Washington State Health Care Authority

Apple Health (Medicaid) clinical policy and billing for COVID-19

In this time of the COVID-19 pandemic, the Health Care Authority is aware that usual and customary ways of providing and billing/reporting services may not be feasible. It is also understood that different providers will have different capabilities. Therefore, in the interest of public health, HCA's Apple Health (Medicaid) program is trying to be as flexible as possible and is creating new policies that will allow you to provide medically necessary services and bill or report the encounter with the most appropriate code you determine applicable using the guidance below.

This FAQ reinforces the agency's current policies regarding telemedicine as defined in WAC 182-531-1730 and covers the new telehealth policies that will only be in effect during this health care crisis. We will update this FAQ as necessary to respond to new information as it develops.

The FAQ below was revised after new information was released Friday, March 20, by the Centers for Medicare & Medicaid Services (CMS) in an all-state call about the use of telehealth in Medicaid. Note: Medicaid is not subject to the same policies as Medicare.

Frequently asked questions

PART I: Billing for LAB, emergency services, and facility fees

How does a lab bill for COVID-19 testing?

What HCPCS codes are covered?

Code	Description	Modifier
U0001	Cdc 2019 novel coronavirus (2019-ncov) real-time rt-pcr diagnostic panel	CR
U0002	2019-ncov coronavirus, sars-cov-2/2019-ncov (covid-19), any technique, multiple types or subtypes (includes all targets), non-cdc	CR
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	CR
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.	CR

You must include the CR modifier on the line level. The Apple Health fee-for-service (FFS) program (see COVID-19 fee schedule) and the Managed Care Organizations (MCOs) have adopted these codes.

The AMA released a new code (87635) for the COVID-19 lab test, are you going to cover that code?

Code	Description
87635	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

Yes, if billing for fee for service clients, bill with modifier CR. See the COVID-19 fee schedule. The MCOs will follow this policy as well.*

What if we set up a drive up/ drive through COVID-19 testing site, how can we bill for those services?

When collecting specimens to test for COVID-19 that is not associated with an E/M visit HCA is allowing CPT code 99001 to be billed.

Code	Description
99001	Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)

Patient cars located in the parking lot of a clinic in which clinic staff provides COVID testing will be considered extensions of the clinic. Patient cars located in the parking lot of a hospital in which ER staff provide COVID testing will be considered extensions of the ER. If these examples do not apply to your situation, bill POS 15 (mobile unit).

You must bill with the CR modifier. Please see the COVID-19 fee schedule. The MCOs will follow this policy as well.*

What if I need to test a client for COVID-19, 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 client comes in to the provider's office just for the specimen collection, then you can bill 99211 for the service. The MCOs will follow this policy as well.*

What if we are submitting a facility claim that is related to COVID-19?

Consistent with Medicare policy, add condition code DR (Disaster Related). The MCOs will follow this policy as well.*

What if care is provided in a tent outside the ED?

If services are provided in a tent located in close proximity to the ED and the ED staff provides COVID care or nonCOVID care, it will be considered extensions of the ED- POS 23. Professional services use CR modifier. For facility fee use modifier DR. The MCOs will follow this policy as well.*

PART II: Telemedicine and telehealth policies, and how to bill

What telemedicine services are covered?

All Apple Health programs (FFS and MCOs) cover telemedicine when:

- Delivered via HIPAA compliant interactive, audio and video telecommunications (including web-based applications), and
- The provider works within their scope of practice to provide a covered service to an Apple Health eligible client.

FFS AND MCOs will reimburse for professional services provided via telemedicine, in the following settings:

- Inpatient hospital, including ICU and CCU
- Outpatient Hospital, including ER, hospital- based clinics
- Free standing clinic and office services

Please see HCA's brief on telehealth services for instructions on how to bill for telemedicine.

For details regarding physical, occupational and speech therapy please see Apple Health (Medicaid) telehealth requirements for physical, occupational and speech therapy during COVID-19 pandemic.

Telemedicine services are paid at the same rate as if the services was provided face –to-face.

*Please confer with the client's MCO regarding billing requirements.

Is store and forward a covered telemedicine modality?

Yes, if you are providing dermatology services, please see the Physician-related/professional services billing guide.

What if I am using telemedicine to provide services within the same facility?

During this time, HCA wants Apple Health providers to be able to use telemedicine services to provide patient care even if it is within the same facility. When providing telemedicine services within the facility, do not submit a claim for the originating site. The MCOs will follow this same policy.*

What modes of technology can I use to provide services to my patients?

Under the circumstances, Apple Health is covering a variety of technology modalities in lieu of in person visits to support evaluation, assessment and treatment of clients. These modalities include: telemedicine for HIPAA compliant, interactive, real-time audio and video telecommunications, which is already covered; and other forms of telehealth, such as on-line digital exchange through a patient portal; telephone calls, Face-Time; Skype; or email. Texting may also be used, but the agency cautions as to the extent this should be used for doing assessments and providing treatment (see section on G2012 below). The MCOs are adopting these policies as well.*

How do I bill if I am using another telehealth technology to provide medical services, e.g. on-line digital exchange through a patient portal; telephone calls, Face-Time; Skype; or email.

Apple Health is aware that there are instances when telemedicine is not an option and providers need to use other methods to provide care.[1] Apple Health is ***temporarily*** allowing other modalities to be used when current practice for providing services is not an option (face to face, telemedicine). Report the service modality code (CPT or HCPC code) as you would if the encounter was in person. Always document the modality used for delivery in the health care record.

- Use the CR modifier
- Use the POS indicator that that best describes where the client is, for example "12" is home; "31" is skilled nursing facility, "13" is assisted living facility, etc. Do not bill with the providers location as the place of service. The MCOs are adopting these policies as well.*

[1] The provider is quarantined at home, the clinic is closed, the client lives remotely and doesn't have access to the internet or the internet does not support HIPPA compliance, or the circumstances require the provider to utilize a different technology modality to provide healthcare services.

Do I need to take any measures to inform the client about these technologies that may not be HIPAA compliant?

Yes, clients must be informed when using a non-HIPAA compliant technology. This can be done in the following ways:

- Using mail to obtain written consent
- Use of an electronic signature
- Verbal - but the information provided and the verbal consent **must** be documented and dated.

Once in-person visits are resumed, the client must sign a consent form that communicates in writing that the client provided consent to use a platform that could not protect their personal health information.

What other codes could be used if the other options above are not applicable to the care provided?

If you are a licensed provider who can bill an E&M code and using the usual procedure code with one of the options above isn't applicable, below is a matrix of codes that also available. The MCOs are adopting these policies as well.*

The following codes are available. Please see the COVID-19 fee schedule for rates.

Code	Description
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

How do I bill these modalities?

Bill the CPT code provided using the CR (catastrophe/disaster) modifier at the line level. The MCOs are adopting these policies as well.*

Can telephone calls be initiated by the provider?

Yes, during this pandemic, we are allowing providers to initiate phone calls.

What medical services described above are encounter eligible for federally qualified health centers (FQHCs), rural health clinics (RHCs), and Tribal Facilities (Direct IHS Clinics, Tribal Clinics and Tribal FQHCs)

The following CPT Codes are encounter eligible: 99441-43, 99421-23, G2012; billed with modifier CR.

Fee For Service (FFS) Claims:

- As with all FFS encounter eligible claims, the above listed CPT codes should be billed directly to ProviderOne with a T1015.

Managed Care Claims:

- FQHCs, RHCs, and Tribes should bill MCOs with these codes for managed care clients. For all FQHCs and those RHCs who reconcile directly with HCA, these claims will be included in the annual reconciliation.
- For those RHCs who receive the full encounter rate, MCOs will ensure these clinics receive their full encounter rate for the above listed services. As with all encounter eligible services, RHCs are required to bill a T1015 in addition the above listed CPT codes in order to get the full encounter rate through MCOs.
- For Tribal Facilities (Direct IHS Clinics, Tribal Clinics, and Tribal FQHCs) – the MCO payment of the encounter rate is scheduled to begin on 04/01/2020 (AI/AN clients) and 07/01/2020 (nonAI/AN clients). Until MCO payment of the encounter rate begins – the balance of the encounter rate may be billed to P1 for Medical services
- MCOs will follow this policy as well.*

What if I am trying to serve a new client, the codes listed above are for established patients?

Apple Health is allowing use of codes 99441-99443, 99421-99423 for new or established patients during this crisis. The MCOs will follow this policy as well.*

What will I be paid for providing services using these modalities?

If billing for an FFS covered client, bill with the CR modifier. You will be paid the corresponding E&M encounter rate. See COVID-19 Fee schedule

Depending on your contract with the MCOs their reimbursement may be different - for example if you are reimbursed at a capitated rate, or another non fee for service methodology.*

What if I am providing telemedicine or telehealth services outside of office hours?

The following codes are available as add on codes for services provided by primary care providers via telemedicine/telehealth outside of Monday- Friday, 8-5 workday hours.

See COVID-19 fee schedule for rates. *The MCO's will follow this policy as well.

Code	Definition	Modifier
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service	CR
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	CR

If I am making the call from my house to the client that is at home, what POS do I use?

Place of Service (POS) is where the client received the medical service. For example, the client is at home, then use POS 12. The MCOs will follow this policy as well.*

What if I need to consult with another provider regarding treatment of my patient?

99446 is already a covered code. See Physician-related/professional services fee schedule. MCOs will follow this policy as well.*

What about e-consults?

During this crisis we are ***temporarily*** allowing the following code to be utilized when consultation between other specialties occurs. See the COVID-19 fee schedule.

Code	Description
99451	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 health care professional, 5 minutes or more of medical consultative time

You must bill with the CR modifier. The MCOs will follow this policy as well.*

Medicare has given guidance to use G2012, is Apple Health covering that code?

Yes. This code is covered and must be billed with modifier CR. Apple Health considers texting a virtual check-in. If billing for texting to complete a telehealth visit with a client, bill the G 2012 code for payment of this service. The MCOs will follow this policy as well.*

Code	Description
G2012	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

What about EPSDT's that were provided via telemedicine or telehealth?

Apple Health is aware that there are components of an EPSDT visit that will not be able to be completed via telemedicine or telehealth. As those component are critical to the well-being of children/youth there will be a need for a follow-up appointment to complete those components. Apple Health is approving the following plan to address this concern. The MCO's will follow this policy as well.*

EPSDT appointment via telemedicine/telehealth bill:

- appropriate EPSDT code plus modifier CR
- plus any of the additional codes that are applicable to the service that was provided (see EPSDT billing guide and Physician-related/healthcare services billing guide)

In-person follow-up appointment to complete EPSDT components bill

- 99429 with modifier CR (see COVID-19 fee schedule)
- plus any of the additional codes that are applicable to the service that was provided (see EPSDT billing guide and Physician-related/healthcare services billing guide)

Code	Description
99429	Unlisted preventive medicine service

How can I provide support to my patients receiving Office Based Opioid Treatment (OBOT) services when patient contact has been limited during the COVID-19 crisis?

During COVID-19, 99211 can be billed when a nurse phone call is utilized to provide contact and support to assist in accomplishing treatment goals. This is a separate E/M billed by the provider to be used in lieu of a face to face E/M. Bill with modifier CR. If the nurse providing the service is funded through a current contract with Health Care Authority (such as SOR/OTN/Hub and Spokes/ Nurse Care Manager Projects), they are excluded from billing this service at this time. The MCOs will follow this policy as well.*

Can residents provide care allowed under the primary care exception (PCE) via telemedicine/telehealth?

Yes, as long as the appropriate level of supervision is in place for all residents based on each resident's level of education/training and ability, as well as patient complexity and acuity. Apple Health (Medicaid) is aligning with Medicare policy to allow levels of an office/outpatient E/M services provided in a primary care center may be provided under direct supervision of the teaching physician in person or by interactive telecommunications technology The MCOs will follow this policy as well.*