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Updated May 12, 2023 - Highlighted text indicates updates.

The COVID-19 national emergency and public health emergency (PHE) ended on May 11, 2023. As a result, Cigna Medicare Advantage made a number of changes:

- Authorizations for facility-to-facility transfers are again required.
- Over-the-counter COVID-19 tests are no longer covered.
- Our temporary accommodation to extend the authorization approval window from three months to six months remains at six months for now.
- For most benefit plans, COVID-19 vaccines remain covered at 100 percent under the preventive benefit (same as the flu shot) when customers go to an in-network provider.
- Customer cost-sharing for telehealth visits and e-consults will resume. Telehealth will follow the same cost-sharing guidelines for in-person care.
- Both COVID-19 and non-COVID telehealth coverage has been extended through December 31, 2024.
- PHE-related flexibilities for services rendered via telehealth that remain in effect can be accessed here.
- Additional transportation for COVID-19 vaccines will end. However, some customers who have a transportation benefit in their MA plan may use this supplemental benefit for this purpose, depending on plan coverage.
- Physician orders will be required for diagnostic tests.
- While authorizations for facility-to-facility transfers will again be required for PAC admission (transfer from an acute facility), transfer to the PAC facility will not require an authorization at this time.
- In order to minimize care disruptions, the Drug Enforcement Agency (DEA) has temporarily extended the in-person exam waiver for an additional 180 days beyond the PHE end date of May 11, 2023, for telemedicine relationships established during the PHE.
- Effective May 1, 2023, Cigna will reissue EOCs to customers to reflect cost-share. Cost-share will be assessed as if the visit occurred in person, through December 31, 2024.

To keep up to date with the important work CMS is doing in response to COVID-19, please visit the Current Emergencies CMS website page and review the detailed information in the pages that follow.

Increasing Available Care
As a reminder, effective July 1, 2022, Cigna Medicare Advantage reverted from its accelerated initial credentialing process for COVID-19-related applications back to standard credentialing timelines. However, Cigna Medicare Advantage will still consider requests for accelerated credentialing on a case-by-case basis.

In addition, Cigna recognizes and expects that providers will continue to follow their usual business practices regarding onboarding new providers, locum tenens, and other providers brought in to cover practices or increase care during times of high demand.

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.
Referral Requirements

Referrals to in-network providers. Referral requirements (if required by customer’s benefit plan) reverted to standard procedure for in-network provider services for dates of service on or after May 12, 2023.

Referrals to out-of-network providers. Referral requirements for out-of-network services remain in place, unless a participating provider is not available. All providers should therefore continue to request referrals for out-of-network providers as they typically would.

Utilization Management Guidelines

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.

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, please click here.

Post-Acute Care, DME and Elective Procedures

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.

Facility authorization waiver

Authorization requirements for facility-to-facility transfers for patients with a Cigna commercial or Cigna Medicare Advantage benefit plan (previously waived from December 12, 2022 through March 15, 2023 to support timely COVID-related care) are again required for PAC admission (transfer from an acute facility), as of May 12, 2023, but transfer to the PAC facility will not require an authorization at this time.

The additional 100 days of SNF Part A coverage for care needed without completion of a “wellness period” given to customers who have exhausted their benefit ended as of May 12, 2023.

Standard practices for facility-to-facility transfers will continue to apply, including:

- Routine and non-emergent transfers to a secondary facility continue to require authorization.
- The facility that the patient is being transferred to (e.g., 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.
- 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 a SNF.
- When a claim is submitted by the facility the patient was transferred to (e.g., SNF, AR, or LTACH), the facility should 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.
DME
Documentation of face to face, physician order, and medical necessity are again required as of May 12, 2023 in order to obtain replacements of DME that is lost, destroyed, irreparably damaged or rendered unusable. Requests prior to May 11, 2023 may be subject to retroactive review in accordance with CMS guidelines. 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 expired on May 12, 2023.

Elective Surgeries & Procedures (Outpatient & Inpatient)
The authorization approval window for elective surgeries and procedures, extended from the standard three-month timeline to a six-month timeline will remain at six months for now. Eligibility should be confirmed prior to scheduling and medical necessity review remains a requirement.

Appeals
Appointment of Representative
Following the expiration of the PHE, customers must submit an Appointment of Representative (AOR) if they would like someone to appeal on their behalf. Likewise, non-physician providers (post-acute care, secondary facilities, DME) will again be required to submit an AOR if they are appealing on behalf of a patient.

Appeals must be submitted within 60 days of the EOB, EOP, or denial. If an appeal is received after the 60-day timeframe, customers and providers will be required to submit Good Cause.

1135 Waiver Information
Hospitals without Walls
The Hospitals Without Walls waiver and temporary rule change ended on May 12, 2023.

Emergency Room and Transport
The following rule changes for ER and transport, which began on March 1, 2020, ended on May 12, 2023.

Emergency Departments. ED testing and screening for patients for COVID-19 returned to traditional settings as of May 12, 2023 (i.e., testing and screening at drive-through and other off-campus testing sites will no longer be reimbursable).

Ambulances. Ambulance transport of patients will return to the standard list of locations, to include:

- Hospital
- Critical Access Hospitals
- Skilled Nursing Facilities
- Dialysis Centers for ESRD
- Patients home (beneficiary’s home)
- From a Skilled Nursing Facility (SNF) to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered Part A stay, including the return trip.

Coronavirus Aid, Relief, and Economic Security Act (CARES Act)
The CARES Act, passed on March 27, 2020, made a number of changes to support the ability of the health care system to respond to the crisis. Changes in the CARES Act are detailed below.
Sequestration
Sequestration is the automatic reduction of certain federal spending as mandated by the federal budget control legislation. As a result of Sequestration, effective April 1, 2013, CMS made 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.

Medicare FFS Claims: 2% Payment Adjustment (Sequestration) Changes
The Protecting Medicare and American Farmers from Sequester Cuts Act affected payments for all Medicare Fee-for-Service (FFS) claims, as follows:

- No payment adjustment through March 31, 2022
- 1% payment adjustment April 1 – June 30, 2022
- 2% payment adjustment beginning July 1, 2022

Accordingly, Cigna modified payment for services rendered to Cigna Medicare and Medicare-Medicaid patients, as follows:

Contracted Providers

- **Fee-for-Service.** Pursuant to the terms of Cigna’s provider contracts 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 suspended Sequestration on claims with DOS or discharge between May 1, 2022 and March 31, 2022. For dates of service April 1 – June 30, 2022, Cigna applied a 1% payment adjustment. For dates of service beginning July 1, 2022, Cigna applied a 2% payment adjustment.

- **Other Reimbursement Type.** For providers whose contracts utilize a different reimbursement methodology (e.g., capitation, per diem, case rate, value based, etc.), there was no change unless the contract specifically called for application of Sequestration (in which case Cigna suspended application of Sequestration May 1, 2020 – March 31, 2022).

Non-Contracted Providers
Cigna suspended Sequestration on claims with DOS or discharge dates of May 1, 2020 – March 31, 2022.

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

Cigna’s increase of 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 ended on May 12, 2023.

This provision was effective with admissions occurring on or after September 1, 2020. Claims eligible for the 20 percent increase in the MS-DRG weighting factor were also required to have a positive COVID-19 laboratory test documented in the patient’s medical record. Positive tests were required 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 January 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**

Testing will continue to be reimbursed according to the CMS pricing outlined by CMS. Please reference the [CPT and Diagnosis Codes](#) table for acceptable testing codes.

**Testing Coverage**

The customer cost-share waiver for diagnostic FDA EUA tests when administered by a provider ended on May 11, 2023. As of May 12, 2023, patient cost-share applies to COVID-19 lab test as well as antiviral and therapeutics approved to the U.S. Food & Drug Administration (FDA). No prior authorization is required for testing.

Additionally, over-the-counter COVID-19 tests and mail order, at-home COVID-19 tests are no longer covered as of May 12, 2023. However, customers can use Health Savings Account (HSA) funds or OTC discounts available through their Cigna Healthy Today card to offset out-of-pocket costs for COVID tests.

**Asymptomatic Individuals**

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. [Physician orders are required for all diagnostic tests as of May 12, 2023](#). Patient cost-share will apply to COVID-19 lab tests as well as antiviral and therapeutics approved by the U.S. Food & Drug Administration (FDA).

**Treatment of Confirmed COVID-19 Cases**

Treatment of COVID-19, according to FDA recommendations, is a covered benefit for Medicare customers. When COVID-19 is confirmed, the applicable ICD-10 codes should be used for treatment.

- Generally speaking, Cigna Medicare Advantage covers FDA emergency use authorized (EUA) treatments of COVID-19, including monoclonal antibody treatments.
- **There is no change in Medicare coverage of monoclonal antibody treatment for those exposed to COVID-19 once the PHE ends, and in cases where cost-sharing and deductibles apply now, they will continue to apply. The end of the COVID-19 PHE does not change access to oral antivirals, such as Paxlovid and Lagevrio, when administered in an inpatient or outpatient setting.**
Treatment of Confirmed COVID-19 Cases: Monoclonal antibodies

Billing for Monoclonal Antibody COVID-19 Infusion

- The EUA for COVID-19 monoclonal antibody treatments will remain in place and the federal government will continue to pay for medication at no cost share. Cigna will reimburse for administration; however, special pricing for administration will end on May 11, 2023. These 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 continue to 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, health care providers should only bill for the administration. Providers should not include the COVID-19 monoclonal antibody codes on the claim when the product is provided for free.

- Effective for dates of service on and after January 1, 2022, Original Medicare won't pay COVID-19 monoclonal antibody administration claims for Medicare Advantage beneficiaries. Instead, reimbursement for monoclonal antibodies (when providers do not receive it for free) and its administration are made by the beneficiary’s Medicare Advantage plan. Therefore, for dates of service on and after January 1, 2022, providers should submit monoclonal antibody administration claims directly to Cigna Medicare Advantage for patients enrolled in a Cigna Medicare Advantage plan. CMS has geographically adjusted vaccine administration rates for COVID-19 vaccines, similar to pricing for other vaccine administration rates (such as flu and pneumonia). As with all CMS pricing, administration rates are subject to change at any time and new COVID vaccine administration rates may change effective December 31, 2023.

Reference the below resources for further information:
- COVID-19 Vaccines and Monoclonal Antibodies
- Medicare Monoclonal Antibody COVID-19 Infusion Program Instruction (cms.gov)

COVID-19 Vaccine

- Medicare payment for the COVID-19 vaccine (if providers do not receive it for free) and its administration for beneficiaries enrolled in a Medicare Advantage plan will continue to be made by the beneficiary’s Medicare Advantage plan. COVID-19 vaccines will continue to be offered with no coinsurance, copayment, or deductible required.

- For most benefit plans, COVID-19 vaccines will be covered at 100 percent under the preventive benefit (same as the flu shot) when customers go to an in-network provider.

For dates of service on or after January 1, 2022, providers should continue to submit vaccine administration claims directly to Cigna Medicare Advantage for patients enrolled in a Cigna Medicare Advantage plan.

COVID-19 Vaccine Transportation Benefit

Cigna customers can access transportation to their provider’s office for COVID treatment or testing using their Cigna MA transportation benefit, as long as it is offered by their plan.
**Telehealth**

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 Inter-professional 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**

In- and out-of-network providers can continue to be reimbursed for telehealth services related to COVID-19. The customer cost-share waiver for these visits ended May 12, 2023. Telehealth will follow the same cost-sharing guidelines for in-person care.

**Non COVID-19 Telehealth Services**

**In-network Providers**

For dates of service June 1, 2020 – December 31, 2020, Cigna waived customer cost-share for non-COVID-19 related telehealth services when the service is performed by a contracted provider. Non-COVID telehealth coverage has been extended for dates of service through December 31, 2024. Certain PHE-related flexibilities will remain in effect through December 31, 2024, and will also follow the same cost-sharing for in-person care, and can be accessed here.

In order to minimize care disruptions, the Drug Enforcement Agency (DEA) has temporarily extended the in-person exam waiver for an additional 180 days beyond the PHE ending date of May 11, 2023, for telemedicine relationships established during the COVID-19 PHE.

Telehealth visits for risk adjustment (including audio and video) may be captured through December 31, 2023.

**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**

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:

- List of covered telehealth services
- Medicare Telehealth Frequently Asked Questions

Audio Only Telehealth (CPT Codes 99441-99443)

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 established separate payment for CPT codes 99441-99443 during the PHE for the COVID-19 pandemic. These 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.

Electronic Consultations (eConsults) aka Inter-professional Consultations

Electronic Consultations (eConsults), aka Inter-professional 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. Cigna reimbursed the treating provider and the consulting provider for eConsults in order to facilitate consultation between providers during the COVID-19 pandemic. In- and out-of-network providers can continue to be reimbursed for telehealth services related to COVID-19.


- Non COVID-19 eConsults.
  - In-network Providers. Customer cost-share was waived for eConsults without a COVID-19 diagnosis performed by in-network providers from June 1, 2020 through December 31, 2020. Patient cost-share continues to apply for services prior to June 1, 2020.
  - Out-of-network Providers. Patient cost-share continues to apply for eConsults without a COVID-19 diagnosis performed by out-of-network providers.

Please reference the below CPT and Diagnosis Codes table for COVID-19 related diagnosis codes.

### CPT and Diagnosis Codes List

<table>
<thead>
<tr>
<th>DIAGNOSIS CODES FOR SCREENING &amp; TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: Append GQ, GT, or 95 modifier if done virtually</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Type</th>
<th>Description and Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SCREENING</td>
<td>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.</td>
</tr>
<tr>
<td>Z03.818</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Z11.59</td>
<td>Encounter for screening for other viral diseases.</td>
<td></td>
</tr>
<tr>
<td>U07.1</td>
<td>2019-nCoV acute respiratory disease.</td>
<td></td>
</tr>
<tr>
<td>J12.82</td>
<td>Pneumonia due to coronavirus disease 2019</td>
<td></td>
</tr>
<tr>
<td>M 35.81</td>
<td>Multisystem inflammatory syndrome</td>
<td></td>
</tr>
<tr>
<td>M 35.89</td>
<td>Other specified systemic involvement of connective tissue</td>
<td></td>
</tr>
<tr>
<td>Z11.52</td>
<td>Encounter for screening for COVID-19</td>
<td></td>
</tr>
<tr>
<td>Z20.822</td>
<td>Contact with and (suspected) exposure to COVID-19</td>
<td></td>
</tr>
<tr>
<td>Z86.16</td>
<td>Personal history of COVID-19</td>
<td></td>
</tr>
</tbody>
</table>

### Testing & Specimen Collection Codes


<table>
<thead>
<tr>
<th>Code Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specimen Collection</td>
<td></td>
<td>NOTE: G2023 and G2024 are no longer active codes, so should be removed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C9803</td>
<td>Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source</td>
</tr>
<tr>
<td></td>
<td>99211</td>
<td>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.</td>
</tr>
<tr>
<td>SARS-CoV-2/2019-nCoV Testing</td>
<td>U0001</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>U0002</td>
<td>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). Note: U0003, U0004, and U0005 are no longer active codes, so should be removed.</td>
</tr>
<tr>
<td></td>
<td>87635</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>86328</td>
<td>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])</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td></td>
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<tr>
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<td>-------------</td>
<td></td>
</tr>
<tr>
<td>86769</td>
<td>Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])</td>
<td></td>
</tr>
<tr>
<td>87426</td>
<td>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, SARS-CoV-2 [COVID-19])</td>
<td></td>
</tr>
<tr>
<td>0202U</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td>0223U</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td>0224U</td>
<td>Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed</td>
<td></td>
</tr>
<tr>
<td>86408</td>
<td>Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); screen</td>
<td></td>
</tr>
<tr>
<td>86409</td>
<td>Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); titer</td>
<td></td>
</tr>
<tr>
<td>87636</td>
<td>Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique</td>
<td></td>
</tr>
<tr>
<td>87637</td>
<td>Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique</td>
<td></td>
</tr>
<tr>
<td>87811</td>
<td>Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])</td>
<td></td>
</tr>
<tr>
<td>0225U</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td>0226U</td>
<td>Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, serum</td>
<td></td>
</tr>
<tr>
<td>0240U</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td>0241U</td>
<td>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</td>
<td></td>
</tr>
</tbody>
</table>
**ANTIBODY TESTING CODES**

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

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](https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf)

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Code</th>
<th>Description and Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANTIBODY TESTING</td>
<td>86318</td>
<td>Immunoassay for infectious agent antibody(ies), qualitative or semi quantitative, single step method (e.g., reagent strip).</td>
</tr>
<tr>
<td></td>
<td>86328</td>
<td>Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])</td>
</tr>
<tr>
<td></td>
<td>86769</td>
<td>Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])</td>
</tr>
<tr>
<td></td>
<td>86413</td>
<td>Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative</td>
</tr>
</tbody>
</table>

**OTHER**

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

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](https://www.cms.gov/files/document/mm11960.pdf)

<table>
<thead>
<tr>
<th>Code Type</th>
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<th>Description and Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Supplies</td>
<td>99072</td>
<td>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</td>
</tr>
</tbody>
</table>

**TELEHEALTH SERVICES**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Code</th>
<th>Description and Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-VISITS (Established Patients Only)</td>
<td>99241</td>
<td>A communication between a patient and their provider through an online patient portal.</td>
</tr>
<tr>
<td></td>
<td>99422</td>
<td>Requirement: Patient portal</td>
</tr>
<tr>
<td></td>
<td>99423</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G2061</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G2062</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G2063</td>
<td></td>
</tr>
<tr>
<td>VIRTUAL CHECK-IN (New or Established Patients)</td>
<td>G2012</td>
<td>A brief (5-10) minute check-in conversation between customer and provider to determine whether an office visit or other service is needed.</td>
</tr>
<tr>
<td></td>
<td>G2010</td>
<td>Requirement: Audio only</td>
</tr>
<tr>
<td></td>
<td>G2012</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G2010</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G2012</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G2010</td>
<td></td>
</tr>
</tbody>
</table>
MEDICARE TELEHEALTH VISITS (New or Established Patients)

Cigna will accept CMS covered telehealth codes for COVID-19 and Non-COVID-19 related services as listed [here](#).

**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.

### ELECTRONIC CONSULTATIONS (eConsults) aka INTERPROFESSIONAL SERVICES

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Code</th>
<th>Description and Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>eCONSULT</strong> (Provider to Provider)</td>
<td>99446 (5-10 min)</td>
<td>Interprofessional telephone/Internet/electronic health assessment and management service provided by a consultative physician, <em>including a verbal and written report</em> to the patient’s treating/requesting physician or other qualified healthcare professional. Number of minutes for medical consultative discussion and review indicated next to code.</td>
</tr>
<tr>
<td></td>
<td>99447 (11-20 min)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99448 (21-30 min)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99449 (31+ min)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99451 (5+ min)</td>
<td>Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, <em>including a written report</em> 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.</td>
</tr>
<tr>
<td></td>
<td>99452 (30 min)</td>
<td>Interprofessional telephone/internet/electronic health <em>record referral service(s) provided by a treating/requesting physician</em> or other qualified healthcare professional, 30 minutes. This code is for use of the treating physician, NP or PA.</td>
</tr>
</tbody>
</table>
Frequently Asked Questions

Utilization Management

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

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: Are there any exceptions to the authorization requirements because of COVID-19?

Yes. Cigna’s waiver of the requirement for authorizations for treatment services with a COVID-19 diagnosis code or for SARS-CoV-2 testing will continue after May 12, 2023.

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

Authorization requirements for facility-to-facility transfers for patients with a Cigna commercial or Cigna Medicare Advantage benefit plan (previously waived from December 12, 2022 through March 15, 2023 to support timely COVID-related care) are again required as of May 12, 2023.

Important notes
- 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).
- This waiver applies to all patients with a Cigna commercial or Cigna Medicare Advantage benefit plan.
- Routine and non-emergent transfers to a secondary facility continue to require authorization.

What the accepting facility should know and do
- The facility that the patient is being transferred to (e.g., 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.
- 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 a SNF.
- When a claim is submitted by the facility the patient was transferred to (e.g., SNF, AR, or LTACH), the facility should 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.

Q: Will Cigna extend the window for prior authorization approvals?

Yes. Cigna will maintain the extended authorization approval window enacted during COVID (from three months to six months).

SARS-CoV-2 TESTING

Q: Will the office visits for SARS-CoV-2 test be covered?

Yes. The waiver for customer cost-share for physician visits for testing (both in-network and out-of-network) ended May 11, 2023. However, laboratory tests for COVID-19 that are ordered by the provider will continue to be covered with no out-of-pocket costs following the end of the PHE on May
Q: How much will providers be reimbursed for SARS-CoV-2 testing?
CMS has released a fee schedule to determine pricing for SARS-CoV-2 testing which varies by state.

Q: What if I need to test a patient for SARS-CoV-2, will I get paid for collecting the specimen?
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?
Cigna waived customer cost-share for COVID-19 treatment with dates of service (DOS) from February 3, 2020 through February 15, 2021. Laboratory tests for COVID-19 that are ordered by a provider will continue to be covered with no out-of-pocket costs following the end of the PHE on May 12, 2023. Over-the-counter tests will still be available, but there may be out-of-pocket costs.

Q: What is considered COVID treatment?
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: Does Cigna Medicare Advantage reimburse for doses of monoclonal antibody treatments and its administration?
When COVID-19 monoclonal antibody doses are provided by the government without charge, providers should only bill for the administration. Cigna Medicare Advantage covers and reimburses the administration of monoclonal antibody treatments consistent with EUA instructions and CMS guidelines.

Q: Are there any Part D medications covered under treatment of COVID-19?
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 was 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.
For calendar year 2022, Medicare payment for COVID-19 vaccine administration for beneficiaries enrolled in a Medicare Advantage plan were made by the beneficiary’s Medicare Advantage plan. Original Medicare won’t pay COVID-19 vaccine administration claims for Medicare Advantage beneficiaries vaccinated on or after January 1, 2022.

Therefore, beginning January 1, 2022, providers should submit vaccine administration claims directly to Cigna Medicare Advantage for patients enrolled in a Cigna Medicare Advantage plan.

**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](https://www.cms.gov).

**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?  
**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?  
Providers can reference the CMS telehealth codes [here](https://www.cms.gov).

**Q:** Can providers do the 360 Comprehensive Assessment or the Health Maintenance Record (HMR) via telehealth?  
**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.

Please reference the [360 Comprehensive Assessments and HMRs via Telehealth](https://www.cms.gov) for additional details.

**Q:** CMS 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?  
**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?  
**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?  
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. Please reference the Emergency Declarations Blanket Waivers for Health Care Providers for additional information.

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.

**Q: What if a pharmacy asks me about early refill overrides, signature pad or other related questions?**
Please contact the Express Scripts Pharmacist Resource Center at 1-800-922-1557 for further assistance.

Additional Resources

**Q: What additional resources are available for providers?**
Providers should reference the CMS Current Emergencies site for additional information on COVID-19. The site can be accessed here.

Evernorth 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