COVID-19 MEDICARE ADVANTAGE BILLING & REFERRAL GUIDELINES FOR PROVIDERS

Contents

These guidelines apply to Medicare Advantage and Medicare-Medicaid customers. Using these recommended billing guidelines and codes will facilitate proper payment and help avoid errors and reimbursement delays.

References made throughout this document in regards to referrals and cost-share are only applicable if required by the customer's benefit plan.

Updated May 4, 2020- *Highlighted text indicates updates*

Background Information

In December 2019, a new kind of coronavirus was identified as the cause of various cases of pneumonia in China. In February 2020, the World Health Organization designated the disease COVID-19. The virus that causes COVID-19 is designated severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

CMS has released several memorandums, provider toolkits and guidance around COVID-19, and the changes to the healthcare environment. The most recent Clinician letter was posted by CMS on 4/7/2020 which summarizes recent changes: https://www.cms.gov/files/document/covid-dear-clinician-letter.pdf.

(REVISED 5/4/2020) The current Public Health Emergency (PHE) period has been extended to end on **7/24/2020**.

To keep up to date with the important work CMS is doing in response to COVID-19, visit the https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page website.

Increasing Available Care

(POSTED 4/1/2020) We recognize these are times of high demand for quality healthcare. In order to support the healthcare needs of our customers and help alleviate pressure to our existing network providers, we have implemented an accelerated initial credentialing process for providers performing critical COVID-19 related services. This process will help to ensure we are able to meet our customers' needs by onboarding critically needed providers into the network quicker.

This accelerated initial credentialing process will be available until **June 30, 2020**. It is requested that providers identify their application as COVID-19 related upon submission. Standard credentialing and onboarding requirements for plan participation apply.

CMS has also established a free hotline for providers to enroll and receive temporary Medicare billing privileges. Reference the CMS Medicare Provider Enrollment Hotline FAQ for details: https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

Interim Authorization & Referral Guidelines

The guidelines below apply during the PHE period. State and federal mandates may supersede these guidelines.

Contracted Provider Services

(REVISED 5/4/2020)

- Referrals: All referral requirements (*if required by customer's benefit plan*) are waived.
- Authorizations:
    - Durable Medical Equipment- Documentation of face to face, physician order, and medical necessity is not required to obtain replacements of DME that is lost, destroyed, irreparably damaged or rendered unusable.

- Elective Surgeries and Procedures (Outpatient and Inpatient)- As more healthcare providers are increasingly being asked to assist with the COVID-19 response, we ask that you consider whether non-essential surgeries and procedures can be delayed so that personal protective equipment (PPE), beds, and ventilators can be preserved. In order to assist providers with this request, routine procedure requests will be extended to six (6) months to allow for rescheduling of needed tests. Eligibility should be confirmed prior to scheduling. Also note that medical necessity review is still required.
- Initial Clinical Review- Initial clinical review is waived for the services listed below. Note: Admission notification still applies in order for us to concurrently review and provide discharge/transition of care planning support.

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  - Home Health Requests
  - SNF Admissions
  - LTAC Admissions
  - Inpatient Rehab Admissions

- Cost-Share: Customer cost-share (*if applicable depending on the customer's benefit plan*) for COVID-19 related services provided by in-network providers is waived until 7/24/2020.

Non-Contracted Provider Services

(REVISED 5/4/2020)

During the PHE, providers should continue to inform us of admissions to Inpatient Acute Care, Skilled Nursing Facilities, Acute Inpatient Rehabilitation and Long-Term Acute Care facilities in order for us to assist in customer discharge planning and transitions of care.

- **Referrals:** All referral requirements (*if required by customer's benefit plan*) are waived.
- **Authorizations:** Authorizations are not required nor will be processed for services requested or delivered by non-contracted providers during this period.
- **Cost-Share:** Customer cost-share (*if applicable depending on the customer's benefit plan*) for COVID-19 related services provided by out-of-network providers is waived until 7/24/2020.

1135 Waiver Information

(POSTED 4/24/2020)

Hospitals without Walls

On March 30th, CMS announced additional waivers and temporary rule changes in an effort to increase hospital capacity to manage patient surges due to COVID-19. Under these temporary rule changes, hospital systems are permitted to perform services outside their hospital buildings and transfer patients to other facilities (e.g. ambulatory surgical centers, inpatient rehabilitations hospitals, hotels and dormitories) while continuing to receive

payment for hospital services from Medicare. This is otherwise known as known as "*Hospitals without Walls*".

Hospitals must continue to exercise the necessary control and responsibility over the use of hospital resources in treating patients regardless of whether the treatment occurs in a hospital setting or outside of a hospital setting.

To ensure proper coverage and reimbursement, a facility providing care outside of a normal hospital setting should bill for the level of care provided, rather than the setting. For example, if the level or care is intensive, regardless of the setting (tent, convention center, etc.) the services should be billed as if they occurred in an ICU under the contracted facility address, Tax ID and NPI.

Emergency Room and Transport

To allow greater flexibility in providing emergency services, the following rule changes are retroactive effective 3/1/2020 through the duration of the PHE.

Emergency Departments. May test and screen patients for COVID-19 at drive through and other off-campus testing sites.

Ambulances. May transport patients to a wider range of locations when other transportation is not medically appropriate. Locations may include:

- Critical Access Hospitals
- Skilled Nursing Facilities
- Community Health Centers
- Federally Qualitied Health Centers
- Physician offices
- Urgent care centers
- Ambulatory surgical centers
- Dialysis Centers
- Patients home (beneficiary's home)

Coronavirus Aid, Relief, and Economic Security Act (CARES Act)

(POSTED 4/24/2020)

As the number of COVID-19 cases in the U.S. continues to grow, the CARES Act, passed on March 27, 2020, makes a number of changes to support the ability of the health care system to respond to the crisis over the coming months. In addition, health care provisions are principally designed to offer financial support and flexibilities to providers as they care for patients during the public health emergency.

Sequestration

(POSTED 4/24/2020)

Sequestration is the automatic reduction of certain federal spending as mandated by the federal budget control legislation. As a result of Sequestration, since April 1, 2013, CMS has been making a 2% payment adjustment (reduction) on Original Fee-for-Service (FFS) Medicare provider payments in addition to the premium amounts paid to Medicare Advantage Organizations like Cigna.

The CARES Act, temporarily suspends Sequestration on Medicare programs for the period beginning May, 1, 2020 and ending December 31, 2020.

Accordingly, Cigna will modify its payments for services rendered to Cigna Medicare and Medicare-Medicaid patients as follows:

Contracted Providers

- Fee-for-Service. Cigna will continue to follow the terms of our provider contracts. Therefore, for providers that are reimbursed as a percent of Original FFS Medicare and for whom Cigna has been applying a two percent (2%) Sequestration related payment adjustment, Cigna will **not apply** Sequestration on claims with DOS or discharge between 5/1/2020 – 12/31/2020.

- Other Reimbursement Type. For providers whose contracts utilize a different reimbursement methodology (e.g., capitation, per diem, case rate, value based, etc.) there will be no change **unless** the contract specifically calls for application of Sequestration (in which case Cigna will suspend application of Sequestration between May 1, 2020 – and December 31, 2020).

Non-Contracted Providers

Cigna will not apply Sequestration on claims with DOS or discharge dates of May 1, 2020 – December 31, 2020.

Inpatient Prospective Payment System (IPPS) Hospitals- DRG Payment Increase

(POSTED 4/24/2020)

Effective 1/27/2020, Cigna will increase the weighting factor of the assigned Medicare DRG by 20% for members hospitalized with a COVID-19 diagnosis and discharged during the COVID-19 Public Health Emergency (PHE) period. Discharges of an individual diagnosed with COVID-19 will be identified by the presence of the following ICD-10 diagnosis codes:

- B97.29- (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after January 27, 2020, and on or before March 31, 2020.
- U07.1- (2019-nCoV acute respiratory disease) for discharges occurring on or after April 1, 2020, through the duration of the COVID-19 public health emergency period.

Cigna will reprocess claims submitted for discharges occurring 1/27/2020 or after that have the applicable COVID-19 diagnosis codes listed. This increase will apply to contracted and non-contracted facilities.

Screening/Testing and Treatment

Note that state and federal mandates may supersede these guidelines. Claims will be processed using the below guidance for dates of service on or after February 4, 2020.

Screening Guidelines

Per the CDC, as well as state and local public health departments, it is recommended that patients first be screened virtually (i.e., by phone or video) by a clinician for potential COVID-19 symptoms. If the clinician determines SARS-CoV-2 testing is

needed, the patient should be referred to a physician's office or a specimen collection center for specimen collection.

(REVISED 5/4/2020) If a patient needs to be tested for SARS-CoV-2 and your office is not able to conduct the test, reference the Testing Site Locator at http://cigna.com/covidtesting. The testing site locator is a searchable tool for customers and providers to find local sites that can test individuals for SARS-CoV-2. The tool does not include antibody testing sites.

Note: The Testing Site Locator is not plan specific, therefore, non-COVID-19 related services or testing obtained by patients at the location may not be covered and will incur cost-share (if applicable depending on the benefit plan) if the location is not contracted with Cigna.

Any physician, nurse practitioner, or physician assistant who has an FDA approved testing kit can collect the specimen.

If the physician's office is not CLIA certified, the specimen must be sent to an approved CLIA certified laboratory.

(POSTED 4/14/2020) Home test kits that are not FDA approved or administered by a CLIA certified lab are not covered.

Testing for SARS-CoV-2

Testing is covered. Providers will be reimbursed for specimen collection and testing (if CLIA certified) for SARS-CoV-2. Customer cost-share (*if applicable depending on the customer's benefit plan*) is waived.

Reference the CPT and Diagnosis Codes table for accepted testing codes to use.

Antibody Testing

(POSTED 4/24/2020)

Antibody testing for SARS-CoV-2 is now available. A Coronavirus antibody test could become a key element in fighting the pandemic by providing a more accurate measure of how many people have been infected. It is not yet clear that the presence of antibodies provides immunity against re-infection.

Cigna will waive customer cost-share (*if applicable depending on the customer's benefit plan*), and cover antibody tests that are approved by the FDA. Antibody tests are just now showing up in the market and we expect that more and more companies will develop antibody tests over the next several months.

NOTE: There is no current guidance from the CDC or FDA on how this test can be utilized in the treatment or evaluation of COVID-19. In addition, there are at least 4 other types of Coronaviruses that can cause a common cold and some antibody tests may have overlap of antibodies between those Coronaviruses and the SARS-CoV-2 Coronavirus. Cigna will continue to monitor and follow the guidance from the CDC in making recommendations on the utility of antibody testing.

Reference the CPT and Diagnosis Codes table for accepted antibody testing codes to use.

Treatment of Confirmed COVID-19 Cases

(POSTED 3/31/2020)

Customer cost-share (*if applicable depending on the customer's benefit plan*) for COVID-19 treatment (inpatient and outpatient) for in-network and out-of-network providers is waived until 5/31/2020.

This applies to treatment with dates of service (DOS) of 2/3/2020 to 5/31/2020. Covered treatment includes all services covered under Medicare and applicable state regulations for the management of a COVID-19 diagnosis. Unless otherwise noted in this document:

- In-network providers will be reimbursed consistent with their fee schedules for services rendered.
- Out-of-network providers will be reimbursed 100% of Medicare or Medicaid allowable depending on the customer's benefit plan.

When COVID-19 is confirmed, the applicable ICD-10 codes should be used for treatment. Reference the CPT and Diagnosis Codes table for applicable codes to use.

Telehealth

(REVISED 4/24/2020)

Telehealth generally refers to the exchange of medical information from one site to another through electronic communication to improve a patient's health. There are several types of telehealth services physicians can provide to Medicare and Medicare-Medicaid (MMP) beneficiaries.

- Telehealth Visits (audio & video)
- Audio Only Telehealth visits
- Virtual Check-Ins
- E-Visits (patient to provider via online portal)
- eConsults (provider to provider) also known as Interprofessional Consults

Reference the CPT and Diagnosis Codes table for technology requirements, details and acceptable telehealth codes.

Coverage for Telehealth Services

While customers are encouraged to use their telehealth benefit with providers who partner with MDLive (www.MDLive.com/CignaMedicare), providers do not have to be enrolled with, or affiliated with MDLive in order to perform telehealth services to customers.

- Non-COVID-19 Related Services. Providers can be reimbursed for telehealth services not related to COVID-19. Customer cost-share (*if applicable depending on the customer's benefit plan*) **applies** for these visits.

- COVID-19 Related Services. Providers can be reimbursed for telehealth services related to COVID-19. Customer cost-share (*if applicable depending on the customer's benefit plan*) **is waived** for these visits.

Billing for Telehealth Services

(POSTED 4/14/2020)

In order to allow for proper payment of telehealth services, providers should only use CPT codes allowed via telehealth by CMS. Reference the CPT and Diagnosis Codes table for accepted telehealth codes. In addition, note the following:

- Place of Service. Physicians and practitioners who bill for Medicare telehealth services should report the POS code that would have been reported had the service been furnished in person.
- Modifier. During the Public Health Emergency Period, the CPT Telehealth modifier, modifier 95, should be applied to claim lines that describe services furnished via telehealth.

CMS has published the following documents to outline telehealth services:

- Medicare Telehealth Frequently Asked Questions released by CMS on March 17, 2020 by visiting for details: https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf
- Medicare Telemedicine Health Care Provider Fact Sheet located at: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Audio Only Telehealth (CPT Codes 99441-99443)

(REVISED 5/4/2020)

CMS recognizes there are customers who may not have the financial means to access the equipment needed for telehealth visits requiring two-way audio and video interaction. In order to assist both providers and customers in getting the clinical care they need when video technology is absent or challenging for our customers, CMS has established separate payment for CPT codes 99441-99443 during the PHE for the COVID-19 pandemic. These new codes allow providers to perform services which typically require an office visit over the phone. Reference CMS's Interim Final Rule with Comment for further details: https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

Electronic Consultations (eConsults) *aka* Interprofessional Consultations

(POSTED 4/24/2020)

Electronic Consultations (eConsults), *aka* Interprofessional Consultations, differ from E-visits. *E-visits* are patient to health care provider telecommunications. *eConsults* are health care provider to health care provider communications. eConsults can help reduce patient and physician COVID-19 exposure by allowing providers to share information in writing, online, telephonically or virtually without bringing the patient into an office setting. In order to

facilitate consultation between providers during the COVID-19 pandemic, Cigna will reimburse the treating provider and the consulting provider for eConsults.

- Patient cost-share is **waived** for eConsults with a COVID-19 diagnosis
- Patient cost-share **applies** for eConsults without a COVID-19 diagnosis

Reference the CPT and Diagnosis Codes table for COVID-19 related diagnosis codes.

CPT and Diagnosis Codes List

(POSTED 4/24/2020)

Customer Cost-share (if applicable depending on customer's benefit plan) is waived for COVID-19 related services only.

DIAGNOSIS CODES FOR SCREENING & TREATMENT		
Note: Append GQ, GT, or 95 modifier if done virtually		
Code Type	**Code**	**Description and Reimbursement**
SCREENING	Z03.818	Encounter for observation for suspected exposure to other biological agents ruled out. To be used for cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation.
	Z20.828	Contact with and (suspected) exposure to other viral communicable diseases. Should be used for cases where there is an actual exposure to someone who is confirmed to have COVID-19.
	Z11.59	Encounter for screening for other viral diseases. *NOTE: Customer cost-share is not waived for this screening code as it is not COVID-19 specific*.
TREATMENT	U07.1	2019-nCoV acute respiratory disease.
	B34.2	Coronavirus infection, unspecified
	B97.2	Coronavirus as the cause of diseases classified elsewhere
	B97.29	Other coronavirus as the cause of diseases classified elsewhere.
	B97.21	SARS-associated coronavirus as the cause of diseases classified elsewhere
	J12.81	Pneumonia due to SARS-associated coronavirus

TESTING & SPECIMEN COLLECTION CODES		
These codes will be reimbursed according to the CMS fee schedule.		
Code Type	**Code**	**Description and Reimbursement**
SPECIMEN COLLECTION	G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source
	G2024	Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source
	C9803 *(POSTED 5/4/2020)*	Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source)
SARS-CoV-2/ 2019-nCoV TESTING	U0001	This HCPC code is used for the tests developed by the Center of Disease Control and Prevention (CDC). 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel.
	U0002	This HCPC code is used by laboratories performing non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). 2019-nCoV Coronavirus, SARS COV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets).
	U0003 *(REVISED 5/4/2020)*	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R. This code will be reimbursed for DOS: 3/18-7/24/2020.
	U0004 *(REVISED 5/4/2020)*	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R. This code will be reimbursed for DOS: 3/18-7/24/2020.
	87635	This new CPT code became available on March 13, 2020. Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique. *NOTE: CMS has not released pricing for this code at this time.*

ANTIBODY TESTING CODES		
These codes will be reimbursed according to the CMS fee schedule.		
(REVISED 5/4/2020) Codes will be accepted with DOS: 4/10/2020 through 7/24/2020		
Code Type	Code	Description and Reimbursement
ANTIBODY TESTING *(POSTED 4/24/2020)*	86318	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (eg, reagent strip);
	86328	severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
	86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])

TELEHEALTH SERVICES		
Note: Customer cost-share (if applicable) will only be waived for COVID-19 related services done via telehealth.		
Service Type	Code	Description and Reimbursement
E-VISITS *(Established Patients Only)*	• 99241 • 99422 • 99423 • G2061 • G2062 • G2063	A communication between a patient and their provider through an online patient portal. Requirement: Patient portal
VIRTUAL CHECK-IN (*New or Established Patients*)	• G2012 • G2010	A brief (5-10) minute check-in conversation between customer and provider to determine whether an office visit or other service is needed. Requirement: Audio only
MEDICARE TELEHEALTH VISITS (*New or Established Patients*) *(REVISED 5/4/2020)*	Cigna will accept CMS covered telehealth codes for COVID-19 and Non-COVID-19 related services as listed here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	A visit with a provider that uses telecommunication systems between a provider and patient. CMS has recently waived the video requirement for certain telephone evaluation and management services and has added them to the list of Medicare telehealth services. As a result, Medicare beneficiaries will be able to use an audio-only telephone to get certain telehealth services. Reference the Interim Final Rule with Comment for further details: https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf Requirement: Video and audio *(unless specified by CMS)*
	The following codes are allowed for audio-only visits • 98966-98968 • 99441-99443	A telephone visit with a provider. Reference CMS's Interim Final Rule with Comment for further details: https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf Requirement: Audio only

ELECTORONIC CONSULTATIONS (eConsults) *aka* INTERPROFESSIONAL SERVICES		
Note: Customer cost-share (if applicable) will only be waived for e-Consults with COVID-19 related diagnosis codes.		
Service Type	Code	Description and Reimbursement
eCONSULT *(Provider to Provider)* *(POSTED 4/24/2020)*	• 99446 *(5-10 min)* • 99447 *(11-20 min)* • 99448 *(21-30 min)* • 99449 *(31+ min)*	Interprofessional telephone/Internet/electronic health assessment and management service provided by a consultative physician, ***including a verbal and written report*** to the patient's treating/requesting physician or other qualified health care professional. Number of minutes for medical consultative discussion and review indicated next to code.
	• 99451 *(5+ min)*	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, ***including a written report*** to the patient's treating/requesting physician or other qualified healthcare professional, 5 minutes or more of medical consultative time. Note that no verbal interaction between providers must occur, this can be accomplished with a written report only.
	• 99452 *(30 min)*	Interprofessional telephone/internet/electronic health ***record referral service(s) provided by a treating/requesting physician*** or other qualified healthcare professional, 30 minutes. This code is for use of the treating physician, NP or PA.

Frequently Asked Questions

SARS-CoV-2 TESTING

Will the SARS-CoV-2 laboratory test be covered? *(REVISED 5/4/2020)*

Yes. Laboratory tests for SARS-CoV-2 are covered similar to a preventive benefit for fully-insured plans – thereby customer cost-share (*if applicable depending on the customer's benefit plan*) is waived. SARS-CoV-2 testing will be **covered** for both **in-network** and **out-of-network** labs **until 7/24/2020**. Note that home test kits that are not FDA approved or administered by a CLIA certified lab are not covered.

Will the office visits for SARS-CoV-2 test be covered? *(REVISED 5/4/2020)*

Yes. Customer cost-share (*if applicable depending on the customer's benefit plan*) for physician visits for testing (both in-network and out-of-network) is waived **until 7/24/2020**.

How does a laboratory submit a claim for testing?

CMS has created Healthcare Common Procedure Coding System codes specifically for testing SARS-CoV-2, the virus that causes novel coronavirus (COVID-19). (https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-02-20#_Toc32923423)

Laboratories performing the test can bill Medicare and other health insurers for services that occurred after **February 4, 2020**, using the HCPCS codes outlined in the billing guidelines document attached.

How much will providers be reimbursed for SARS-CoV-2 testing performed by commercial labs, such as LabCorp and Quest?

CMS has released a fee schedule to determine pricing for SARS-CoV-2 testing which varies by state. (https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf)

Are there any prior authorizations required for SARS-CoV-2 lab testing?

No. Prior authorization is not required for SARS-CoV-2 lab testing.

Will cost-sharing be waived for diagnostic testing with a Respiratory Viral Profile (RVP) prior to a provider ordering a SARS-CoV-2 testing?

No. Cost-share (*if applicable depending on the customer's benefit plan*) is only waived for the commercial laboratory testing of SARS-CoV-2. Cost-share is not waived for other laboratory testing at this time.

COVID-19 MEDICAL TREATMENT

Will cost-sharing be waived for customers with costs related to COVID-19 treatment?
(REVISED 3/31/2020)

Yes. We are committed to our patients receiving the appropriate treatment should they become infected with COVID-19. Treatment of COVID-19 is covered according to the benefit plans and provider contracts as appropriate. Depending on the customer's benefit plan, applicable deductibles and cost-sharing related to treatment for COVID-19 for in-network providers is waived until 5/31/2020.

What is considered COVID treatment? *(POSTED 3/31/2020)*

Treatment is any care given at any location (hospital, doctor's office, urgent care, virtual care, skilled nursing facility, etc.) that contains a COVID-19 diagnosis code as listed in the Billing Guidelines.

Are any medications covered under treatment of COVID-19? *(POSTED 3/31/2020)*

Currently there are no medications covered under Medicare Part D for the treatment of COVID-19. However, this is a fluid situation and the Medicare rules may change as the circumstances necessitate. If and when notice is received from CMS that certain drugs are covered, the medications will be covered under the customer's Part D benefit.

What happens if a customer is diagnosed with COVID-19 on a date of service after May 31, 2020? *(POSTED 3/31/2020)*

After 5/31/2020, regular customer benefits apply, however, as the COVID-19 pandemic situation continues to evolve, we are monitoring new developments. At this time, we are not able to predict what the situation will be as of 5/31/2020. Currently, the customer cost-share (*if applicable to the customer's benefit plan*) is waived until 5/31/2020. If this changes, this document will be updated accordingly.

What will providers be reimbursed for providing services related to COVID-19 screening and treatment?

In-network providers will be reimbursed consistent with their fee schedules for services rendered. Out-of-network providers will be reimbursed 100% of Medicare or Medicaid allowable depending on the customers benefit plan.

Will providers who cannot submit claims or request authorizations on time because of staffing shortages be penalized?

Every effort will be made to accommodate facilities and provider groups who are adversely affected by COVID-19. We may request to review the care that was provided for medical necessity post-service.

COVID-19 Telehealth Policy

In lieu of having an office visit, can providers that are not contracted through MDLive for telehealth services get reimbursed for telehealth services? *(REVISED 4/3/2020)*

Yes. Physicians who bill for a telehealth visit for the duration of the COVID-19 Public Health Emergency will be reimbursed according to their contracted rate if in-network or Medicare allowable if out-of-network.

What codes should providers use for billing telehealth services? *(REVISED 4/3/2020)*

Providers should reference the CMS telehealth codes on the following website: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

Can providers do the 360 Comprehensive Assessment or the Health Maintenance Record (HMR) via telehealth? *(POSTED 4/14/2020)*

Yes. Providers **must use audio and video equipment** permitting two-way, real-time interactive communication between the patient and practitioner in order to complete the 360 Comprehensive

Assessments/HMR via telehealth. The vitals section, such as blood pressure, pulse, BMI, etc., and the physical exam section of the form, are no longer required fields.

Reference the 360 Comprehensive Assessments and HMRs via Telehealth for details here: https://medicareproviders.cigna.com/static/medicareproviders-cigna-com/docs/covid-19-360-telehealth-assessment.pdf

CMS recently added the annual wellness visit codes G0438 and G0439 to the list of codes that are allowed with audio only. Will Cigna still continue to require both video & audio for the 360 Comprehensive Assessment or the Health Maintenance Record (HMR) via telehealth? *(POSTED 5/4/2020)*

Yes. Cigna continues to require both the audio and video component for all 360 exams and will provide further guidance if that changes.

Can providers resubmit telehealth claims that were previously submitted using POS 02 instead of the in person POS code? *(POSTED 4/24/2020)*

Yes. Providers can submit corrected claims for reprocessing. The adjusted POS code should be included along with modifier 95 to indicate the service occurred via telehealth.

Why should providers not bill with POS 02 for telehealth services? *(POSTED 4/24/2020)*

Consistent with CMS guidance, billing a face-to-face place of service will ensure providers receive the same reimbursement as they typically get for a face-to-face visit.

Is using the in person POS code instead of POS 02 fraudulent since the service was not performed in person but providers are being asked to bill as if it was a face to face visit? *(POSTED 4/24/2020)*

CMS has implemented this coding and billing guidance as a temporary measure. CMS guidance is to append modifier 95 to the claim indicating the service was performed via telehealth. As long as providers are following CMS guidance and billing appropriately, Cigna does not consider this fraudulent.

Will providers be reimbursed for providing non-COVID-19 related services via telehealth? *(POSTED 4/24/2020)*

Yes. Providers will be reimbursed for COVID-19 and non-COVID-19 related services. Applicable patient cost-share is waived for COVID-19 related services and will apply for non-COVID-19 related services.

PHARMACY

Are prescription refill limits/requirements being lifted?

Our focus is to help customers stay on track with their medication. As part of our normal business practice, retail pharmacists can enter a submission clarification code to allow early refills using their professional judgement. Cigna/Express Scripts communicated a reminder of the process to pharmacies in light of COVID-19.

Are there any drug shortages? *(POSTED 4/6/2020)*

Our Express Scripts pharmacy network team has been keeping in close daily contact with pharmacies to monitor volumes and supply. Due to a national shortage, patients utilizing

albuterol inhalers on a chronic basis may need to switch to albuterol solution via a nebulizer until supplies can be replenished. As there may be a risk of spreading virus laden droplets to other household members, an albuterol inhaler, if available, might still be a more appropriate choice for patients infected with COVID-19 illness.

What if a pharmacy asks me about early refill overrides, signature pad or other related questions? *(POSTED 3/31/2020)*

Please direct pharmacies to the Express Scripts Pharmacist Resource Center at https://PRC.Express-Scripts.com or dial 1-800-922-1557 for further assistance.

Special Needs Patients (SNP)

What is Cigna Medicare Advantage doing to support your high risk Special Needs Plan patients? *(POSTED 4/14/2020)*

As a response to the Coronavirus (COVID-19) outbreak, Cigna Medicare Advantage is partnering with one of our existing vendors, Medtronic Care Management Services, to proactively reach out to pre-identified "high risk" Special Needs Plan (SNP) patients.

As part of the program, Medtronic will reach out to patients to:

- Answer their questions about COVID-19
- Conduct daily health checks
- Connect them to a clinical professional for additional assessment if necessary.

The program provides patients with the tools needed to check in and monitor their health, and ensure they have access to talk with a registered nurse if needed.

Program Participation

This program includes patients participating in the special needs plan identified by Cigna as high-risk. No provider referrals are accepted for program participation. This program is managed by Medtronic and is included with the patient's health plan, there is no additional cost to the patient for participation. The program is offered to the selected patients for 30 days. Patients can disenroll at any time. If needed, the patient's health information may be shared with members of their health care team which may include their doctor, nurse, or other health care professionals.

CMS Advanced Payments

What type of financial assistance is available for providers? *(REVISED 5/4/2020)*

In order to increase cash flow to providers of services and suppliers impacted by the 2019 Novel Coronavirus (COVID-19) pandemic, the Centers for Medicare & Medicaid Services (CMS) has expanded their Accelerated and Advance Payment Program. The expansion of this program is only for the duration of the public health emergency. Details on eligibility, the request process and listing by state are outlined here:
https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf
https://www.cms.gov/files/document/covid-accelerated-and-advance-payments-state.pdf

Business Continuity

What are the contingency plans to ensure appropriate staffing for customer service, claim review, authorization requests, etc.?

We have been actively engaged in business continuity planning to better protect our employees and serve our customers and plan participants during an emergency situation. Maintaining business operations is a core area of planning.

- We have a matrix of call and claim and health care facilitation centers in multiple locations around the United States and abroad. The systems capability in place gives the company the flexibility to re-route calls to other facilities as necessary in order to help ensure business continuity. We have employed this system for natural disasters such as hurricane season or during other weather-related facilities closures.
- We have systems capability and flexibility, with the option to further expand these capabilities as warranted, to allow many of our employees to work from home in the event of an outbreak. Depending on the circumstances, we may encourage that practice in the event of any widespread disease.
- Travel guidelines and restrictions have been developed and implemented to minimize the spread of the virus within the employee population and to generally minimize the spread of the virus from region to region, or country to country.