# Priority Health:  COVID-19: Billing, coding and credentialing

## Coding for COVID-19 diagnoses

As of Apr. 1, add ICD-10 code U07.1 COVID19 when your patients have confirmed a diagnosis of COVID-19. This helps your patients get the right coverage and costs waived for their COVID-19 treatment. Per ICD10 coding guidelines, please use additional codes to identify pneumonia or other manifestations.

For services prior to Apr. 1, conditions confirmed due to (or associated with) COVID-19, such as pneumonia, acute bronchitis, lower respiratory infection and ARDS, are coded with B97.29 (other coronavirus as the cause of diseases classified elsewhere).

Note that diagnosis code B34.2, Coronavirus infection, unspecified, would in general not be appropriate for COVID-19 because the cases have universally been respiratory in nature, so the site would not be "unspecified."

## Coding for services that result in COVID-19 testing

**Provider offices, urgent care and emergency rooms**: Anytime an E&M visit results in COVID-19 test being ordered, you must add modifier CS or CR. Both identify the service as being related to COVID-19.

For a COVID-19 lab test to be covered by the member's plan with no copays, deductibles or coinsurance, it must be medically necessary. Effective June 3, 2020, use the SC modifier to indicate medical necessity.  Use of this modifier will ensure your patients have a $0 cost share for any visit and services related to the diagnostic testing and administration of the test.

If you have claims that resulted in the ordering of a COVID-19 test and they denied or were processed with member liability, you should rebill claims using a CR or CS modifier dating back to February 4, 2020.

This modifier should not be added to services billed for treatment of COVID-19, such as labs and x-rays.

# Coding for COVID-19 testing

When you order a COVID-19 test, whether molecular, serologic, or antigen, use the SC modifier to indicate if the test was medically necessary. Testing is only covered when it's medically necessary.

Make sure to keep medical necessity documentation. We reserve the right to audit for medical necessity.

## Antibody testing

We'll cover, with no member copay, deductibles or coinsurance, COVID-19 testing (any type) when it is ordered by a provider and medically necessary.  Providers must use the SC modifier to indicate if the test was medically necessary. Testing is only covered when it's medically necessary.

The antibody testing codes are 86328 and 86769. See our table of codes for more description and reimbursement amounts.

# Coding and payments for COVID-19 lab tests

To report lab testing services that diagnose the presence of the novel coronavirus, use the following codes. For more information:

- U0001 and U0002, see the CMS FAQ
- U0003 and U0004, see the CMS ruling
- 87635, see the AMA's website

The Michigan Department of Health and Human Services (MDHHS) advises you complete the Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form if a patient tests positive for COVID-19.

# Credentialing providers quickly

If you're a new provider who needs to be credentialed with us to meet demands for capacity during COVID-19, complete our Provider Information Form and be sure to check "yes" on the COVID-19 question at the top.

For more information, see our Disaster Credentialing process within the Practitioner Credentialing Overview policy.

**Behavioral health providers**: There's no change to your credentialing process. See behavioral health credentialing for more details.

## Moving providers to different locations

Participating providers can treat our members at different locations under a different tax ID. You will be reimbursed at your current rates. Your patient may have different out-of-pocket costs depending on their benefits.

To make temporary changes to a provider's location and tax ID:

- For POs, PHOs and other large organizations, complete the COVID-19 Provider Move Spreadsheet and email it to PH-PELC@priorityhealth.com
- For individuals or small groups, complete our Provider Information Form and be sure to check "yes" on the COVID-19 question at the top

Do not hold your claims. Submit claims with the location and tax ID where the service was provided. We'll process claims using the temporary location through June 30. If we extend that date, we'll let you know.

If you have permanent changes, follow our normal provider change process.

## Collecting copays from Medicare Advantage members for primary care services

Medicare Advantage members will have no cost share for in-person and telehealth primary care services May 1 - Dec. 31, 2020. Because we're waiving cost-sharing for these members, providers **should not** collect copays for these services. Providers will still be reimbursed the full contracted amount for these services.

# DRG uplift and suspending Medicare Advantage sequestration

To help our partners as they care for our Medicare members during this financially challenging time, we're making two temporary changes:

## Providing a 20% DRG reimbursement uplift for hospitalized Medicare members with COVID-19

Hospitals will receive a weighting increase of 20% for members diagnosed with COVID-19 and discharged.

The uplift is applicable for claims with COVID-19 discharges between:

- January 27, 2020 to March 31, 2020 for B97.29

- April 1, 2020 to the end of the public health emergency—as determined by CMS—for U07.1

  The 20% will be added on to the diagnosis-related groups (DRG) payments, without any budget neutrality adjustment.

  We'll be holding these claims until we're able to update our payment systems. We anticipate claims will begin paying around May 20.

### Suspending Medicare Advantage sequestration

CMS started sequestration in 2013 as a 2% claims payment reduction to applicable services for Medicare Advantage. From May 1, 2020 to Dec. 31, 2020, we'll be suspending sequestration and passing along the 2% to providers for services impacted by sequestration.

### Reprocessing claims

If claims have already processed, we'll reprocess to ensure appropriate payment.

Due to the accelerated timeframes in which CMS changes were made, we'll audit claims in May that may be impacted by these scenarios to ensure appropriate payment.

Priority Health reserves the right to modify these policies should circumstances warrant.

## COVID-19: Prior authorization information and updates

Prior authorizations are expected by our members and the employers who purchase our plans, to ensure the right care at the right time. Prior authorizations also help us understand and review utilization and meet the terms of our risk-based contracts.

We remain committed to serving you quickly by:

- Processing all urgent inpatient admission and post-acute requests within 24 hours
- Shortening the processing time for post-acute authorizations to help you discharge patients quickly
- Never having required authorization for observation stays

### COVID-19 testing

We do not require prior authorization for COVID-19 testing. Patients must work with their health care provider to get tested and cannot get testing without a provider's order for testing.

# Supporting you with existing and new auth processes

Prior authorizations should be quick and easy. Even before this situation, we:

- Processed urgent inpatient admissions and post-acute requests in 24 hours
- Never required authorization for observation stays
- Reviewed and auto-approved ICU and critical care cases
- Worked seven days a week for quick turnaround

We've also made changes to remove barriers and facilitate access to patient care during COVID-19.

## Facilities

- You have 90 days to submit a retro authorization
- We're processing authorization requests for inpatient and post-acute admissions within 24 hours
- Intra-hospital transfers via ambulance to create bed capacity for COVID-19 treatment do not require authorization

## Post-acute care

We have:

- Never required a three-day inpatient stay before transfer to post-acute care
- Shortened the processing time for post-acute authorizations to 24 hours to help discharge patients quickly

## Elective procedures

We've extended prior authorizations through the end of the year for elective procedures approved prior to the COVID-19 outbreak that were canceled or are pending rescheduling for members who have continuous enrollment in their plan at the time of service.

## High-tech imaging, genetic testing and musculoskeletal services

In response to COVID-19, we've:

- Removed all out-of-network rendering site restrictions for Medicare Advantage and Medicaid, effective Mar. 23, 2020
- Moved all authorizations to a 180-day period, effective Mar. 26, 2020, dependent on continuous enrollment at time of service

- Streamlined COVID-19-related high-tech imaging guidelines

### Pharmacy

For pharmacy prior authorizations set to expire through the end of June, we've extended the approval date by 90 days from the date it was set to expire. This does not include prior authorizations with intentionally short approval durations, such as short-term treatments.

This applies to commercial and Medicaid. Medicare authorization durations are through the end of the plan year, unless the approval is intentionally less than 12 months.

# COVID-19: Virtual visits and telehealth

At Priority Health, we've long supported telehealth, including phone visits and virtual care.

## We've temporarily expanded billable telehealth services

Effective March 26 through June 30, 2020, we'll temporarily allow credentialed providers to bill routine practice codes for services provided through telehealth.

### Professional providers:

**New May 1**: We're changing our reimbursement, and aligning to CMS's billing guidance.

- From March 26 - April 30, 2020: We're paying at the standard facility-based rate when billed with a Place of Service 02
- From May 1 - June 30, 2020: We're paying the same rate for telehealth as you're accustomed to receiving for in-person visits

Starting May 1, follow the same process used by CMS to bill for telehealth services. That means you'll bill with the place of service you'd normally use for in-person visits. Add the 95 modifier to identify the visit as telehealth. For Medicaid members, continue to use the GT modifier.

For example, office procedures billed with an evaluation and management (E/M) code of 99201-99215, when performed in real-time by credentialed providers through interactive audio and/or video, can use their standard place of service, add the 95 modifier and receive the non-facility professional payment as of May 1, 2020.

**Audio visits also temporarily allowed**

We're also allowing for real-time, interactive audio-only telehealth encounters, so you can serve your patients who don't have internet access or audio-visual capabilities.

### Facilities (RHC, FQHC, facility-based providers)

Continue to bill as you did prior to COVID-19. When reporting services performed via telehealth, add modifier 95 to these services. For Medicaid, use modifier GT.

- **RHC/FQHCs**: Use the following codes for virtual visits: G0071, 99421, 99422, 99423, 99441, 99442, 99443, G2012. Modifiers are not required on these codes.
- Distant site telehealth services furnished by facility-based providers, RHC and FQHCs are reported with the appropriate CPT or HCPCS code that falls within their scope of practice and within their fee schedule.

### Visits must follow coding guidelines

The visit must follow the guidelines of each code, including the time requirements.

Providers and facilities cannot:

- Use codes that specify in-person or describe services that can only be performed in-person
- Bill for services they are not contracted to provide
- Perform services outside scope of practice, licensure or credentialing
- Bill for a code that requires both an audio and visual component if both audio and visual components are not present throughout the entirety of the visit

#### Coding guidelines for audio-only visits

As stated above, providers must follow the guidelines of each code. This means that if a code requires both an audio and visual component, providers may not bill this code if an audio-only visit was performed.

If a code does not require both audio and visual and, if in the providers professional judgement, the service can be performed via audio only, then providers may bill this code.

## Who can bill for telehealth?

Any credentialed provider or facility can conduct a telehealth visit for all product lines, including commercial group and individual, Medicare and Medicaid.

## What's the reimbursement for telehealth?

For existing telehealth codes, we continue to pay the same rates.

For our temporarily expanded codes:

- From March 26 - April 30, 2020: We’re paying at the standard facility-based rate

- From May 1 - June 30, 2020: We’re paying the same rate for telehealth as you’re accustomed to receiving for in-person visits

## Your patients' costs

We're covering the cost of virtual care for most members for virtual visit codes: 99441-99443, 99421-99423 and 98970-98972, starting March 19, 2020 through June 30, 2020.

Other codes billed as telehealth will have the member's normal cost share.

## HIPAA compliance

Given the government's notification, we're temporarily suspending the requirement for Health Insurance Portability and Accountability Act (HIPAA)-compliant systems. This means if providers do not have a virtual care tool in place, they can use non-public facing tools, like FaceTime, Facebook Messenger video chat, Skype, etc. Providers cannot use public-facing tools like Facebook Live, TikTok or chat rooms, like Slack. All other elements of our medical policy remain in effect, including documentation requirements. See the Office of Civil Rights FAQ for more information.

## Care management virtual and phone visits

To support ongoing care management, we've expanded your options. The following codes can be performed via telehealth G9001, G9002, G9007, G9008, 99484, 99490, 99492, 99493, 99494, 99495, 99496, 98966, 98967, 98968.

Make sure to review the other information on this page for information on member cost share, audio-only options, and billing telehealth services.