PROVIDER RESOURCE

COVID-19
Resource Document
IOWA

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 Jan. 2. 2021

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.
  - o 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.
  - o 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/2WQowXl
- 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 January 31, 2021.

Aetna • MA

- **For commercial plans**:
  - Through January 31, 2021, 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:**
  - Aetna's telemedicine policy is available to providers on the Availity and NaviNet portals (bit.ly/2VFkssS).
- Through January 31, 2021, Aetna has extended all member cost-sharing waivers for covered in-network telemedicine visits for outpatient behavioral health and mental health counseling services for their commercial plans. 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 January 31, 2021, 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 January 31, 2021.
- 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
- To address circumstances where PCP offices are closed due to COVID-19, Aetna has relaxed the PCP rule so no referral is necessary for Medicare Advantage plans. Aetna has not changed its PCP referral requirements for commercial plans

Vaccine Information:

- Aetna members in Commercial and Medicaid plans will not have to pay any out-of-pocket costs for a COVID-19 vaccine. For Medicare beneficiaries, CMS will cover the full cost of the vaccine, including those in a Medicare Advantage plan.
- Aetna will cover COVID-19 vaccine administration fees without cost-sharing for both in- and out-of-network providers, for both Commercial and Medicaid members.
- Aetna will cover any COVID-19 vaccine that has received FDA authorization, at no added cost to members.
- Telehealth tips: bit.ly/31pBr6A
- For more information go to: aet.na/3bsNgvj

Blue Cross Blue Shield

- Appropriate medically necessary in-network medically appropriate diagnostic testing for COVID-19 will be paid without member cost share for all members through April 20, 2021. 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.
  - Starting Nov. 1, 2020, COVID-19 testing done for non-diagnostic purposes, such as public surveillance or employment, will not be covered because it is not considered medically appropriate. Surveillance testing is when an individual has no COVID-19 symptoms (is asymptomatic) and has no known exposure to COVID-19.
- BCBS is waiving member cost-sharing for in-network treatment of COVID-19 from March 1, 2020, through December 31, 2021. This means members with medical plan coverage will pay nothing for in-network medically appropriate testing and treatment administered at a doctor's office, urgent care facility and emergency room, as well as inpatient hospital stays. This applies to all fully insured group and individual health plan members, along with those who receive their insurance through Medicare Supplement and Medicare Advantage plans. Starting January 1, 2021, BCBSNE will apply member cost shares to treatment of COVID-19. Self-funded groups that are currently covering treatment without member cost shares may extend that coverage past December 31, 2021. Employees of self-funded groups should check with their employer to find out about their cost shares.

NEW

- Effective immediately,
  - 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.
  - 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.
  - 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.
- Member costs shares will continue to be waived for all in-network telehealth visits directly related to a COVID-19 diagnosis through April 20, 2021.
- For all other covered telehealth services, normal plan cost shares will once again apply beginning July 1,2020.
- **Vaccine Information**: BCBSNE members will receive the FDA-approved vaccinations *(Pfizer-BioNTech and Moderna)* at no cost. Through the CARES Act, the government is paying for the cost of the vaccine and health plans will cover the cost of the administration and related office visit is applicable.

Blue Cross Blue Shield

- 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:

Bright Health

- The COVID-19 diagnostic test is included with preventative care, at no cost to members regardless of network. Testing for other purposes, such as return to work or checking one's own antibody levels will not be covered through the health plan. (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.
  - o If you choose to use a telehealth provider other than Doctor On Demand you may be required to pay upfront and submit a claim to be reimbursed by Bright Health. The reimbursement forms are located here for: Individual and Family and Employer-sponsored health plans bit.ly/2Lc7Ecf or Medicare bit.ly/3bkpwwm.
- 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.
- COVID-19 Vaccine:
  - o As FDA-authorized vaccines for COVID-19 become available, Bright Health will cover the cost of the administration of the vaccine for our members. The vaccine will be available to providers at no cost until further notice. When vaccinating a member, a provider doesn't need to bill for a visit unless other services are provided at the same time.

Authorizations:

- For post-acute care setting we do not require an authorization for admission.
- For contracted SNF providers we auto-approve the first seven days of the stay and required an authorization for services starting on day eight.
- For contracted home care providers, Bright Health will auto-approve the first six visits and require an authorization for services that go beyond the six visits.
- Bright Health does require a prior authorization for LTACs and Acute Rehabilitation.
- 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

- For the 2021 plan year, Humana will cover out-of-pocket costs for COIVD-19 treatment for Humana Medicare Advantage Members.
- Eligible members will have no co-pays, deductibles or coinsurance out-of-pocket costs for covered services for treatment of confirmed cases of COIVD-19, regardless of where the treatment takes place. This could include telehealth, primary care physician visits, facility visits, labs, home-health, and ambulance services.
- Members are encouraged to check their plan documents for details about their 2021 coverage.
- Medicaid plans will continue to follow state requirements for COVID-19 treatment and cost-share waivers.
- No all member plans are eligible
  - o Effective January 1, 2021, employer group members' standard benefit and cost-sharing will apply for COIVD-19 treatment.
  - o NOTE: This does not apply o Part D-only plan members. Part D-only plan members continue to be eligible for prescription benefits.
- Humana will cover FDA-approved medications as they become available. This includes Veklury (remdesivir), which has been approved by the FDA for the treatment of patients with COVID-19 requiring hospitalization. If a member is prescribed non-FDA-approved medications for the treatment of COVID-19, he or she will be responsible for any cost-sharing required per his or her plan design. Non-FDA approved drugs are excluded Part-D drugs and ineligible for any Part D coverage.
- Humana encourages members to continue to seek care from the healthcare providers they already know, We will cover eligible members' copays, deductibles or coinsurance costs for in-network or out-of-network COVID-19-related covered benefits during this time.
- For Skilled nursing facilities (SNFs) Humana has extended suspension of prior authorization requirements until January 31, 2021 for Medicare Advantage and commercial members in Dodge and Douglas County in Nebraska and all of the state of Iowa.
- Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.
- All other services requiring prior authorization are not included in this suspension
- As we resume regular authorization processes, we will continue to monitor local situations and adjust policy accordingly. This includes continuing to suspend authorizations wherever a state executive order to do so exists.

- *Please note: Humana continues to waive out-of-pocket costs related to COVID-19 testing. Additionally, Humana will waive out-of-pocket costs related to treatment for confirmed cases of COVID-19. These cost share waivers apply to all of our Medicare Advantage, Medicaid and fully-insured commercial members. Finally, there are no prior authorization requirements related to COVID-19 testing.*

- 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.• 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.
- Humana announced a national pilot for home-testing program that will enable at-home COVID-19 diagnostic testing for members, making Humana the first insurer to provide LabCorp's at-home test collection. Humana also announced an innovative new collaboration with Walmart and Quest Diagnostics to help members more easily get tested by offering tests at hundreds of Walmart Neighborhood Market drive-thru pharmacy locations across the country. By the end of the summer, there will be 500 locations for Humana members to access drive-thru testing at Walmart. Humana will continue to waive member costs related to COVID-19 diagnostic tests. For more information please visit: huma.na/3jdQVjY
- 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.
- **Vaccine Information:**
  - All FDA-authorized COVID-19 vaccines will be covered at no additional cost during the public health emergency. Coverage applies no matter where the Humana patient gets the vaccine—including at both in-network and out-of-network providers. It also covers instances in which two vaccine does are required.
  - For MA members all Vaccine-related claims should be submitted to the Medicare Administrative Contractors. Humana will deny any vaccine product or administration claims received for Medicare Advantage members. **NEW**
- For more information visit: humana.com/provider/coronavirus
- Teleheath FAQs to support physicians: huma.na/39BYlok

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 April 30, 2021, dates of service.
    - Medica covers rapid diagnostic tests as well as standard nasal and saliva diagnostic tests. All tests must be medically necessary and ordered by a medical professional.
    - If COVID-19 testing takes place at an out-of-network provider, all other services associated with the out-of-network provider will be covered at the out-of-network benefit, including, but not limited to influenza tests, blood draws, strep tests, chest x-ray, etc.
- 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.
- 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 June 30, 2021.
- 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 April 30, 2021, dates of service.
- Extended through April 30,2021 - Medica will continue to suspend prior authorization for admission to a post-acute care setting. Also, for the repair or replacement of durable medical equipment (DME), we continue to waive a new physician's order, face-to-face visit or medical necessity documentation.
- Medica will temporarily suspend the "Medicare Sequester" from May 1, 2020, until March 31, 2021, 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 March 31, 2021.

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

Medica

- As the public health emergency (PHE) continues to evolve, additional codes may be created in order to accurately report and reimburse for services related to COVID-19. We encourage providers to reference Medica's COVID-19 Testing reimbursement policy for the latest coding considerations. bit.ly/32VixoT

Vaccine Information:

- Medica will waive costs for the vaccine and administration of the vaccine for all members
- Vaccines, once widely available, will be administered at various in-network and out-of-network retail pharmacies, doctor's offices and hospitals.

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.
- Medicare covers FDA-approved COVID-19 vaccines.
- 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
  - 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

Vaccine Information

- Nebraska Total Care will configure its systems to properly adjudicate COVID-19 vaccine-related claims, both for the vaccine and its administration, in accordance with Nebraska MLTC's coverage determinations for Medicaid beneficiaries
- Member liability will be $0
- Non-participating provider pre-auth requirements will be waived
- Additionally, CMS has also published a set of toolkits to help providers prepare to swiftly administer the vaccine once it is available. If you have any further questions about this upcoming vaccine or the COVID-19 services Nebraska Total Care covers, please contact Provider Relations.
- The COVID-19 global pandemic has created unprecedented changes to our lives and healthcare systems. While we continue to connect our members to COVID-19 services, we wanted to reach out to our provider partners on how we can work together to better support their care needs.

  As a primary care physician (PCP), you are at the heart of our members' healthcare. They trust and rely on you to help them access appropriate, affordable, coordinated care from the right providers, at the right time. If you refer our members to an out-of-network provider – or send their test specimens to a non-participating laboratory – they could be responsible for the out-of-network charges according to their benefits. These costs can quickly add up, especially for patients who do not have out-of-network benefits.

  You can help your patients avoid this and keep their medical costs down by referring them to providers within their Nebraska Total Care network, as denoted on their Member ID card. Understanding it can sometimes be challenging to navigate multiple payor networks to connect patients to appropriate in-network providers and facilities, we want to share two easy methods for you to access this information quickly:

- **Search In-Network Providers Online**: Our provider directory offers the current list of our in-net work providers.
- **Call to your Provider Services Representative at 1-844-385-2192, Nebraska Relay Service 711.** They can help you quickly identify in-network specialists and labs.

  Thank you for your continued partnership during this time of heightened concern. If you have any questions regarding our networks, please contact Provider Services at 1-844-385-2192, Nebraska Relay Service 711.

UHC Medicare Advantage

COVID-19 Diagnostic Testing:
- From Feb. 4, 2020 through the national PHE period, currently scheduled to end April 20, 2021, UHC is waiving cost-sharing for in-network and out-of-network tests. (Diagnostic tests (virus/antigen) must be medically appropriate and ordered by a physician or appropriately licensed health care professional. UHC will only cover testing for employment, education, public health or surveillance purposes when required by applicable law.).

COVID-19 Antibody Testing:
- From April 10, 2020 through the national PHE period, currently scheduled to end April 20, 2021, UHC is waiving cost-sharing for in-network and out-of-network tests. (Tests must be FDA-authorized and ordered by a physician or appropriately licensed health care professional, consistent with CMS guidelines).

COVID-19 Testing-Related Visits:
- From Feb. 4, 2020 through the national PHE period, currently scheduled to end April 20, 2021, UHC is waiving cost-sharing for in-network and out-of-network testing-related visits, including testing-related telehealth visits.

COVID-19 Treatment:
- From Feb. 4, 2020 through Feb. 28, 2021, UHC is waiving cost-sharing for in-network and out-of-network visits, for inpatient and outpatient COVID-19 treatment, including telehealth treatment visits. This includes:
  - 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

Transportation:
- Coverage and cost sharing will be adjudicated in accordance with the member's benefit plan.

NON-COVID-19 Telehealth Visits:
- From Oct 1, 2020 through December 31,2020, UHC will extend the cost share waiver for in-network and covered out-of-network primary care telehealth services.
- As of October 1, 2020, cost sharing for non-primary care telehealth services will be adjudicated in accordance with the member's benefit plan.

Telehealth expansion:
- From Jan. 1, 2021 through the end of the PHE, currently scheduled to end April 20, 2021, UHC will cover all in-network and out-of-network telehealth services as outlined in the current CMS guidelines

.

UHC Medicaid:
- State Regulations apply to all telehealth expansion and cost-share waivers.

UHC Individual and Group Market Health Plans:

COVID-19 Diagnostic Testing:
- From Feb. 4, 2020 through the national PHE period, currently scheduled to end April 20, 2021, UHC is waiving cost-sharing for in-network and out-of-network tests. (Diagnostic tests (virus/antigen) must be medically appropriate and ordered by a physician or appropriately licensed health care professional. UHC will only cover testing for employment, education, public health or surveillance purposes when required by applicable law.)

COVID-19 Antibody Testing:
- From April 10, 2020 through the national PHE period, currently scheduled to end April 20, 2021, UHC is waiving cost-sharing for in-network and out-of-network tests (Tests must be FDA-authorized and ordered by a physician or appropriately licensed health care professional, consistent with CMS guidelines)

COVID-19 Testing-Related Visits:
- From Feb 4, 2020 through the national PHE period, currently scheduled to end April 20, 2021, UHC is waiving cost-sharing for in-network and out-of-network testing-related visits, including testing-related telehealth visits

COVID-19 Treatment:
- EXPIRED: From Oct. 23 through Dec 31, 2020, UHC is waiving cost-sharing for in-network visits, for inpatient AND OUTPATIENT COVID-19 treatment
- From Jan 1, 2021 through Jan. 31, 2021, UHC is waiving cost sharing for COVID-19 inpatient treatment at in-network facilities. Beginning February 1, 2021 cost sharing will be adjudicated in accordance with the member's benefit plan. Implementation for self-funded customers may vary. NEW
- Starting Oct 23, 2020, out-of-network coverage will be determined by the member's benefit plan.

Transportation:
- EXPIRED: From Feb 4, 2020 through Dec 31, 2020, UHC is waiving cost-share.
- From Jan. 1, 2021 through Jan. 31, 2021 cost-share will be waived for emergency ground transportation that results in an inpatient admission for COVID-19 treatment at an in-network facility. EXPIRED

NON-COVID-19 Telehealth Visits:
- As of October 1, 2020, benefits will be adjudicated in accordance with the member's benefit plan

Telehealth expansion:
- From Jan. 1, 2021 and beyond, UHC will reimburse in-network telehealth services as outlined in current CMS guidelines and additional codes as outlined in our telehealth reimbursement policy. bit.ly/3hPWYMq

- COVID-19 Vaccine Trial
  UnitedHealth Group is collaborating with Janssen to identify people to participate1 in a clinical research trial to test an investigational COVID-19 vaccine.
  For information about the study, visit ENSEMBLE study.
  Information about selection criteria can also be found at unitedinresearch.com.
  - This is an independent study and volunteer opportunity. Membership in a UnitedHealthcare benefit plan is not required for participation. If your patients have questions about their benefits, ask them to sign in to their health plan account.

- Effective immediately through June 30,2021, 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.

- For providers who are due for re-credentialing from March 1, 2020 through Dec. 31, 2020, UnitedHealthcare is following National Committee for Quality Assurance (NCQA) guidelines and is extending the care provider recredentialing cycle by two months, to 38 months. This will allow care provider offices additional time to respond to recredentialing requests. UnitedHealthcare will continue to initiate the recredentialing requests for information based on standard timeframes and will complete all that are received prior to the 38 months.

PT/OT/Speech Therapy

- UnitedHealthcare will reimburse physical, occupational and speech therapy (PT/OT/ST) telehealth services provided by qualified health care professionals when rendered using interactive audio-video technology.

- Reimbursable codes are limited to the specific set of physical, occupational and speech therapy codes listed bit.ly/2MHixTL

- UnitedHealthcare will reimburse eligible codes using the place of service that would have been reported had the services been furnished in person on a CMS 1500 with 95 modifier or a UB04 form with applicable revenue codes.

Originating Site Expansion

- UnitedHealthcare is continuing its expansion of telehealth access, including temporarily waiving the Centers for Medicare & Medicaid Services (CMS) originating site requirements.

- Please review each health plan for specific plan details and reimbursement guidance.

Timely Filing

- 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
  - 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.*

Controlled-Substance Rx Policy Change

- 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.

Prior Authorization

- To streamline operations for providers, we're extending prior authorization time frames for open and approved authorizations and we're suspending prior authorization requirements for many services. bit.ly/3iCqowe

Discharge Planning Assistance

- 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.

- Summary of COVID-19 Dates by Program: bit.ly/2SwF855

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

Wellmark

- Effective September 1, 2020:

o Fully Insured Members
Wellmark has and will continue to provide benefits for telehealth (or virtual) visits for fully insured members. The $0 member cost-share for virtual visits will expire on Aug. 31 for fully insured members. This has been offered since the start of the pandemic to help the health care systems in Iowa and South Dakota by minimizing in-person visits to ERs or clinics as they prepared to potentially care for COVID-19 patients. After Aug. 31, a fully insured member will need to pay their standard cost-share for that benefit, which is no more for telehealth than an in-person visit.

o Self-Funded Members
Some employers are self-funded, which means they make the decisions as to what benefits are offered on their plan. A few self-funded employer group plans do not provide coverage for or have limited telehealth benefits. Now that the health care systems have adapted and are able to serve more patients in-office, some of these self-funded plans are returning to our standard telehealth benefits. After Aug. 31, providers are encouraged to log into the Provider portal to check members' benefits prior to delivering telehealth services.

o Telehealth Payment Parity
In addition, Wellmark will continue payment parity for appropriate medical and behavioral health virtual visits with an in-network provider in Iowa until June 30, 2021, and in South Dakota until further notice.

- Wellmark is complying with the CMS, AMA and CDC coding guidelines for COVID-19.
  - o More information is available at AMA Resource Center for Physicians.
- Beginning March 21,2020, fully insured members will be allowed to fill up to a 90-day supply of medication if, in the judgement of their physician or pharmacist, they should practice social distancing or remain quarantined for a long period of time. For self-funded customers who allow 90-day supply of medication, the process will be the same as fully insured. Without this benefit, they can still access up to 30-day supply on an early refill.
- Effective March 23,2020, all prior authorizations for drugs that are due to expire before July will be extended through July to lessen the administrative burden on both pharmacies and provider offices.
- Members will have no cost-share for appropriate testing to establish the diagnosis of COVID-19
- Wellmark will waive members' cost-share related to the treatment of COVID-19 (copay, coinsurance and deductible) when seeking care from an in-network provider, effective Feb. 4, 2020, through at least June 16, 2020. Effective for admissions beginning June 17, 2020, cost share will be waived for inpatient COVID-19 treatment only. Some self-funded plans that Wellmark administers may elect to require cost share of their members.

Wellmark

- COVID-19 tests are covered by Wellmark when the member is under the care of a physician or other licensed practitioner who recommends and orders testing based on: direct exposure (e.g., family member) relevant symptoms, or asymptomatic patients for whom the testing would alter the course of care.
- Testing of individual members that does not fall within the categories outlined under "Covered by Wellmark". This would include: a COVID-19 test obtained by a member without an order by a health care practitioner; a COVID-19 antibody test requested by a member without known exposure, relevant symptoms or another clinically appropriate reason to order the test.
- Public health surveillance and other broad population-based serologic/antigen testing. For example, serologic testing to meet university requirements for returning college students, regardless of symptoms or exposure, would not be covered by Wellmark.
- Employee screening and COVID-19 testing for employment purposes, which is considered occupational health and the responsibility of the business and employee.
- Any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19. Examples include testing to return to school or to play sports.

- Precertification and concurrent review requirements suspended bit.ly/3jR0AND. To facilitate inpatient capacity across the health care system during the COVID-19 pandemic, Wellmark had made the following changes for all in-network, eligible Iowa and South Dakota providers from October 23, 2020, through April 30, 2021:
  - Suspension of precertification and concurrent review requirements
  - Suspension of penalties, if applicable

- **Eligible facilities include:**
  - Acute rehabilitation
  - Home health
  - Psychiatric medical institution for children (PMIC)
  - Residential treatment centers (RTC)
  - Skilled nursing facility (SNF)

- **Requirements that continue to apply:**
  - Providers should continue to provide discharge dates and destination information.
  - Acute Facility (hospital)
    - Iowa and South Dakota
      - Notification of admission and discharge is required. Notifications by facilities will allow Wellmark nurses to assist members during their care transitions, including to the home.
    - Out-of-state
      - Precertification of admission and concurrent review, and discharge notification is required.

- **Long Term Acute Care (LTAC)**
  - LTAC is not an approved provider type to apply for credentialing and network participation, nor is it a covered benefit, therefore is not applicable.

Prior Approval extensions:

- Any new prior approval request received on or after November 17, 2020 for the below services, if approved, will have the approval end date extended to 180 days. This process will remain intact until further notice. Extending the end date will give both providers and members additional time to complete the service without the additional burden of submitting a new request. See Wellmark for detailed list of included procedures: bit.ly/39g6KmT

Amerigroup

NOT AFFILIATED WITH THE NHN

- Waive member costs for COVID-19 testing, prior authorization is not required for diagnostic services related to COVID-19 testing
- Support telehealth—Anthem's telehealth provider is LiveHealth Online
- Prescription coverage Amerigroup is providing coverage for members to have an extra 30-day supply of medication on hand. We are encouraging that when member plans allow they switch from 30-day home delivery to 90-day home delivery.
- There will be no cost sharing associated with COVID-19 testing. Test samples may be obtained in many settings including a doctor's office, urgent care, ER or even drive-thru testing once available. While a test sample cannot be obtained through a telehealth visit, the telehealth provider may connect members with testing.
- Telehealth (video + audio): There will be no cost sharing for telehealth visits, including visits for mental health or substance use disorders.
- Telephonic-only care: Effective March 19, 2020 through the duration of the pandemic emergency as defined in each individual market, Amerigroup will cover telephonic-only visits with in-network providers. Out-of-network coverage will be provided where required through June 14th, 2020. This includes covered visits for mental health or substance use disorders and medical. Exceptions include chiropractic services and physical, occupational and speech therapies, and any services which require physical contact with the patient. These services require face-to-face interaction and therefore are not appropriate for telephone-only consultations.

Vaccine Information

- The cost of COVID-19 FDA-approved vaccines will initially be paid for by the government
- Amerigroup will reimburse for the administration of COVID-19 FDA-approved vaccines in accordance with Federal and State mandates

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.