PROVIDER RESOURCE

COVID-19
Resource Document
NEBRASKA

NEBRASKA HEALTH NETWORK

Nebraska Health Network assembled this growing list of resources for you and your patients. This list includes resources from our payers and data extracted from the new Community Relay website. Community Relay is a social care network that enables users to search for free or reduced cost services like food, job training, legal services and more.

In addition, we have a dedicated patient-resource library filled with educational materials to help patients track their medications, record their blood pressure, manage chronic conditions and more. Materials can be viewed online or downloaded and emailed directly to patients.

Visit **COMMUNITYRELAY.COM** for additional listings

Visit **NEBRASKAHEALTHNETWORK.COM/PATIENTRESOURCES** for the NHN's patient library

Payer Information

Information subject to change. Valid as of Aug. 8, 2020.

Aetna • MA

- Aetna will cover, without cost share, diagnostic (molecular PCR or antigen) tests to determine the need for member treatment.13 This applies to direct-to-consumer/home-based diagnostic or antigen tests. Aetna's health plans generally do not cover a tests performed at the direction of a member's employer in order to obtain or maintain employment or to perform the member's normal work functions or for return to school or recreational activities, except as required by applicable law. Aetna will cover, without cost share, serological (antibody) tests that are ordered by a physician or authorized health care professional and are medically necessary. Aetna's health plans do not cover serological (antibody) tests that are for purposes of: return to work or school or for general health surveillance or self-surveillance or self-diagnosis, except as required by applicable law. This policy for diagnostic and antibody testing applies to Commercial, Medicare and Medicaid plans.
  - Cost-sharing waiver applies to testing performed or ordered by in-network or out-of-network providers. The policy aligns with Families First legislation and regulations requiring all health plans to provide coverage of COVID-19 testing without cost share. An order can often take place as part of being tested at a COVID-19 drive-through test site or purchasing a direct-to-consumer/home-based test.
  - An order from an authorized health care professional is required for covered COVID-19 tests for Aetna Commercial and Medicare plans. An order can often take place as part of being tested at a COVID-19 drive-through test site or purchasing a direct-to-consumer/home-based test.
- In effort to expand testing capabilities, U.S. Department of Health & Human Services (DHS) authorized pharmacists to order and administer COVID-19 tests, including serology tests, that the FDA has authorized. Pharmacists, in partnership with other health care providers, are well positioned to aid COVID-19 testing expansion.
- As many states recommence elective services, Aetna is resuming our standard prior authorization protocols for inpatient admissions effective May 7, 2020, except in certain states with executive orders or DOI mandates in place. For more specific information visit: aet.na/2WQowXI
- Aetna is waiving member cost-sharing (Cost sharing is defined as co-pay, co-insurance and deductible) 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 for a COVID-19 test. The member cost-sharing waiver applies to all commercial, Medicare and Medicaid lines of business. Per guidance from the Centers for Medicare & Medicaid Services (CMS), the Department of Labor and the Department of the Treasury, all Commercial and Medicaid plans must cover serological (antibody) testing with no cost-sharing.
- Aetna will cover the cost for treatment of COVID-19 for our Medicare Advantage members in full in the provider office. We will also cover the cost of the hospital stay for all of our Medicare Advantage members admitted March 25, 2020, through September 30, 2020.

Aetna • MA

- **For commercial plans**:
  - o Until June 4, 2020, Aetna will waive member cost-sharing for any covered telemedicine visit – regardless of diagnosis with any in-network provider. EXPIRED
  - o Through September 30, 2020, Aetna is extending all member cost-sharing waivers for covered in-network telemedicine visits for outpatient and mental health counseling services for their Commercial plans. Self-insured plans offer this waiver at their own discretion.
- **For Medicare plans:**
  - o Aetna's telemedicine policy is available to providers on the Availity and NaviNet portals (bit.ly/2VFkssS).
- Through September 30, 2020, Aetna will offer zero co-pay primary care and behavioral health telemedicine visits with network providers to all Individual and Group Medicare Advantage members. Aetna Medicare Advantage members should continue to use telemedicine as their first line of defense for appropriate symptoms or conditions to limit potential exposure in physician offices. Cost sharing will be waived for all Teladoc® virtual visits. Cost sharing will also be waived for real-time virtual visits offered by in-network providers (live video conferencing or telephone-only telemedicine services). Medicare Advantage members may use telemedicine for any reason, not just COVID-19 diagnosis.
- For Medicare Advantage plans, effective May 13, 2020, through September 30, 2020, Aetna is waiving member out-of-pocket costs for all in-network primary care visits, whether done in-office and via telehealth, for any reason, and encourages member to continue seeking essential preventive and primary care during the crisis.
- Medicare Advantage will continue to waive cost shares for in-network primary care and specialist telehealth visits, including outpatient behavioral and mental health counseling services through December 31, 2020.
- Aetna MA members may request early refills on 90-day prescription maintenance medications at retail or mail pharmacies if needed. For drugs on specialty tier, we are waiving early refill limits for a 30-day supply
- Patients will not have to pay a fee for home delivery of prescription medications from CVS pharmacy
- For more information go to: aet.na/3bsNgvj

Blue Cross Blue Shield

- Appropriate medically necessary diagnostic testing for COVID-19 will be paid without member cost share for all members. The COVID-19 testing kit, swab, interpretation of the test and the related office/urgent care/emergency room visit will be paid without member cost share.
- BCBS is waiving member cost-sharing for in-network treatment of COVID-19 from March 1, 2020, through September 30, 2020. This means members with medical plan coverage will pay nothing for in-network testing and treatment administered at a doctor's office, urgent care
- Effective immediately,
  - o BCBSNE has updated their cost-share waiver process for medications when used for the treatment of COVID-19. BCBSNE is following the FDA recommendation to caution the use of hydroxychloroquine and chloroquine outside of a hospital setting or clinical trial. We have made the decision to remove the cost share waiver for these drugs. For more information on the FDA information, please visit the FDA website.
  - o At this time, the evaluation of Actemra for the treatment of COVID-19 will also be considered. BCBSNE will follow already-established processes for its use given it is also included in Medical Policy X.42. A cost-share waiver may be granted if Actemra is used for COVID-19 treatment. This applies to BCBSNE fully insured, individual plan members, and some self-funded employers.
  - o In addition to BCBSNE, other Blue Cross and Blue Shield Plans, as well as the BCBS Federal Employee Program (FEP), are waiving member cost shares related to COVID-19 treatment. For more information, go to bcbs.com.
- BCBS will waive early medication refill limits on 30-day prescription maintenance. Patients will not be liable for additional charges for non-preferred medications if medication is not available due to shortage or access issues. EXPIRED
- Member costs shares will continue to be waived for all in-network telehealth visits directly related to a COVID-19 diagnosis through Sept. 30, 2020.
- For all other covered telehealth services, normal plan cost shares will once again apply beginning July 1,2020.
- Link to resources for BCBS members: nebraskablue.com/coronavirus
- Member communication link: newsroom.nebraskablue.com
- Member registration and coupon link: bit.ly/2XlvANW
- Telehealth member brochure: bit.ly/2Ue4Ugn

Bright Health

- The COVID-19 diagnostic test is included with preventative care, at no cost to members regardless of network. (mail-order and OTC COVID-19 tests do not qualify)
- Early medication refills are authorized for members impacted by the outbreak. Contact your pharmacist and ask them to request approval for early refills through Bright Health's pharmacy help line.
- Telehealth: All telehealth services (online and virtual care) obtained in connection with doctor-ordered COVID-19 testing and diagnosis are now covered, at no cost to our members.
- Bright Health is making non-emergency transportation available to all members and is waiving ride limits for non-emergency visits to and from your doctor
- Individual and Family Programs (IFP): The reimplementation of authorization requirements will be a phased approach.
- Effective May 1,2020:
  - o Hospital and Post-Acute Care Inpatient Stays: Inpatient initial/concurrent and prior authorization will return to normal utilization review process using MCG criteria to determine medical necessity and length of stay. This includes long-term acute care (LTAC), acute inpatient rehabilitation, and skilled nursing facility. Inpatient stays related to COVID-19 will continue to follow a "notification only" process.
  - o Outpatient Services: Authorization required for a subset of Level 1 (network validation) and Level 2 (medical necessity) CPT/HCPC codes where authorization requirements were suspended in March 2020.
  - o Network Validation: Providers not contracted with Bright Health (out of network) will need to submit an authorization for all services and procedures.
- Effective June 1,2020:
  - o Return to normal utilization management authorization requirements. Remaining authorization requirements for Level 1 (network validation) and Level 2 (medical necessity) CPT/HCPC codes that were suspended in March 2020 will be reimplemented beginning June 1, 2020.
- Created a blog for members with comprehensive information about COVID-19, a list of resources, health precautions, an update to coverage is available at: bit.ly/3blUhOe
- For more information visit: brighthealthplan.com/covid-19

Humana

- Member cost share for outpatient behavioral health visits is waived to encourage members to seek needed behavioral health care.
- Member cost share for all in-network primary care visits is waived for the remainder of the calendar year to encourage members to seek needed care from their primary care provider.
- Humana MA has extended member cost-sharing waivers through the end of the calendar year for in-network telehealth visits.
- To support providers with caring for their Humana patients while promoting both patient and provider safety, we have updated our existing telehealth policy. Humana is waiving member cost share for all telehealth services delivered by participating/in-network providers.
  *Please do not collect traditional member responsibility for these services from any Humana member, as it will result in avoidable refund transactions and may inhibit member from seeking care.
  humana.com/provider/coronavirus/telemedicine
- Humana MA is waiving member cost share for COVID-19 testing and urgent care telemedicine visits and we have expanded these waivers to now cover all COVID-related medical treatment.
- Humana will plan to reinstate authorizations and referrals for Medicare Advantage, Medicaid and Commercial lines of business effective for all required services per Humana policy with a date of service on or after May 22, 2020. This return to our standard authorization policy includes authorizations for outpatient services, inpatient services, post-acute transitions of care and durable medical equipment, and applies to participating/in-network and non-participating/out-of-network providers. From a process standpoint, availability and telephonic authorization tools will continue to provide an automatic approval upon submission of an authorization request or notification through May 21, 2020, and no process changes are required through that date. On May 22, 2020, authorization requests for required services will not automatically be approved, and authorization responses will be provided in normal processing time-frames; please plan accordingly. As we resume regular utilization management processes, there will continue to be key exceptions for authorization and referral requirements:
  1. We will continue to suspend all medical authorizations and referrals for COVID-related diagnoses for both in-network/participating and out-of-network/non-participating providers.
  2. Wherever a state executive order exists to suspend authorizations and referrals, we will continue to monitor and follow state rules. This will apply to Medicaid and Commercial lines of business only.
- As a reminder, for any authorization approved prior to April 1, that was not completed, Humana applied an additional 90 days to the authorization expiration date.
- In the interest of our members' health and to help support future transitions of care, please continue to submit a notification as normal when your Humana-covered patients are admitted to the hospital, even when authorization is not required. The notification will allow us to track patients' progress through the health-care delivery system and provide assistance in real time. You will receive automatic approval when you submit the notification.

Humana

- Medical record requests for claim reviews, will resume effective May 15, 2020.
  1. Resuming pre-payment medical record claims review. As of May 15, 2020, Humana may begin to request medical records from your organization prior to issuing payment, consistent with our policy in place prior to the April 1, suspension.
  2. Resuming post-payment medical record claims review. Since April 1, Humana has not requested medical records in connection with our post-payment review process. Our post-payment claims review team will now resume making requests for medical records as required, consistent with our policy in place prior to April 1, 2020.
- Humana will cover out-of-network telehealth claims related to COVID-19 even if the HMO does not have out-of-network benefits. Telehealth claims not related to COVID-19 will be processed in accordance with the plan's out-of-network benefit if the HMO has out-of-network benefits. Medical necessity, as well as applicable CMS guidelines and other plan rules, will continue to apply.
- Telehealth can be used for annual wellness visits if provided consistent with applicable CMS guidance, state guidance and Humana policy.
- Humana will adopt all waivers CMS publishes for services provided via telehealth to its Medicare Advantage members, including those pertaining to originating site requirements. In accordance with current CMS policy, the originating site may be the patient's home. For further details, please refer to Humana policy and the CMS website.
- For providers with a current Practitioner Assessment Form (PAF) contract amendment in place, Humana will continue to pay providers for completing elements of the PAF they are able to address through telehealth or other virtual technology. We will continue to reassess the PAF program and communicate any updates with our physician groups at that time.
- Stars and Risk Adjustment:
  - In response to the COVID-19 PHE, the Centers for Medicare & Medicaid Services (CMS) released guidance via the Interim Final Rule, published April 6, 2020. This guidance minimizes exposure risks and grants flexibilities that enable health plans, healthcare providers and physician offices to focus on caring for Medicare beneficiaries – and avoid contributing to the strain on the healthcare system resulting from this pandemic.
  - For a summary of the changes to quality improvement and data collection activities for measurement years 2019 and 2020 that impact Star Ratings for plan years 2021 and 2022 please visit humana.com/provider/coronavirus/stars.
- For more information visit: humana.com/provider/coronavirus
- Teleheath FAQs to support physicians: huma.na/39BYlok

Medica

Telehealth

- Medica is temporarily waiving the CMS and state-based site restrictions and will allow a member to be located at home when they receive telehealth services.
- Home tests for COVID-19 that are FDA-approved, ordered by a practitioner and medically necessary are eligible, except when done for a return to work or public surveillance.
- Medica is recommending that telehealth include both audio and visual, but is waiving the policy requirement of a visual component for the duration of the Emergency Telemedicine Reimbursement Policies related to COVID-19. Providers should continue to follow proper coding guidelines for services provided.
- In accordance with CMS and state guidance, Medica will waive the HIPAA security requirements and allow audio-visual applications such as Skype and FaceTime, to be used for telehealth visits.
- Applies to both medical and behavioral health services
- Member liability will continue to apply in accordance with the member's benefit plan except when a telemedicine visit results in an order for or administration of COVID-19 lab testing, as defined in CMS guidance and for other telemedicine services only to the extent as required by applicable law.
- Medica is covering certain preventative health services provided via telehealth. Covered CPT Codes are 99381 – 99387 and 99391 – 99397. This temporary change applies for all Medica members (other than Medicare Members) receiving telehealth services from June 1, 2020 through July 31, 2020, dates of service, or for the duration of the public health emergency, whichever is later.
- To ensure that provider reimbursements are not slowed down during the current Public Health Emergency, and ensure that members have uninterrupted access to health care services and medications at this critical time, Medica is paying Individual and Family Business (IFB) member claims even for members not current on their premiums, beginning with March 1, 2020, dates of service. However, when the national health emergency is over and IFB member accounts are fully reconciled, some provider recoupments may result if a member's coverage is terminated retroactively due to non-payment of premiums.
- Cost-sharing is waived for COVID-19 diagnostic testing and provider services for the testing. This change applies to Medicare, Medicaid, self-funded groups, fully-insured groups, and individual health insurance coverage, retroactive to March 1, 2020, and extended through July 31, 2020, dates of service.
- To properly reflect the waiver of member cost-sharing for COVID-19 testing during the public health crisis (PHE), please use the CS modifier only for services relating to the order for or administration of a COVID-19 diagnostic test. Also, network providers may append the CS modifier to codes used for the evaluation of an individual for purposes of determining the need for diagnostic testing. This guidance applies for all Medica members.

Medica

- Member cost-sharing for in-network COVID-19 hospital care will be waived. This includes copays, co-insurance and deductibles and applies to fully insured group, individual, Medicare and Medicaid members. Self-insured employers will have an opportunity to also waive member cost-sharing for inpatient hospital services. (Effective Mach 1, 2020, through September 30, 2020)

- Medica is waiving member cost-sharing for FDA-approved antibody tests for all Medica members, as long as tests are ordered by a medical professional and medically necessary. Our coverage for the antibody test applies both in-network and out-of-network and will extend to office visits and other charges related to the antibody test when performed at in-network locations for a suspected COVID-19 diagnosis. This new coverage runs at least through July 31, 2020, dates of service.

- Extended through September 30,2020 - Prior authorization requirements have been waived. This applies to admissions to long-term care facilities, acute inpatient rehabilitation and skilled nursing facilities and home health care.

- Medica will temporarily suspend the "Medicare Sequester" from May 1, 2020, until December 31, 2020, as outlined in the Coronavirus Aid, Relief, and Economic Security (CARES) Act. This will apply for both in-network and out-of-network providers who have had the 2% sequestration applied to their Medicare rates – specifically, it will apply for all physician, facility, ancillary provider and other health care professional payments on Medicare services for dates of service or dates of discharge from May 1, until December 31, 2020. On January 1, 2021, Medica intends to resume reimbursement in the manner that was in effect prior to May 1, 2020.

Medication

- Early refills will be available to Medica members. To request early refill, please contact Customer Service at 1-866-398-7411. Pharmacists can also enter a submission clarification code of 13 to allow the claim to process.
  - Effective May 4, 2020, Medica is adding quantity limits on certain drugs used for COVID-19. The fear of COVID-19 and subsequent stockpiling of medications used to treat this virus has put stress on the supply chain, limiting access and availability of these medications. In order to prevent stockpiling, as well as misuse and overuse, Medica is adding quantity limits (QLs) to certain medications effective May 4, 2020, as outlined below. These QLs apply to Medica's commercial, Individual and Family Business (IFB) and Minnesota Health Care Programs (MHCP) members who have pharmacy drug coverage through Medica.

  - For details on specific limits please visit: bit.ly/3b3GrPJ

- For more information go to: medica.com/corp/covid-19

Medicare

- Medicare covers the lab tests for COVID-19. Patient pays no out-of-pocket costs.

- Medicare covers all medically necessary hospitalizations. This includes if you're diagnosed with COVID-19 and might otherwise have been discharged from the hospital after an inpatient stay, but instead you need to stay in the hospital under quarantine.

- At this time, there's no vaccine for COVID-19. However, if one becomes available, it will be covered by all Medicare Prescription Drug Plans (Part D).

- Waiving certain requirements for skilled nursing facility care.

- If you have a Medicare Advantage Plan, you have access to these same benefits. Medicare allows these plans to waive cost-sharing for COVID-19 lab tests. Many plans offer additional telehealth benefits beyond the ones described below. Check with your plan about your coverage and costs.

- As part of an effort to address the urgent need to increase capacity to care for patients, hospitals can now provide hospital services in other health-care facilities and sites that aren't currently considered part of a health care facility. This includes off-site screenings.

- For more information visit: medicare.gov/medicare-coronavirus

Nebraska Total Care

- Telehealth: Effective immediately, the policies we are implementing include:
  - Continuation of zero member liability (copays, cost sharing, etc.) for care delivered via telehealth
  - Any services that can be delivered virtually will be eligible for telehealth coverage
  - All prior authorization requirements for telehealth services will be lifted for dates of service from March 17, 2020, through June 30, 2020 **EXPIRED**
  - Telehealth services may be delivered by providers with any connection technology to ensure patient access to care** (**Providers should follow state and federal guidelines regarding performance of telehealth services including permitted modalities)

- This coverage extension follows the Centers for Medicare & Medicaid Services' (CMS) guidance that coronavirus tests will be fully covered without cost-sharing for Medicare and Medicaid plans, a decision that Nebraska Total Care fully supports for our members covered under these programs. We also support the administration's guidance to provide more flexibility to Medicare Advantage and Part D plans. The specific guidance includes:
  - Waiving cost-sharing for COVID-19 tests
  - Waiving cost-sharing for COVID-19 treatments in doctor's offices or emergency rooms and services delivered via telehealth
  - Removing prior authorizations requirements
  - Waiving prescription refill limits
  - Relaxing restrictions on home or mail delivery of prescription drugs
  - Expanding access to certain telehealth services

- UHC is waiving member cost-sharing for the treatment of COVID-19 through Oct. 22, 2020, for its fully-insured commercial, MA, and Medicaid members. UHC will also work with self-funded customers who want to implement a similar approach on their behalf.
- Starting March 31, 2020, through June 8, 2020, UHC will now also waive cost-sharing for in-network, non-COVID-19 telehealth visits for its MA, Medicaid, and Individual and Group market fully insured health plans.
- Effective immediately through September 20, 2020, UHC is temporarily updating the credentialing policies to implement provisional credentialing for out-of-network care providers who are licensed independent practitioners and want to participate in one or more of our networks. The full credentialing process will be completed within 180 calendar days from when provisional credentialing is granted.
- UnitedHealthcare is waiving member cost sharing for the treatment of COVID-19 until July 24, 2020, for its Medicare Advantage, Medicaid and Individual and Group Market fully insured health plans. Implementation for self-funded customers may vary.
- If a member receives treatment under a COVID-19 admission or diagnosis code between Feb. 4, 2020, and Oct. 22, 2020, we will waive cost sharing (copays, coinsurance and deductibles) for the following:
  - o Office visits
  - o Urgent care visits
  - o Emergency department visits
  - o Observation stays
  - o Inpatient hospital episodes
  - o Acute inpatient rehab
  - o Long-term acute care
  - o Skilled nursing facilities
- Expanded Provider Telehealth Access: UnitedHealthcare is waiving the Centers for Medicare & Medicaid Services (CMS) originating site restriction:
  - o For Individual and fully insured Group Market health plans, this waiver is applicable from March 18, 2020, through the end of the public health emergency. Eligible care providers can bill for telehealth services performed using either interactive audio-video or audio only, except in the cases where we have explicitly denoted the need for interactive audio-video, such as with PT/OT/ST, while a patient is at home. Additional benefits or limitations may apply in some states and under some plans during this time.
- For COVID-19-related visits, cost sharing will be waived for in-network and out-of-network telehealth services for medical, outpatient behavioral, PT/OT/ST, chiropractic therapy, home health and hospice, and remote patient monitoring services from March 31, 2020, through the end of the national public health emergency, with opt-in available for self-funded employers.
- For COVID-19 in-network and out-of-network telehealth services, UHC will extend the cost share waiver from July 25th, 2020 through the end of the public health emergency.
- For non-COVID-19 visits, cost sharing will be waived for in-network telehealth services for medical, outpatient behavioral, PT/OT/ST, chiropractic therapy, home health and hospice and remote patient monitoring services from March 31, 2020, through September 30,2020 (Date subject to change based on direction from CMS) with opt-in available for self-funded employers.
- Additional benefits or limitations may apply in some states and under some plans during this time.
- UHC will cover cost share for COVID-19 antibody testing for our members.
- UHC is eliminating many non-essential administrative requests, such as surveys and data requests.
- The implementation date for UHC's new Medicare Advantage Emergency Department Professional E/M Coding Policy has been delayed until Aug 1, 2020. The policy focuses on professional ED claims submitted with a level 5 (99285) E/M code for MA claims. A reminder to providers of the new effective date will be in the June Network Bulletin.
- For MA and Medicaid plans: Extending timely filing deadlines for claims during the COVID-19 public health emergency period for MA, Medicaid, and individual and Group Marketing Health Plans. Claims with a DOS on or after Jan. 1, 2020 will not be denied for failure to meet timely filing deadlines if submitted through June 30, 2020.

EXPIRED

- For Individual and group market plans: Extended timely filing deadlines follow the IRS/DOL regulation. This regulation pauses the timely filing requirements time clock for claims that would have exceeded the filing limitation during the national emergency period that began on March 1, 2020
  - o Timely filing requirements have been extended an additional 60 days following the last day of the national emergency period; UHC standard filing requirements apply to claims that exceed requirements prior to the national emergency period**
    - ***The national emergency as declared by President Trump, is distinct from the national public health emergency declared by the U.S. Department of Health and Human Services.*
- Effective April 10, 2020, Optum Rx home delivery pharmacy is placing its mandatory ePrescribing policy for controlled substances (EPCS) temporarily on hold until further notice. The policy went into effect on March 1, 2020, and required care providers to send e-prescriptions for controlled substances. Optum Rx pharmacy will fill any controlled substance prescription the receive, as long as the prescription meets federal and state regulatory requirements.
- Members affected by COVID can fill existing prescriptions early (one time, up to 90-day fill) through direct pharmacy or mail order.
- To streamline operations for providers, we're suspending prior authorization requirements for COVID-19 diagnostic radiology, post-acute care, member transfers to a new provider and site of service review for many surgical codes. Visit our COVID-19 prior authorization page for effective dates and specific details.

- If you need assistance with COVID-19 discharge planning, please email UnitedHealthcare at *covid-19dischargeplanning@uhc.com*. Your questions will be handled by a special team focused on COVID-19 discharge matters. During this national emergency, we will generally respond to requests within two hours, from 7 a.m. to 7 p.m. CST. Team members are available to assist you seven days a week.

- If you need assistance with COVID-19 discharge planning, please email UnitedHealthcare at *covid-19dischargeplanning@uhc.com*. Your questions will be handled by a special team focused on COVID-19 discharge matters. During this national emergency, we will generally respond to requests within two hours, from 7 a.m. to 7 p.m. CST. Team members are available to assist you seven days a week.

Telehealth

- Through, UHC will waive the CMS site restriction and audio-video requirement for MA, Medicaid and commercial members. Eligible providers can now bill telehealth services performed using audio-video or audio-only while a patient is at home.

- Benefits will be processed in accordance with member's plan. Member cost sharing will be waived for COVID-19 testing related visits during this national emergency.

- UHC will allow physical, occupational and speech therapists to bill telehealth services when they are rendered using interactive audio/video technology.

In-Network and Out-of-Network Telehealth coverage:

- For Medicare Advantage in-network expanded telehealth services for medical, outpatient behavioral and PT/OT/ST services from March 31,2020 through the national public health emergency period.
- Medicaid coverage is based on stated regulation or will expire June 18, 2020.
- Individual and fully insured Group Market health plan with opt-in available for self-funded employers in- and out-of-network COVID-19 related visits will be covered through the national health emergency, for in-network Non-COVID 19 telehealth coverage will be extended through September 30, 2020 and out-of-network coverage for NON-COVID telehealth (EXPIRED) through 7/25/2020.

EXPIRED

- For medical and outpatient behavioral telehealth visits, providers can utilize both interactive audio-video and audio-only. For PT/OT/ST provider visits, interactive audio/video technology must be used.

- Cost sharing will be waived for in-network telehealth visits. According to plan benefits, out-of-network providers also qualify for telehealth and member benefit and cost sharing will apply, if applicable.

- Cost Share covered for COVID-19 Anti-body testing: UHC will cover FDA-authorized COVID-19 antibody tests ordered by a physician or appropriately licensed health care professional without cost sharing (copayment, coinsurance or deductible). This coverage applies to members enrolled in MA, Medicaid, and Individual and group market health plans and extends through the end of the public health emergency.

- UnitedHealthcare is requesting all physicians and health care professionals who perform and bill for COVID-19 antibody tests to register the test(s) that will be used for our members. This includes both hospital-affiliated and freestanding laboratories, as well as physician practices with in-house laboratories.
  - o Please complete the COVID-19 Antibody Test Registration as soon as possible. To complete the test registration, you'll need:
    - The laboratory tax ID number (TIN)
    - The type of antibody test rendered

- Health care professionals can access resources from across UnitedHealth Group to help support their mental and physical well-being during the COVID-19 national public health emergency. Learn more: bit.ly/3damE35

- Summary of COVID-19 Dates by Program: bit.ly/37y0vKd

- For more information visit: bit.ly/2RmtvNT

Wellcare of Nebraska
NOT AFFILIATED WITH THE NHN

- Coverage extension follows the Centers for Medicare & Medicaid Services' (CMS) guidance that coronavirus tests will be fully covered without cost-sharing for Medicare and Medicaid plans, a decision that WellCare fully supports for our members covered under these programs. We also support the administration's guidance to provide more flexibility to Medicare Advantage and Part D plans.
  The specific guidance includes:
  - o Waiving cost-sharing for COVID-19 tests
  - o Waiving cost-sharing for COVID-19 treatments in doctor's offices or emergency rooms and services delivered via telehealth
  - o Removing prior authorizations requirements
  - o Waiving prescription refill limits
  - o Relaxing restrictions on home or mail delivery of prescription drugs
  - o Expanding access to certain telehealth services
- We will not require prior authorization, prior certification, prior notification and/or step therapy protocols for medically necessary COVID-19 diagnostic testing, medical screening services, and/or treatment when medically necessary services are ordered and/or referred by a licensed health care provider.
- We will temporarily waive requirements that out-of-state Medicare and Medicaid providers be licensed in the state where they are providing services when they are licensed in another state.
- All member cost share (co-payment, coinsurance and/or deductible amounts) will be waived across all products for any claim billed with the new COVID-19 testing codes.
- We have configured our systems to apply $0 member cost share liability for those claims submitted utilizing the new COVID-19 testing codes.
- In addition to cost share, authorization requirements will be waived for any claim that is received with those specified codes.
- Providers billing with these codes will not be limited by provider type and can be both participating and non-participating.
- Adjudication of claims is currently planned for the first week of April 2020.
- All prior authorization requirements for telehealth services will be lifted for dates of service from March 17, 2020, through June 30, 2020.

  EXPIRED
- For more information visit: www.wellcare.com/en/Nebraska/COVID-19

Information for Specific Insurance Plans:
ahip.org/health-insurance-providers-respond-to-coronavirus-covid-19/
Includes specific links for information on the following:
1. CDC Information Page
2. CDC Symptoms Check
3. Confirmed Cases of COVID-19
4. Health Insurance Providers Respond to (COVID-19)

Documenting, Coding and Billing Information

POS: 02 (indicates Telehealth visit)

Modifiers: Use for Telehealth services. Certifies the patient received services via an audiovisual telecommunications system
- **95 mod** (used by commercial plans) real-time audio and video telecommunications system
- **GT mod (**used by Medicare) service rendered via interactive audio and video telecommunication system
- **G0 mod** (telestroke services) services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke

ICD-10 Codes
- **B34.2 -** Coronavirus infection, unspecified
- **B97.2 -** Coronavirus as the cause of diseases classified elsewhere
- **B97.21 -** SARS-associated coronavirus, causing diseases classified elsewhere
- **B97.29 -** Other coronavirus as the cause of the diseases classified elsewhere
- **U07.1 -** COVID-19, virus identified
- **J12.81 -** Pneumonia due to SARS-associated coronavirus
- **Z03.818 -** Possible exposure to COVID-19 (ruled out after evaluation)
- **Z20.828 -** Contact with (suspected) and exposure (to other biological agents ruled out) Used for cases when there is an actual exposure to someone who is confirmed to have COVID-19

CPT Codes

87635 effective March 13, 2020, and issued as "the industry standard for reporting of novel coronavirus tests across the nation's health care system." Lab testing code for SARS-CoV-2: (severe acute respiratory syndrome)

HCPCS

U0001 - For CDC developed tests only - 2019-nCoV Real-Time RT-PCR Diagnostic Panel.

U0002 - For all other commercially available tests - 2019-nCoV Real-Time RT-PCR Diagnostic Panel.