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COMMERCIAL HEALTH PLAN COVID-19 POLICIES

Updated 10.2.2020

Health Plan	Advance Payment Policies	Telehealth Policies	Prior Authorization Policies	Billing/Coding and Other COVID-19 Policies
Aetna	No advanced payment policy at this time	• 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. • Through September 30, 2020, Aetna extended all member cost-sharing waivers for covered in-network telemedicine visits for outpatient behavioral and mental health counseling services for their Commercial Plans. Self-insured plans offer this waiver at their own discretion. Coverage of telemedicine service liberalizations will continue through 2020. • For Medicare members, primary care and behavioral health telemedicine visits are covered with no cost-sharing to the member, through September 30, 2020. Aetna reimburses all providers for telemedicine at the same rate as in-person visits. • Telephone only services 99441 – 99443 are now set to equal 99212 – 99214 (e.g. 99441 is set to equate to 99212). This change will remain in effect until further notice. • **Aetna's liberalized coverage of Commercial telemedicine services, as described in its telemedicine policy, will now extend through December 31, 2020.** • Additional Telehealth FAQS: https://www.aetna.com/health-care-professionals/covid-faq/telemedicine.html •	• Temporary Changes in Prior Authorization/Pre-certification and Admissions **Protocols** (as of 4/14/20)	• **POS codes for telemedicine:** For commercial members non-facility telemedicine claims must use POS 02 with the GT or 95 modifier. Fee schedules have been updated so claims with approved telemedicine CPT codes and modifiers with POS 02 will be reimbursed at the same rate as an equal office visit. For example, a telemedicine service 99213 GT with POS 02 will reimburse the same as a face-to-face in-office visit 99213. Facilities should continue to use their respective POS; CPTs and the telemedicine modifiers must be noted on the UB-04 form as the Rev Code will not be sufficient. • Aetna reimburses all providers for telemedicine at the same rate as in-person visits. • Please note, for telephone only codes (98966-98968, G2010, G2012) there are reimbursement rates in the fee schedule that are not the same as E&M office visits 99201- 99215. Given those telephone only codes do not equate to an office visit, they will not result in an office visit reimbursement rate. • Is there rate parity for a face-to-face visit vs. a telemedicine visit? (Updated 6/5/2020) Yes. In or out of network benefit levels will apply, depending on the provider's network participation status. • Complete COVID-19 billing and COVID testing FAQs**: https://www.aetna.com/health-care-professionals/covid-faq/billing-and-coding.html** • •

Disclaimer: The information provided in this document is believed to be accurate at the time of its posting. However, this resource should not be construed to be financial, legal, or medical advice. Practice leaders should exercise professional judgement when providing medical services and should seek legal advice regarding any legal questions. Readers should not assume any MGMA endorsement of any of the materials or links supplied in this resource. ***Note: the policy statements included here are drawn directly from each health plan website.***

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Anthem	No advanced payment policy at this time	• **Telehealth (video + audio):** • **Effective September 30, 2020, Anthem's affiliated health plans will no longer waive member cost shares for non-COVID-19 telehealth visits** • For COVID-19 treatments via telehealth visits, Anthem's affiliated health plans will cover telehealth and telephonic-only visits from in-network providers and will waive cost shares through December 31, 2020." • **Telephonic-only care** • Effective from March 19 through September 30, 2020, Anthem's affiliated health plans will cover telephonic-only visits with in-network providers. Out-of-network coverage will be provided where required. This includes visits for behavioral health, for our fully insured employer plans, individual plans, Medicare plans and Medicaid plans, where permissible. Cost shares will be waived for in-network providers only. Self-insured plan sponsors may opt out of this program. •	• **Does Anthem require a prior authorization on the focused test used to diagnose COVID-19? NO**, prior authorization is not required for diagnostic services related to COVID-19 testing	• **COVID-19 testing and visits associated with COVID-19 testing:** Anthem's affiliated health plans will waive cost shares for our fully-insured employer, individual, and Medicare plan members — inclusive of copays, coinsurance and deductibles — for COVID-19 test and visits associated with the COVID-19 test, including visits to determine if testing is needed. Tests 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 can help you get to a provider who can do so. The waivers apply to members who have individual, employer-sponsored, and Medicare plans. • **Should providers who are establishing temporary locations to provide health care services during the COVID-19 emergency notify Anthem of the new temporary address(es)?** Providers do not need to notify Anthem of temporary addresses for providing health care services during the COVID-19 emergency. Providers should continue to submit claims specifying the services provided using the provider's primary service address along with your current tax ID number. • **What codes are appropriate for COVID-19 lab testing?** Anthem is encouraging providers to bill with codes U0001, U0002, U0003, U0004, 86328, 86769, or 87635 based on the test provided.

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Blue Cross Blue Shield Association	**Interactive map** for the COVID-19 policies of all the nation's 36 blues plans			
Blue Shield of CA	Offer several programs including: • Advanced payments • Low interest loans with flexible repayment terms • Transition to a value-based care contract • For more information and to receive an application for the programs, providers are asked to send an email to **Finance communication@blueshieldca.com**	• **Review telehealth and other virtual care** **= Copays and co-insurance for any Teladoc Medical and Behavioral Health visits will be waived for members enrolled in all of Blue Shield's fully-insured commercial plans until Dec 31, 2020, including Individual and Family and all group-sponsored plans that offer Teladoc." This waiver of the patient co-pay only applies when the encounter uses the Teledoc service. As well: "Blue Shield of California will continue waiving copayments, coinsurance and deductible requirements for COVID-19 treatment for members who are covered under fully insured commercial HMO and PPO plans, and Medicare Advantage plans through Dec 31, 2020."**	To help reduce administrative burden for providers during the COVID-19 public health emergency, we have streamlined prior authorization requirements and concurrent reviews. • New and existing prior authorizations for elective procedures have been extended from the usual 120 days to 180 days to support provider operations. • We have streamlined initial clinical concurrent reviews to reduce provider documentation requirements. We will call providers for additional information as infrequently as possible. • Following confirmation of a suspect or positive COVID-19 admission, the following 7 days are immediately approved at the current level of care to minimize review requests for facilities. • We are approving up to an additional 3 days at the current level of care to accommodate the wait for COVID-19 test results. • We have waived prior authorizations for patient transfers of post-acute patients when a member is moved to a different site of care, including skilled nursing facilities and extended acute rehabilitation facilities. Admitting facilities are required to notify Blue Shield within 24 hours of the admission.	• Blue Shield of California will continue waiving copayments, coinsurance and deductible requirements for COVID-19 treatment for members who are covered under fully insured commercial HMO and PPO plans, Medicare Advantage plans, and Medicare Supplemental plans through September 30, 2020. • Blue Shield of CA strongly urges you to consider sending electronic claims — now more than ever — as another way to reduce exposure between those who send the claims and vendors and team members who handle the claims received. In addition to the ongoing benefits of submitting claims electronically, moving to non-manual solutions may be one way you and your practice can pitch in to reduce exposure through the type of unnecessary contact that postal mail may generate. • **Do you anticipate any delay in processing claims due to COVID-19?** No, Blue Shield does not anticipate delays in claims processing. • Complete cost sharing, coding, and billing policies: https://www.blueshieldca.com/bsca/bsc/public/common/PortalComponents/provider/StreamDocumentServlet?fileName=PRV_Claims_and_operations.pdf

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Cigna	No advanced payment policy at this time	• **Cigna: will cover virtual care by a provider or virtual vendor (e.g., MDLive) through December 31, 2020. Patient co-pay policy is as follows:** • **For COVID-19 related screening (i.e., quick phone or video consult): No cost-share for customer through October 31, 2020** • r **For non-COVID-19 related services (e.g., oncology visit, routine follow-up care): Standard customer cost-share** • **Virtual screening telephone consult (5-10 minutes)Cost-share will be waived for all services (including non COVID-19 related services) until October 31, 2020** • **Coverage applies until December 31, 2020** • **For non COVID-19 virtual visit (i.e., telehealth) Cigna will reimburse usual face-to-face rates** • **Services can be performed by phone, video, or both** • **Standard cost-share will apply** • **Interim guidelines apply until at least December 31, 2020**	• Will Cigna extend the timeframe of prior authorization decisions? Yes. Effective March 25, 2020 and forward, for all requests received for all Cigna lines of business, we are temporarily increasing the authorization window for all elective inpatient and outpatient services from three months to six months and will continue until at least **Oct. 31, 2020.** Elective inpatient and outpatient prior authorization decisions made between January 1, 2020 and March 24, 2020 will be assessed when the claim is received and will go payable as long as it is within six months of the original authorization. • Has Cigna removed prior authorization requirements for advanced imaging? No. Cigna continues to require prior authorization reviews for routine advanced imaging.	• **Billing:** Cigna allows modifiers GQ, GT, or 95 to indicate virtual care for all services. This further aligns with CMS and feedback from our provider partners. Also consistent with CMS, providers should bill their standard face-to-face place of service for virtual care (e.g., POS 11). – Billing a POS 02 for virtual services may result in reduced payment or denied claims due to current Cigna system limitations. 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. – – While Cigna does not require any specific placement for COVID-19 diagnosis codes on a claim, we recommend providers include the COVID-19 diagnosis code for confirmed or suspected COVID-19 patients in the first position when the primary reason the patient is treated is to determine the presence of COVID-19. For services where COVID-19 is not the initial clinical presentation (e.g., appendectomy, labor and delivery, etc.), but the patient is also tested for COVID-19 for diagnostic reasons, the provider should bill the diagnosis code specific to the primary reason for the encounter in the first position, and the COVID-19 diagnosis code in any position after the first. This will help ensure Cigna properly waives cost-share for appropriate COVID-19 related care. • **As federal guidelines continue to evolve in support of the COVID-19 pandemic, we have extended customer cost-share waivers and other administrative benefits through at least October 31, 2020. We have also extended our interim virtual care and eConsult guidelines through at least December 31, 2020.**

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Harvard Pilgrim	No advanced payment policy at this time	• Telehealth services may be reimbursed when all the following conditions are met: – Services rendered are clinically appropriate, medically necessary covered services. – The components of any evaluation and management services (E&M) provided via the telemedicine technologies includes at least a problem focused history and straight forward medical decision making, as defined by the current version of the Current Procedural Terminology (CPT) manual. – Providers performing and billing telemedicine/telehealth services are eligible to independently perform and bill the equivalent face-to-face service. • The encounter satisfies the elements of the patient-provider relationship, as determined by the relevant healthcare regulatory board of the state where the patient is physically located. – The service is conducted and a permanent record of online communications relevant to the ongoing medical care and follow-up of the patient is maintained as part of the patient's medical record. • Complete telehealth **policies**	• Prior authorization is reinstated for dates of service beginning 6/30/2020 – Additional prior authorization **policies** – Authorization updates for commercial members can also be viewed in the HPHConnect portal	**Telehealth billing** • Harvard Pilgrim has developed an interim Telemedicine and Telehealth Payment Policy to provide guidance for providers and office staff, including billing/coding guidance for our commercial products. Please refer to CMS guidelines for billing instructions for Medicare Advantage. • **Commercial plans:** To ensure that your commercial claim processes correctly, in addition to your standard claim coding it's important to report all telemedicine/telehealth that are provided by synchronous two-way audio-visual technology should be reported with modifier 95 and the place of service that would be reported if the services were provided in person. • All traditionally covered Medicare telehealth claims should be reported with a place of service 02, in accordance with Medicare billing requirements. • **● Harvard Pilgrim will cover COVID-19 treatment in full without member cost sharing (no copayments, deductibles, or coinsurance) for all our fully insured commercial, Medicare Advantage, Medicare Supplement, and Medicare Enhance plans through Dec. 31, 2020.** **Credentialing** • Pilgrim will fast-track credentialing and enrollment of clinicians (including those coming from out of state) being activated to directly assist with this public health crisis and will provisionally credential them for 180 days. • Complete expedited credentialing **policies**

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Humana	No advanced payment policy at this time	**Extending** member cost-share waivers through the end of the calendar year for in-network telehealth visits • We are extending our cost-share waivers through the end of the year for individual and group Medicare Advantage members. This waiver applies to audio and video telehealth visits with all participating/in-network providers, including primary care, behavioral health and other specialist providers. In support of this waiver, please do not collect a copay from any Humana individual or group Medicare Advantage patients for any of and telehealth visits outlined above. **Temporary expansion of telehealth service scope and reimbursement rules** • To ease systemic burdens arising from COVID-19 and support shelter-in-place orders, Humana is encouraging the use of telehealth services to care for its members. Please refer to CMS, state, and plan coverage guidelines for additional information regarding services that can be delivered via telehealth • In response to this emergency, Humana will temporarily reimburse for telehealth visits with participating/in-network providers at the same rate as in-office visits. In order to qualify for reimbursement, telehealth visits must meet medical necessity criteria, as well as all applicable coverage guidelines **Temporary expansion of telehealth channels** • Humana understands that not all telehealth visits will involve the use of both video and audio interactions. For providers or members who don't have access to secure video systems, we will temporarily accept telephone (audio-only) visits. These visits can be submitted and reimbursed as telehealth visits. Please follow CMS or state-specific guidelines and bill as you would a standard telehealth visit • Further information on using mobile devices for telehealth can be found below **Temporary expansion of telehealth to broader types of providers** • Both participating/in-network primary and specialty providers can render care using telehealth services, provided that CMS and state-specific guidelines are followed. For telehealth visits with a specialist, members are encouraged to work with their primary care physician to facilitate care coordination • Complete telehealth **policies**	We 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, Availity 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 timeframes; 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.	**Telehealth claims** • Enacted a new telehealth policy on March 6. Humana has received ongoing federal and state guidance on telehealth since that time. To ensure Humana processes telehealth claims accurately and avoid additional receivables posting and rework for providers, Humana began pending telehealth claims beginning in mid-March. At this time, Humana has accounted for all current regulatory guidance and have modified our systems and processes to support the accurate administration of these new telehealth benefits. Humana began to process telehealth claims again the week of April 20, with a priority on processing previously pended claims first. Humana expects to have all pended claims processed and to begin normal processing of telehealth claims the week of April 27. • Complete billing and coding **policies** **Pre- and post-paid claim reviews** • Given that health system capacity is opening up and procedures are increasing steadily, we will begin to resume some of the regular processes that we suspended on April 1, 2020, to support providers with the strain on the healthcare system posed by COVID-19 at the heart of the crisis. These processes play an important role in facilitating care and managing costs for our members and employer plan sponsors, and now that health systems are slowly resuming their activities, we will slowly resume ours. • The first of these is for medical record requests for claim reviews, which we will resume effective May 15, 2020. 1. Resuming pre-payment medical record claims review. As of May 15, 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 postpayment claims review team will now resume making requests for medical records as required, consistent with our policy in place prior to April 1. • Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery, and will review our policies and procedures as necessary as this crisis evolves.

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United-Healthcare	• On April 7, 2020, UnitedHealth Group announced that it would accelerate payments and provide other financial support to assist providers in UnitedHealthcare's Medicare Advantage, Medicaid, and Individual and Group Market fully insured health plans. • Learn more **here**.	• UnitedHealthcare is waiving the CMS originating site restriction and audio-video requirement for Medicare Advantage, Medicaid, and Individual and Group Market health plan members from March 18, 2020 until July 24, 2020. Eligible care providers can bill for telehealth services performed using interactive audio-video or audio-only, except in the cases where UnitedHealthcare has explicitly denoted the need for interactive audio/video, such as with PT/OT/ST, while a patient is at home. • **For audio-only:** For Medicare Advantage plans, audio-only services must be billed under designated audio-only codes, including audio E/M, e-visit and virtual check-in codes as designated by CMS. • For Individual and Group Market health plans and Medicaid plans, UnitedHealthcare has waived audio-video requirements and will reimburse medical and outpatient behavioral telehealth visits provided through either interactive audio-video or audio only. For PT/OT/ST provider visits, interactive audio-video technology must be used. • **Telehealth patient cost share is no longer waived for Medicare Advantage members for both primary and specialty office care visits after Sept. 30.** • **Beginning Oct. 1, 2020, benefits will be adjudicated in accordance with the member's benefit plan." UnitedHealthcare is waiving cost share through Oct. 22, 2020 for COVID-19 related services (date subject to change).** •	The following prior authorization provisions apply to all Individual and Group Market health plans, and Medicaid and Medicare Advantage plans. • A 90-day extension, based on original authorization date, of open and approved prior authorizations with an end date or date of service between March 24, 2020 and May 31, 2020, for services at any care provider setting. For example, for a prior authorization with an original end date or date of service of April 30, 2020, the prior authorization would now extend through July 29, 2020. • Applies to existing prior authorizations for medical, behavioral health and dental services. This includes existing prior authorizations for many provider-administered drugs. • Authorizations issued on or after April 10, 2020 will not be subject to extension. • Applies to in-network and out-of-network existing prior authorizations. • Prior authorizations for inpatient procedures will extend 90 days from the expected admission date. • Providers should re-confirm member eligibility before providing services, when authorized dates of service are extended, to help ensure that accurate coverage and benefits are applied. • If a prior authorization approves the number of visits or services, then providers must obtain a new prior authorization for additional units, visits or services beyond what was approved in the original authorization. **•Beginning Oct. 1, 2020, for all commercial and UHC Community Plan plans included in the genetic and molecular testing program, we are suspending prior authorization and notification requirements for the following three genetic and molecular CPT codes performed in an outpatient setting:** **•87480: Infectious agent detection by nucleic acid (DNA or RNA); candida species, direct probe technique** **•87660: Infectious agent detection by nucleic acid (DNA OR RNA); Trichomonas vaginalis, direct probe technique** **•87661: Infectious agent detection by nucleic acid (DNA OR RNA); Trichomonas vaginalis, amplified probe technique:**	• Telehealth services will be reimbursed based on national reimbursement determinations, policies and contracted rates, as outlined in a care provider's participation agreement (if applicable). You can find a breakdown by network plan under the Billing Guidance section above. The policy changes apply to members whose benefit plans cover telehealth services and allow those patients to connect with their doctor through live, interactive audio-video or audio-only visits. (Some of our self-funded customers may not cover provider-based telehealth services under their member benefit plans.) UnitedHealthcare reimburses telehealth services according to its telehealth reimbursement policies. Depending on whether a claim is for a Medicare Advantage, Medicaid or Individual and Group Market health plan member, those policies require slightly different modifiers or place of service indicators for a telehealth claim to be reimbursed. • Claim coding, submissions, and reimbursement **policies** (includes Office Billing Scenarios) • •