COVID-19 information for providers

(updated as of 7/14/2020)

We're actively working to monitor the new Coronavirus disease—COVID-19—and its impacts to make sure we provide our members the care they need when they need it while supporting our providers.

Coverage for members

From February 4, 2020 through December, 31, 2020 THC will cover 100% of the cost (waiving deductibles, coinsurance and co-pays) of the following COVID-related services ***when medically necessary:***

- COVID-19 screening and antibody testing (see additional details below).
- Other services related to diagnostic testing and the administration of the test, such as office visits, blood draws or specimen handling.
- Virtual Care

Prior Authorization Updates

THC is not waiving any authorization requirements at this time. THC will work with our physicians and hospitals to provide required authorizations in a timely manner.

Use CR or CS modifier for claims related to diagnosing COVID-19; facilities add condition code DR

Provider offices, urgent care and emergency rooms should bill us using a CR or CS modifier anytime the visit resulted in a COVID-19 test being ordered. Facilities should also use condition code DR to identify when the services provided resulted in a COVID-19 test being administered.

If you have claims that resulted in the administration of a COVID-19 test, you should rebill claims using a CR or CS modifier or DR modifier with condition code dating back to February 4, 2020. Using this modifier will ensure your patients have a $0 cost share for any visit and services related to the diagnostic testing and administration of the test.

These codes should not be added to services billed for treatment of COVID-19.

Virtual visits billing and coverage

Effective March 1, 2020 through December 31, 2020 , we will allow credentialed providers to bill routine practice codes with a Place of Service 02 (to include GT modifier for Medicaid; GT or 95 modifier for Commercial). **As of July 1, 2020, we will pay according to the non-facility Medicaid rate and no longer require a COVID diagnosis to waive patient cost share.** The visit must follow the guidelines for the code billed, including time requirements.

What does this mean? Any credentialed practitioner can conduct a telemedicine visit and bill with a Place of Service 02 and the appropriate modifier, which identifies the visit as being virtual.

For example, office procedures billed with an evaluation and management (E/M) code of 99201-99215, when performed in real-time by credentialed providers through an interactive tool that can be audio-only, can have a Place of Service 02 with modifier added and receive the standard non-facility-based rate.

What's not included? You cannot:

- Use codes that specify in-person or describe services that can only be performed in person
- Bill for services you're not contracted to provide
- Perform services outside of your scope of practice, licensure or credentialing
- Beacon Health is providing telemedicine visits without cost-sharing through their provider network.

Given the government's notification, we're temporarily suspending the requirement for HIPAA compliant systems and are also allowing for real-time, interactive audio-only telehealth encounters to service patients who don't have internet access or audio-visual capabilities. This means that if you don't have a virtual care tool in place, **you can use non-public facing tools, like FaceTime, Facebook Messenger video chat, Skype, etc.** You cannot use public-facing tools like Facebook Live, TikTok or chat rooms like Slack. See the Office for Civil Rights FAQ for more information.

Visit codes billable by physicians

THC reimburses fee-for-service for the below listed codes when billed with POS 02 on a professional claim. Co-pays and deductibles will apply based on office visits. Claims will be reimbursed based on the non-FAC fee at your contractual rate as of 6/1/2020.

- Telephone Visits – Medicaid and Commercial
  - 99441
  - 99442
  - 99443
- Evaluation & Management Codes – Commercial and Medicaid
  - GT modifier is **required** for Medicaid

- Commercial can bill with modifiers GT or 95

Billing for COVID-19 lab tests

The Centers for Medicare and Medicaid Services (CMS) released the below codes for COVID-19 lab tests that can be used starting April1, 2020 for dates of services starting Feb. 4, 2020.For more information, see the CMS FAQ at https://www.cms.gov/files/document/cms-2020-01-r.pdf.

Code	Type	Base fee	Note
U0001		$29.74	Institutional claims require condition code DR. Denial code UMD264 will be used if DR is missing from the claim.
U0002		$42.48	
U0003		$82.80	
U0004		$82.80	
87635		$42.48	
86328	Anti-body testing	$37.45	See the AMA's website for more information. Codes must be billed with SC Modifier to indicate medical necessity.
86769	Anti-body testing	$34.88	

For commercial rates, your contractual rate will be applied to the base fee.

The Michigan Department of Health and Human Services (MDHHS) advises you complete the Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form if a patient tests positive for COVID-19.

Diagnosis Codes

Starting April 1, add ICD-10 code U07.1 COVID19 when your patients have a diagnosis of COVID-19. Until April 1, you should continue to follow the CDC's recommendation for coding.

Note that diagnosis code B34.2, Coronavirus infection, unspecified, would in generally not be appropriate for the COVID-19, because the cases have universally been respiratory in nature, so the site would not be "unspecified."

Antibody Testing

THC will cover antibody testing with no member cost share, COVID-19 testing (any type) when it is ordered by a provider and medically necessary. **Providers must use the SC modifier to indicate if the test was medically necessary**. Testing is covered ONLY when medically necessary. See the following table of appropriate diagnosis codes for coverage.

The antibody testing codes are **86328** and **86769.**

If a COVID-19 lab test is billed with the following diagnosis codes, the SC modifier MUST be used. The below diagnosis codes require the SC modifier and would pay. Audits for medical necessity may occur.

Diagnosis Code	Diagnosis Description
Z20 – Z20.9X	Exposure to unspecified communicable disease
R05	Cough
R06.02	Shortness of breath
J22	Acute respiratory infection
J80	Acute respiratory distress syndrome
J12.89	Viral pneumonia
J20.8, J40	Acute bronchitis , bronchitis
J98.8	Other specified respiratory disorders

The following list of diagnosis codes are not considered medically necessary for COVID testing and will deny as member responsibility.

Diagnosis Code	Diagnosis Description
Z0000	Encounter for general adult medical examination without abnormal findings
Z0001	Encounter for general adult medical examination with abnormal findings
Z00129	Encounter for routine child health examination without abnormal findings
Z008	Encounter for other general examination
Z01411	Encounter for gynecological examination (general) (routine) with abnormal findings
Z01810	Encounter for preprocedural cardiovascular examination

Z01818	Encounter for other preprocedural examination
Z0184	Encounter for antibody response examination
Z0189	Encounter for other specified special examinations
Z020	Encounter for examination for admission to educational institution
Z021	Encounter for pre-employment examination
Z022	Encounter for examination for admission to residential institution
Z023	Encounter for examination for recruitment to armed forces
Z026	Encounter for examination for insurance purposes
Z0271	Encounter for disability determination
Z0282	Encounter for adoption services
Z0289	Encounter for other administrative examinations
Z029	Encounter for administrative examinations, unspecified
Z0389	Encounter for observation for other suspected diseases and conditions ruled out
Z0489	Encounter for examination and observation for other specified reasons
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z111	Encounter for screening for respiratory tuberculosis
Z113	Encounter for screening for infections with a predominantly sexual mode of transmission
Z114	Encounter for screening for human immunodeficiency virus [HIV]
Z1159	Encounter for screening for other viral diseases
Z119	Encounter for screening for infectious and parasitic diseases, unspecified
Z1211	Encounter for screening for malignant neoplasm of colon
Z125	Encounter for screening for malignant neoplasm of prostate
Z131	Encounter for screening for diabetes mellitus
Z136	Encounter for screening for cardiovascular disorders
Z1383	Encounter for screening for respiratory disorder NEC
Z1389	Encounter for screening for other disorder
Z139	Encounter for screening, unspecified
Z228	Carrier of other infectious diseases
Z298	Encounter for other specified prophylactic measures
Z299	Encounter for prophylactic measures, unspecified
Z362	Encounter for other antenatal screening follow-up
Z3689	Encounter for other specified antenatal screening
Z419	Encounter for procedure for purposes other than remedying health state, unspecified
Z539	Procedure and treatment not carried out, unspecified reason

Z578	Occupational exposure to other risk factors
Z579	Occupational exposure to unspecified risk factor
Z655	Exposure to disaster, war and other hostilities
Z711	Person with feared health complaint in whom no diagnosis is made
Z7184	Encounter for health counseling related to travel
Z7189	Other specified counseling
Z719	Counseling, unspecified
Z7252	High risk homosexual behavior
Z789	Other specified health status
Z79818	Long term (current) use of other agents affecting estrogen receptors and estrogen levels
Z79891	Long term (current) use of opiate analgesic
Z79899	Other long term (current) drug therapy