COVID-19 MEDICARE ADVANTAGE BILLING & AUTHORIZATION GUIDELINES

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These guidelines apply to Cigna Medicare Advantage customers. Using these recommended billing guidelines and codes will help facilitate proper reimbursement and help to avoid errors and potential 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 September 2, 2022 - Highlighted text indicates updates (pages 7, 8, and 16).

On June 15, 2022, the Secretary of Health and Human Services (HHS) renewed the national public health emergency (PHE) period for COVID-19 through October 13, 2022. Consistent with the new end of the PHE period, Cigna is extending cost-share waivers for COVID-19 diagnostic testing and related office visits through October 13, 2022. We also continue to make additional key accommodations related credentialing and virtual care as outlined on this page.

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.

Increasing Available Care

As a reminder, Cigna Medicare Advantage accelerated its initial credentialing process for COVID-19 related applications through June 30, 2022. As of July 1, 2022, standard credentialing timelines again apply. 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

In-network Providers. Referral requirements (if required by customer's benefit plan) are waived for in-network provider services through October 13, 2022.

Out of network Providers. Referral requirements (if required by customer's benefit plan) are waived for out-of-network provider services through October 13, 2022.

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

Effective with facility-to-facility transfers on and after April 1, 2022, authorizations are again required for Cigna Medicare Advantage plans.

However, as a reminder, we continue to consider a provider's failure to request an authorization due to COVID-19 an extenuating circumstance in the same way we view care provided during or immediately following a natural catastrophe (e.g., hurricane, tornado, fires, etc.). Therefore, we will not enforce an administrative denial for failure to secure authorization (FTSA) on appeal if an extenuating circumstance due to COVID-19 applied. In such cases, we will review the services provided on appeal for medical necessity to determine appropriate coverage.

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 13, 2022.

Elective Surgeries & Procedures (Outpatient & Inpatient)

Considering the pressure facilities are under, we will extend the authorization approval window from three months to six months on request. Eligibility should be confirmed prior to scheduling. Also note that medical necessity review is still required.

1135 Waiver Information

Hospitals without Walls

On March 30, 2020 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 March 1, 2020 through October 13, 2022.

Emergency Departments. EDs may test and screen patients for COVID-19 at drive through andother off-campus testing sites.

Ambulances. May transport patients to a wider range of locations when other transportation isnot medically appropriate. Locations may include:

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

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

The CARES Act, passed on March 27, 2020, makes a number of changesto support the ability of the health care system torespond 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 thepublic health emergency.

Sequestration

Sequestration is the automatic reduction of certain federal spending as mandated by the federal budget control legislation. As aresult 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.

Medicare FFS Claims: 2% Payment Adjustment (Sequestration) Changes

The Protecting Medicare and American Farmers from Sequester Cuts Act affects 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 is modifying payment for services rendered to Cigna Medicare and Medicare-Medicaid patients, as follows:

Contracted Providers

- Fee-for-Service. Cignawill continue to followthe 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 May 1, 2022 and March 31, 2022. For dates of service April 1 – June 30, 2022, Cigna will apply a 1% payment adjustment. For dates of service beginning July 1, 2022, Cigna will apply 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 will be no change unless the contract specifically calls for application of Sequestration (in which case Cigna will suspend application of Sequestration May 1, 2020 – March 31, 2022).

Non-Contracted Providers

Cigna will not apply 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 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 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 be reimbursed according to the CMS pricing outlined by CMS. Please reference the CPT and Diagnosis Codes table for acceptable testing codes.

Testing Coverage

To help remove any barriers to receive testing, Cigna is waiving customer cost-share for diagnostic FDA EUA tests when administered by a provider. No prior authorization is required for testing.

Please note that while Cigna Medicare Advantage plans do fully cover the costs for COVID-19 tests done in a clinical setting, costs of at-home COVID-19 tests are not a covered benefit at this time.

However, CMS published additional details about their new initiative to cover FDA approved, authorized, or cleared over-the-counter (OTC) COVID-19 tests at no cost.

- As of April 4, 2022, individuals with Medicare Part B and Medicare Advantage plans can get up to eight OTC tests per calendar month from participating pharmacies and health care providers for the duration of the COVID-19 public health emergency (PHE).
- This initiative enables payment from original Medicare for submitted claims directly to participating eligible pharmacies and other health care providers, which allows Medicare beneficiaries to receive tests at no cost.
- For more information, including details on how you can get reimbursed for these tests from original Medicare when you directly supply them to your patients with Part B or Medicare Advantage plans, please review the CMS guidance.

Finally, please note that the federal government recently announced that they have suspended taking orders for free COVID-19 tests through COVIDTests.gov. This initiative previously allowed all households to order three sets of four at-home test kits with no cost. The last day for individuals to have placed new orders was September 2, 2022.

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. 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

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) February 3, 2020 through February 15, 2021. 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 February 15, 2021 and treatment extends beyond February 15, 2021.

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. This includes antiviral medications Paxlovid™ and molnupiravir, as well as Remdesivir infusions 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 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, 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.

- Health care providers who administered these services in 2020 and 2021 to enrollees in a Medicare Advantage Plan should submit claims to Original Medicare for all patients. Beginning with 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 will be 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.

- On August 15, 2022, drug manufacturer Eli Lilly started commercial distribution of their COVID-19 monoclonal antibody therapy, bebtelovimab (175 mg), and the federal government will no longer purchase it. Therefore, effective with August 15, 2022 dates of service, Cigna Medicare Advantage will reimburse providers consistent with CMS rates for doses of bebtelovimab that they purchase directly from the manufacturer. Reimbursement for the administration of the injection will also remain consistent with CMS. Please note that prior authorization is not required.

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

For calendar Years 2020 and 2021, Medicare payment for the COVID-19 vaccine and its administration for beneficiaries enrolled in Medicare Advantage plans were made through the original fee-for-service Medicare program. Providers should 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 the COVID-19 vaccine (if providers do not receive it for free) and its administration for beneficiaries enrolled in a Medicare Advantage plan will be 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.

COVID-19 Vaccine Transportation Benefit

Effective April 1, 2021, Cigna 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

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 be reimbursed for telehealth services related to COVID-19. Customer cost-share is waived for these visits through October 13, 2022.

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.

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 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.

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. 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 13, 2022.

- 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.

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

CPT and Diagnosis Codes List

DIAGNOSIS CODES FOR SCREENING & TREATMENT		
Note: Append GQ, GT, or 95 modifier if done virtually		
Code Type	**Code**	**Description and Reimbursement**
SCREENING	**Z03.818**	Encounter for observation for suspected exposure to other biological agents ruled out. To be used for cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation.
	Z20.828	Contact with and (suspected) exposure to other viral communicable diseases. Should be used for cases where there is an actual exposure to someone who is confirmed to have COVID-19.
	Z11.59	Encounter for screening for other viral diseases.
TREATMENT	**U07.1**	2019-nCoV acute respiratory disease.
DX Codes Effective 1/1/21	**J12.82**	Pneumonia due to 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
	Z20.822	Contact with and (suspected) exposure to COVID-19
	Z86.16	Personal history of COVID-19

TESTING & SPECIMEN COLLECTION CODES		
Reference the MAC COVID-19 Test Pricing at: https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf		
Code Type	**Code**	**Description and Reimbursement**
SPECIMEN COLLECTION	**G2023**	Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source
	G2024	Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source
	C9803	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	**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	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	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	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])
	87426	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	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	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	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed
	86408	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); screen
	86409	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); titer
	87636	severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique
	87637	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	severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (Coronavirus disease [COVID-19])
	0225U	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	Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, serum
	0240U	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	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.		
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	**86318**	Immunoassay for infectious agent antibody(ies), qualitative or semi quantitative, single step method (e.g., 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	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.		
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	**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)*	Cigna will accept CMS covered telehealth codes for COVID-19 and Non-COVID-19 related services as listed here.	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.

ELECTORONIC CONSULTATIONS (e Consults) *aka* INTERPROFESSIONAL SERVICES		
Service Type	**Code**	**Description and Reimbursement**
e CONSULT *(Provider to Provider)*	**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)?

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 is not requiring authorizations for treatment services with a COVID-19 diagnosis code or for SARS-CoV-2 testing.

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

Effective with facility-to-facility transfers on and after April 1, 2022, authorizations are again required. However, as a reminder, we continue to consider a provider's failure to request an authorization due to COVID-19 an extenuating circumstance in the same way we view care provided during or immediately following a natural catastrophe (e.g., hurricane, tornado, fires, etc.). Therefore, we will not enforce an administrative denial for failure to secure authorization (FTSA) on appeal if an extenuating circumstance due to COVID-19 applied. In such cases, we will review the services provided on appeal for medical necessity to determine appropriate coverage.

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

Yes. Considering the pressure facilities are under, we will extend the authorization approval window from three months to six months on request.

SARS-CoV-2 TESTING

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

Yes. Customer cost-share for physician visits for testing (both in-network and out-of-network) is waived through October 13, 2022.

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 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?

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.

On August 15, 2022, drug manufacturer Eli Lilly started commercial distribution of their COVID-19 monoclonal antibody therapy, bebtelovimab (175 mg), and the federal government will no longer purchase it. Therefore, effective with August 15, 2022 dates of service, Cigna Medicare Advantage will reimburse providers consistent with CMS rates for doses of bebtelovimab that they purchase directly from the manufacturer. Reimbursement for the administration of the injection will also remain consistent with CMS. Please note that prior authorization is not required.

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 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.

For calendar year 2022, Medicare payment for COVID-19 vaccine administration for beneficiaries enrolled in a Medicare Advantage plan will be 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.

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.

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 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