the 3.30.20 press release, CMS expanded telehealth by adding 80 more eligible codes and eliminating some of the frequency requirements associated with those codes.

- In the 4.30.2020 press release, CMS expanded telehealth to allow physical therapists, occupational therapists, and speech language pathologists.
- TH services can now be provided in metropolitan and rural communities and in all settings *including patient home*s.
- TH services are now paid at the same rate as regular, in-person visits
- TH services can be provided to new or established patients
- Practices who are performing "non-traditional" telehealth, may use the place of service code for the location the provider would normally be delivering the service (e.g., 11, 22, 19, etc.)
- **Note**: You may want to consider refiling and correcting any claims that were previously billed and processed with the "02" Place of Service code to capture that additional revenue. Novitas Solutions recommends using (or registering to use) the Novitasphere portal or use the Reopening Gateway (which does not require enrollment).
- Practices who are performing "non-traditional" telehealth and are billing a POS other than 02, should also affix modify -95 to all services.
- CS modifier should be used on all claim lines to identify the service as subject to the cost-sharing wavier for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services
- Providers providing telehealth services from their home do not need to add their home as a service location to their profile, but they should enter the home address on the CMS 1500 claim form.
- Medicare TH visits can now be selected based on based on MDM or time .

2. Medicaid
   - State specific policies
     - Louisiana Medicaid page 173 [Link] [Link2]
     - Arkansas Medicaid section 105.190 [Link] and Memorandum DMS-01 [Link]
3. Commercial
   - May bill with POS-02 or 11, 22, 23 (where service should have been rendered if provided as face-to-face)
   - May require modifier (e.g., GQ, GT or 95)
   - Appendix P of the CPT book lists codes that can be paid via telehealth

   Payor policies and requirements vary.

## Other Remote Services

1. **Virtual check-in** (Brief communication through synchronous or asynchronous technology)
   - G2012 – telephone

- G2010 – captured video or image
  - For new or established patients
  - Co-insurance and deductible *may* apply to these services
  - Limited to providers who can bill E/M services (not billable when provided by unlicensed staff)
  - Patient consent must be documented
  - Will not be paid within seven days of an office visit
  - Not paid if an office visit is paid within 24 hours following
  - Telephone or smart phone technology are acceptable (G2012)
  - Follow-up from receipt must be within 24 hours (G2010)
  - Billed with POS code 11
  - Some payors require modifiers

2. E-visit (Non face-to-face patient initiated communication with provider's office using patient portal)
   - **99421-99423** (by a qualified healthcare professional)
   - **G2061-G2063** (by a non-qualified non-physician healthcare professional)
     - Patient initiated
     - Established patient
     - Must provide an evaluation and management service (This code is not to be used for scheduling appointments, reporting test results, etc.) [Link]
     - Can only be billed once per 7-day period
     - Co-insurance and deductible may apply to these services

**Please refer to your 2020 CPT® and ICD-10-CM codebooks for the guidelines and documentation requirements. Always check with your biller or a certified coder before using any new codes.**