

COVID-19 MEDICARE ADVANTAGE BILLING & AUTHORIZATION GUIDELINES

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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 August 19, 2021 - **Highlighted text** indicates update

Background Information

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 April 4, 2020 which summarizes recent changes: <https://www.cms.gov/files/document/covid-dear-clinician-letter.pdf>.

(Revised 07/28/2021) The current Public Health Emergency (PHE) period has been extended through **October 17, 2021**.

<https://www.phe.gov/emergency/news/healthactions/phe/Pages/COVID-15April2021.aspx>

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

(Revised 4/26/2021)

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 through** the end of the calendar year. 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>

Referral Requirements

(Revised 07/28/2021)

In-network Providers. Referral requirements (if required by customer's benefit plan) are waived for **in-network** provider services through **October 17, 2021**.

Out of network Providers. Referral requirements (if required by customer's benefit plan) are waived for **out-of-network** provider services through **October 17, 2021**.

Utilization Management Guidelines

(REVISED 6/22/2020)

Authorization Requirements

Cigna requires authorization of certain services, medications, procedures, and/or equipment prior to performing or providing the service to prevent unnecessary utilization while safeguarding beneficiary access to the most appropriate medically necessary care.

Authorization **requirements apply for services provided by in and out of network providers** according to plan rules as listed in the online provider manual (<https://medicareproviders.cigna.com/>).

Exceptions: No authorizations are required for in or out of network providers for the following:

- SARS-CoV-2 testing
- Treatment services associated with a COVID-19 diagnosis

For further information on **Prior Authorization Guidelines**, click [here](#). ([prior-authorization-requirements-2021.pdf\(cigna.com\)](#))

Post-Acute Care, DME and Elective Procedures

(Revised 08/20/2021)

Cigna has made the modifications below to the initial clinical reviews, DME and routine procedure requests. These modifications apply to both in and out of network providers:

Post-Acute Care Review

To help facilitate freeing up bed space for facilities at or near capacity because of the current surge in COVID-19 admissions, Cigna will allow direct emergent or urgent transfers from an acute inpatient facility to a second acute inpatient facility, skilled nursing facility (SNF), acute rehabilitation facility (AR), or long-term acute care hospital (LTACH) **without prior authorization until October 17, 2021** for both commercial and Medicare businesses when the transferring facility (e.g., hospital) notifies their Provider Services or Contracting representative of their intent to transfer patients **without authorization.**

- SNF, AR, and LTACH facilities are responsible for notifying Cigna of admissions the next business day.
- Coverage reviews for appropriate levels of care and medical necessity still apply to SNF, AR, and LTACH admissions.
- Concurrent review will start the next business day with no retrospective denials.
- Per usual policy, Cigna does not require three days of inpatient care prior to transfer to an SNF.

Please note that routine and non-emergent transfers to SNF, AR, and LTACH continue to require precertification, and if a hospital is not at capacity and requiring the need to free up bed space for COVID-19, all of these transfers still require precertification.

DME

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. All other authorization requirements for contracted providers apply unless specifically outlined in the Additional Authorization Guidelines Outside of PHE section below. **The face to face waiver applies through October 17, 2021.**

Elective Surgeries & Procedures (Outpatient & Inpatient)

(Revised 1/19/2021)

As COVID-19 cases and concerns continue, 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 submitted through 03/31/2021 will be extended to six months to allow for rescheduling of needed tests. Routine procedure requests that are submitted on 4/1/2021 or after and have received authorization will be active for ninety days, according to our standard policy. Eligibility should be

confirmed prior to scheduling. Also note that medical necessity review is still required.

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. EDs 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 Qualified 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

(Revised 4/26/2021)

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** through **December 31, 2021**.

Accordingly, Cigna is modifying payment for services rendered to Cigna Medicare and Medicare-Medicaid patients.

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 – 12/31/2021.
- **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 – December 31, 2021).

Non-Contracted Providers

Cigna will not apply Sequestration on claims with DOS or discharge dates of May 1, 2020 – 12/31/2021.

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

(Revised 12/7/2020)

Cigna increased 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.

Effective with admissions occurring on or after September 1, 2020, claims eligible for the 20 percent increase in the MS-DRG weighting factor will also be required to have a positive COVID-19 laboratory test documented in the patient's medical record. Positive tests must be demonstrated using only the results of viral testing (i.e., molecular or antigen), consistent with CDC guidelines. The test may be performed either during the hospital admission or prior to the hospital admission. For this purpose, a viral test performed within 14 days of the hospital admission, including a test performed by an entity other than the hospital, can be manually entered into the patient's medical record to satisfy this documentation requirement. Cigna Medicare may conduct post-payment medical review to confirm the presence of a positive COVID-19 laboratory test and, if no such test is contained in the medical record, the additional payment resulting from the 20 percent increase in the MS-DRG relative weight will be recouped.

For more information on this CMS directive please reference: [SE20015 \(cms.gov\)](#)

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 Guidelines

Note that state and federal mandates may supersede these guidelines.

Testing Reimbursement

(POSTED 6/1/2020)

Testing will be reimbursed according to the CMS pricing outlined here:

<https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf>

Reference the [CPT and Diagnosis Codes](#) table for acceptable testing codes.

Testing Coverage

(REVISED 12/7/2020)

To help remove any barriers to receive testing, Cigna is waiving customer cost share for FDA authorized tests. No prior authorization is required for testing. Home test kits that have received FDA authorization will also be covered with no cost share according to the CMS and CDC guidelines.

Asymptomatic Individuals

(Posted 04/26/2021)

Cigna will cover a COVID-19 test for an asymptomatic individual when the individual seeks and receives a diagnostic test from a licensed or authorized health care provider, or when a licensed or authorized health care provider refers an individual for a COVID-19 diagnostic test. In these cases, Cigna generally assumes that the receipt of these tests reflects an "individualized clinical assessment," and the test will therefore be covered without cost sharing, prior authorization, or other medical management requirements.

Treatment of Confirmed COVID-19 Cases

(REVISED 2/17/2021)

Treatment of COVID-19, according to FDA recommendations, is a covered benefit for Medicare members.

Cigna will waive customer cost-share for COVID-19 treatment with dates of service (DOS) after 2/3/2020 through 2/15/2021. **Note:** Cigna will continue to waive customer cost share for COVID-19 treatment if a patient is diagnosed with a COVID-19 diagnosis on or before 2/15/2021 and treatment extends beyond 2/15/2021.

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.

Treatment of Confirmed COVID-19 Cases: Monoclonal antibodies

(Added 12/7/2020)

Billing for Monoclonal Antibody COVID-19 Infusion

- The EUA for COVID-19 monoclonal antibody treatments contain specific requirements for administration that are considerably more complex than for other services that are billed using roster billing. CMS expects that health care providers will maintain appropriate medical documentation that supports the medical necessity of the service. This includes documentation that supports that the terms of the EUAs are met. The documentation should also include the name of the practitioner who ordered or made the decision to administer the infusion, even in cases where claims for these services are submitted on roster bills.
- When COVID-19 monoclonal antibody doses are provided by the government without charge, providers should only bill for the administration. Health care providers should not include the COVID-19 monoclonal antibody codes on the claim when the product is provided for free.

Health care providers who provide these services to enrollees in a Medicare Advantage Plan should submit claims for monoclonal antibodies to treat COVID-19 that are covered by Part B in accordance with Section 3713 of the CARES Act to Original Medicare for all patients enrolled in Medicare Advantage in 2020 and 2021.

Reference the below resources for further information:

- [Medicare Monoclonal Antibody COVID-19 Infusion Program Instruction \(cms.gov\)](#)
- <https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies>

COVID 19 Vaccine

For calendar Years 2020 and 2021, Medicare payment for the COVID-19 vaccine and its administration for beneficiaries enrolled in Medicare Advantage plans will be made through the original fee-for-service Medicare program. Providers will need to submit claims for administering the COVID-19 vaccine to the CMS Medicare Administrative Contractor (MAC) using product-specific codes for each vaccine approved.

COVID-19 Vaccine Transportation Benefit

(Posted 04/26/2021)

Effective 4/1/2021, Cigna has partnered with Access2Care (A2C) to provide our customers with **four one-way trips** to get their COVID-19 vaccine. At this time transportation to drive through vaccine sites/events is not available in order to maintain member privacy and safety. To learn more about this benefit visit the [Coronavirus \(COVID-19\) Information for Medicare and Medicaid](#).

[Customers](#)

[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

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.

Reference the [CPT and Diagnosis Codes](#) table for technology requirements, details and acceptable telehealth codes.

[COVID-19 Telehealth Services](#)

(REVISED 07/28/2021)

In and out-of-network providers can be reimbursed for telehealth services related to COVID-19. Customer cost-share **is waived for these visits** through **October 17, 2021**.

[Non COVID-19 Telehealth Services](#)

(REVISED 6/1/2020)

For those concerned about face-to-face encounters, Cigna is also waiving customer cost-share for non COVID-19 related telehealth services as outlined below. This allows customers not only multiple modalities to engage with their physicians but also free access to their physicians from the safety of their homes.

[In-network Providers](#)

As of 6/1/2020, Cigna began waiving customer cost-share for non-COVID-19 related telehealth services when the service is performed by a contracted provider. This waiver further supports our customers and the medical community as we work together to prevent the spread of COVID-19. Customer-cost share was waived until **12/31/2020**.

[Out-of-network Providers](#)

Customer cost-share applies for non COVID-19 related telehealth services performed by out-of-network providers.

[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:

- (POSTED 5/12/2020) List of covered telehealth services:
<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>
- 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>

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

(REVISED 07/28/2021)

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.

- **COVID-19 eConsults.** Customer cost-share is **waived** for eConsults with a COVID-19 diagnosis received by in and out-of-network providers through **October 17, 2021**.
- **Non COVID-19 eConsults.**
 - **In-network Providers.** Customer cost-share is waived for eConsults without a COVID-19 diagnosis performed by in-network providers from 6/1/2020 through 12/31/2020. Customer cost-share applies for services prior to 6/1/2020.
 - **Out-of-network Providers.** Patient cost-share applies for eConsults without a COVID-19 diagnosis performed by out-of-network providers.

Reference the [CPT and Diagnosis Codes](#) table for COVID-19 related diagnosis codes.

CPT and Diagnosis Codes List

(Revised 7/28/2021) DIAGNOSIS CODES FOR SCREENING & TREATMENT

COVID-19 Related Services		
Code Type	Code	Description and Reimbursement
Reference the MAC COVID-19 Test Pricing at: https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf		
Customer Cost-share is waived for the COVID-19 listed services when the applicable codes are used.		
Non COVID-19 Services: • In-network Providers. Customer cost-share is waived when the face to face or telehealth service is received by a contracted physician with QOS through 12/31/2020. Cost-share applies for services received prior to 1/1/2021.	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.
	Z11.52	Encounter for screening for other viral diseases.
	U07.1	2019-nCoV acute respiratory disease.
TREATMENT • Out of network Providers. Customer cost-share applies for non COVID-19 related face to face or telehealth services received by out-of-network physician.	J12.82	Human coronavirus disease 2019
	M 35.81	Multisystem inflammatory syndrome
	M 35.89	Other specified systemic involvement of connective tissue
	Z11.52	Encounter for screening for COVID-19
New DX Codes Effective 1/1/21 Reimbursement: Providers will be reimbursed at their contracted rate or the CMS fee schedule if there is no pre-negotiated rate. Non-contracted labs will be reimbursed at their billed rate.	Z20.822	Contact with and (suspected) exposure to COVID-19
	Z86.16	Personal history of COVID-19

TESTING & SPECIMEN COLLECTION CODES

Code Type	Code	Description and Reimbursement
SPECIM EN 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	Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source)

	99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
SARS-CoV-2/ 2019-nCoV TESTING (Revised 10/28/2020)	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	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.
	U0004	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.
	U0005 (Posted 10/19/2020, effective 1/1/2021)	High throughput test add-on payment; completed within two calendar days of the specimen being collected effective 1/1/2021
	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.
	86328 (Effective 4/10/2020)	Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
	86769 (Effective 4/10/2020)	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
	87426 (Effective 6/25/2020)	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (e.g, SARS-CoV, SARSCoV-2 [COVID-19])
	0202U (Effective 5/20/2020)	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected
	0223U (Effective 6/25/2020)	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected
0224U (Effective 6/25/2020)	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed	

	86408 (Effective 8/10/2020)	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); screen
	86409 (Effective 8/10/2020)	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); titer
	87636 (Effective 10/6/2020)	severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique
	87637 (Effective 10/6/2020)	severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (Coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique
	87811 (Effective 10/6/2020)	severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (Coronavirus disease [COVID-19])
	0225U (Effective 8/10/2020)	Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected
	0226U (Effective 8/10/2020)	Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, serum
	0240U (Effective 10/6/2020)	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected or not detected
	0241U (Effective 10/6/2020)	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each pathogen reported as detected or not detected

ANTIBODY TESTING CODES

These codes will be reimbursed according to the CMS fee schedule.

(REVISED 10/28/2020) Codes will be accepted with DOS 4/10/2020 and after. These codes will be reimbursed according to the CMS pricing: <https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf>

Code Type	Code	Description and Reimbursement
ANTIBODY TESTING (POSTED 4/24/2020)	86318	Immunoassay for infectious agent antibody(ies), qualitative or semi quantitative, 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])
	86413 (Effective 9/8/2020)	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative

OTHER

These codes will be reimbursed according to the CMS fee schedule.

(REVISED 10/28/2020) Codes will be accepted with DOS **9/8/2020** and after. These codes will be reimbursed according to the CMS pricing once published. Additional information can be found here:
<https://www.cms.gov/files/document/mm11960.pdf>

Code Type	Code	Description and Reimbursement
Additional Supplies (Effective 9/8/2020)	99072	Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease

TELEHEALTH SERVICES

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 5/12/2020)	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/Tel ehealth-Codes	A visit with a provider that uses telecommunication systems between a provider and patient. Requirement: Video and audio (note exception below) Exception: 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 .

ELECTRONIC CONSULTATIONS (eConsults) aka INTERPROFESSIONAL SERVICES

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

Utilization Management

Q: Do authorization requirements apply to non-contracted provider services (with the exception of COVID testing & treatment)? (REVISED 04/26/2021)

Yes. Any claim received from a non-contracted provider for a service listed on the authorization grid as requiring an authorization will require such authorization. Any claim without such authorization on file will be denied. Providers will need to follow the standard appeal process as necessary.

Q: Where are the Cigna Medicare Authorization Requirements listed? (REVISED 04/26/2021)

The 2021 authorization requirements can be located here: [prior-authorization-requirements-2021.pdf \(cigna.com\)](#) **Note:** These requirements may change, reference our provider website for the latest information. (<https://medicareproviders.cigna.com/>)

Q: Are there any exceptions to the authorization requirements because of COVID-19? (REVISED 6/22/2020)

Yes. Given the COVID-19 circumstances, Cigna is not requiring authorizations for treatment services with a COVID-19 diagnosis code or SARS-CoV-2 testing.

Q: Is Cigna temporarily waiving the authorization requirement for facility-to-facility transfers?

(New 08/20/2021)

To help facilitate freeing up bed space for facilities at or near capacity because of the current surge in COVID-19 admissions, Cigna will allow direct emergent or urgent transfers from an acute inpatient facility to a second acute inpatient facility, skilled nursing facility (SNF), acute rehabilitation facility (AR), or long-term acute care hospital (LTACH) without prior authorization until October 17, 2021 for both commercial and Medicare businesses.

What the transferring facility must do:

- The transferring facility (e.g., hospital) **must initiate this transfer authorization waiver** by notifying their Provider Services or Contracting representative of their intent to transfer patients without authorization when a public health emergency (PHE) exists and bed space is needed to accommodate inpatient demand.

What the accepting facility must do and know:

- The facility that the patient is being transferred to (e.g., acute inpatient facility, SNF, AR, or LTACH) is responsible for notifying Cigna of admissions the next business day.
- Coverage reviews for appropriate levels of care and medical necessity will still apply to SNF, AR, and LTACH admissions.
- Concurrent review will start the next business day with no retrospective denials.
- Per usual policy, Cigna does not require three days of inpatient care prior to transfer to an SNF.
- When a claim is submitted by the facility the patient was transferred to (e.g., SNF, AR, or LTACH), the facility must note that the patient was transferred to them without an authorization in an effort to quickly to free up bed space for the transferring facility.

Additional important notes

- **Notification is required if a facility is at or near capacity before this accommodation will be made.**
- Routine and non-emergent transfers to SNF, AR, and LTACH continue to require precertification, and if a hospital is not at capacity and requiring the need to free up bed space for COVID-19, all of these transfers still require precertification.
- State mandates may supersede the above guidelines for our commercial customers (e.g., mandates that require coverage of post-acute placements without authorization).

SARS-CoV-2 TESTING

Q: Will the office visits for SARS-CoV-2 test be covered? *(Revised 07/28/2021)*

Yes. Customer cost-share for physician visits for testing (both in-network and out-of-network) is waived through **October 17, 2021**.

Q: 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](https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf) to determine pricing for SARS-CoV-2 testing which varies by state. (<https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf>)

Q: What if I need to test a patient for SARS-CoV-2, will I get paid for collecting the specimen?

(POSTED 5/12/2020)

If you are a provider that can bill for an E/M service, the testing is part of the E/M service. If the patient goes in to the provider's office just for the specimen collection, then you can bill code 99211 for the service.

COVID-19 Medical Treatment

Q: Will cost-share be waived for customers with costs related to COVID-19 treatment?

(REVISED 02/17/2021)

Yes. Cigna will waive customer cost-share for COVID-19 treatment with dates of service (DOS) after 2/3/2020 through 2/15/2021. **Note:** Cigna will continue to waive customer cost share for COVID-19 treatment if a patient is diagnosed with a COVID-19 diagnosis on or before 2/15/2021 and treatment extends beyond 2/15/2021.

Q: 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.

Q: Are there any Part D medications covered under treatment of COVID-19?

(Revised 12/7/2020)

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.

Q: 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 Medical Vaccine

Q: Who will reimburse providers for the administration of the COVID-19 vaccine for Cigna Medicare Advantage or Group Medicare Advantage customers?

For calendar Years (CYs) 2020 and 2021, Medicare payment for the COVID-19 vaccine and its administration for beneficiaries enrolled in Medicare Advantage plans will be made through the original fee-for-service Medicare program. Medicare Advantage plans should inform their contracted providers about this coverage policy and direct them to submit claims for administering the COVID-19 vaccine to the CMS Medicare Administrative Contractor (MAC) using product-specific codes for each vaccine approved.

Q: For a Medicare Advantage or Group Medicare Advantage member can providers bill the member?

No, providers that receive the COVID-19 vaccine free from the federal government are prohibited from seeking reimbursement from consumers for vaccine administration costs – whether as cost sharing or balance billing. Providers that administer vaccinations to patients without health insurance or whose

insurance does not provide coverage of vaccination administration fees, may be able to file a claim with the provider relief fund, but may not charge enrollees directly for any vaccine administration costs.

Q: What will happen if the provider bills Cigna in error for the vaccine instead of the MAC?

The claim will be denied letting the provider know that it should be rebilled to traditional Medicare. For more information please refer to the CMS toolkit: [COVID-19-toolkit-issuers-MA-plans.pdf\(cms.gov\)](https://www.cms.gov/medicare/coverage/coverage-guidance/2020/covid-19-toolkit-issuers-ma-plans.pdf)

COVID-19 Telehealth Policy

Q: 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.

Q: 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>.

Q: 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](https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes) for details here:

<https://medicareproviders.cigna.com/static/medicareproviders-cigna-com/docs/covid-19-360-telehealth-assessment.pdf>

Q: 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.

Q: 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 telehealth services.

Q: Who are the eligible practitioners that can perform services via telehealth?

(POSTED 5/12/2020)

CMS has expanded the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services. Reference the Emergency Declarations Blanket Waivers for Health Care Providers at:

<https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>

Pharmacy

Q: 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.

Q: 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.

Additional Resources

Q: What additional resources are available for providers? *(REVISED 5/12/2020)*

Providers should reference the CMS Current Emergencies site for additional information on COVID-19

The site can be accessed here: <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>

Cigna Behavioral Health has also created the following resources to help providers cope with COVID-19 related challenges they may be facing.

- [Health care workers: Self-care in stressful times webcast](#)
- [Relaxing Techniques](#)
- [Fatigue Awareness](#)
- [Self-Care Checklist](#)
- [Understanding Grief](#)