Washington State Health Care Authority

Washington Apple Health (Medicaid)

COVID-19 Testing Clinical Policy Billing Guide

November 21, 2022

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide[1]

This publication takes effect ***November 21, 2022,*** and supersedes earlier versions of this guide.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with HCA.

How can I get HCA Apple Health provider documents?

To access providers alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Where can I download HCA forms?

To download an HCA form, see HCA's Forms & Publications webpage. Type only the form number into the Search box (Example: 13-835).

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[1] This publication is a billing instruction.

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Copyright disclosure

Confidentiality toolkit for providers

The **Washington State Confidentiality Toolkit for Providers** is a resource for providers required to comply with health care privacy laws. To learn more about the toolkit, **visit the HCA website**.

What has changed?

Subject	Change	Reason for Change
Entire guide	• Revised format of entire guide	• To comply with accessibility standards. No policy changes
	• Added new sections: *Disclaimer*, *About this guide*, *How can I get HCA Apple Health provider documents*, *Where can I download HCA forms*, *Copyright disclosure*, and *Client Eligibility*	• To be consistent with other HCA billing guides
	• Punctuation, grammar, and organization	• To improve clarity and usability. No policy changes
Telehealth policy, billing, or coding questions	Added HCA contact information for providers to request assistance with telehealth policy, billing, or coding questions	To improve customer service

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COVID-19 Testing

Overview

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

Provider requirements

Qualified providers are those who are eligible to bill HCA for reimbursement, such as health care providers, pharmacists, and dentists as listed in Chapter 182-502 WAC.

Providers that perform Coronavirus disease 2019 (COVID-19) testing are expected to meet the Washington State Department of Health Reporting Requirements and have the appropriate credentials to perform testing.

Telehealth policy, billing, or coding questions

Email HCA with any telehealth policy, billing, or coding questions.

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Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's **Apple Health managed care webpage** for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the Client Eligibility, Benefit Packages, and Coverage Limits section in HCA's **ProviderOne Billing and Resource Guide**.

If the patient is eligible for Apple Health, proceed to Step 2. If the patient is not eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's **Program benefit packages and scope of services webpage**.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to Washington Healthplanfinder - select the "Apply Now" button.
- **Mobile app:** Download the WAPlanfinder app – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, Forms & Publications webpage. Type only the form number into the Search box (Example: **18-001P**).
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the Health Benefit Exchange Navigator.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Medicaid-eligible clients are enrolled in one of HCA's MCOs. For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

Note: HCA continues to pay for the following through fee-for-service (FFS):

- Professional fees for dental procedures using CDT® codes
- Professional fees using CPT® codes only when the provider's taxonomy starts with 12

See the Dental-Related Services Billing Guide or the Physician-Related Services/Health Care Professional Services Billing Guide, or both, for how to bill professional fees.

Managed care enrollment

Most Apple Health (Medicaid) clients are enrolled in HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may still start their first month of MC eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination. Providers must check eligibility to determine enrollment for the month of service.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get Help Enrolling webpage.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account:** Go to the Washington Healthplanfinder website.
- **Available to all Apple Health clients:**
  - Visit the ProviderOne Client Portal website:
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

- Request a change online at **ProviderOne Contact Us** (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

For online information, direct clients to HCA's **Apple Health Managed Care webpage**.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the fee-for-service (FFS) Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO, except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care (IMC)

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

For full details on integrated managed care, see HCA's **Apple Health Managed Care webpage** and scroll down to "Changes to Apple Health managed care."

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as
"Coordinated Care Healthy Options Foster Care."

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer?*

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

What if a client has third-party liability (TPL)?

If the client has third-party liability (TPL) coverage (excluding Medicare), prior authorization must be obtained before providing any service requiring prior authorization. For more information on TPL, refer to HCA's **ProviderOne Billing and Resource Guide**.

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Laboratory testing

Coverage

Limitations

HCA limits the following laboratory codes to a total of 12 tests, per client, per month. If additional tests are needed, providers can submit a limitation extension request to HCA. See the Physician-related services/health care professional services billing guide for information regarding limitation extensions.

Note: These codes are not encounter-eligible for Indian Health Service (IHS), Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) providers:

PCR tests

Procedure code	Short description	Professional claims	Facility claims
CPT® 87635	Sars-cov-2 covid-19 amp prb	Modifier CR	Modifier CR and Condition code DR
CPT® 87636	Sarscov2 & inf a&b amp prb	Modifier CR	Modifier CR and Condition code DR
CPT® 87637	Sarscov2&inf a&b&rsv amp prb	Modifier CR	Modifier CR and Condition code DR
CPT® 87913	Nfct agt gntyp alys Sarscov2	Modifier CR	Modifier CR and Condition code DR
HCPCS U0001	2019-ncov diagnostic p	Modifier CR	Modifier CR and Condition code DR
HCPCS U0002	Covid-19 lab test non-cdc	Modifier CR	Modifier CR and Condition code DR
HCPCS U0003	Cov-19 amp prb hgh thruput	Modifier CR	Modifier CR and Condition code DR
HCPCS U0004	Cov-19 test non-cdc hgh thru	Modifier CR	Modifier CR and Condition code DR

Antigen tests

CPT® code	Short description	Professional claims	Facility claims
87426	Sarscov coronavirus ag ia	Modifier CR	Modifier CR and Condition code DR
87428	Sarscov & inf vir a&b ag ia	Modifier CR	Modifier CR and Condition code DR
87811	Sars-cov-2 covid19 w/optic	Modifier CR	Modifier CR and Condition code DR

Payment

Apple Health (Medicaid) pays for COVID-19 molecular, antigen, and antibody testing for diagnostic and screening services ordered by a qualified provider. In accordance with Chapter 182-530 WAC, HCA pays for tests with Food and Drug Administration (FDA) approval or FDA Emergency Use Authorization (EUA) only.

See the COVID-19 fee schedule for maximum allowable fees. This policy applies to HCA-contracted managed care organizations.

Billing

Modifier QW is used to indicate that the diagnostic laboratory service is a Clinical Laboratory Improvement Amendment (CLIA) waived test and that the provider has a Certificate of Waiver. Include QW modifier when appropriate.

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Over the Counter (OTC) Testing

Coverage

HCA covers over the counter (OTC) COVID-19 tests with or without a prescription for clients.

Limitations

HCA limits the following OTC COVID-19 test to a total of 12 tests, per client, per month. If additional tests are needed, providers can submit a limitation extension request to HCA. See the Physician-related services/health care professional services billing guide for information regarding limitation extensions.

HCPCS code	Short description
K1034	Covid test self-admn/collect

Note: If additional tests are needed, pharmacy providers may submit a prior authorization (PA) request to HCA. See HCA's Prescription Drug Program Billing Guide for information on how to obtain PA.

Payment

HCA requires an adjudicated pharmacy claim to reimburse pharmacies for an OTC COVID-19 test. See the COVID-19 fee schedule for maximum allowable fees.

Billing

Pharmacies may not bill for test administration of an OTC COVID-19 test; these tests are to be used by the patient in the home setting.

To bill the OTC COVID-19 tests, pharmacies must follow the National Council for Prescription Drug Programs (NCPDP) standard and use the national drug code (NDC) or universal product code (UPC) found on the package.

You may submit claims with single packs (1 test) or multi-pack test kits (2 tests), equaling a total of 12 OTC COVID-19 tests per month. As an example:

- 1 Single pack kit (1 test) –12 kits per calendar month allowed
- 1 Multi pack kit (2 tests) – 6 kits per calendar month allowed

No Prescription

When there is no prescription:

- For clients in managed care, contact the client's managed care plan for billing instructions.
- For fee-for-service clients, pharmacies must use the following prescriber information:
    - Prescriber ID Qualifier (466-EZ): 01
    - Prescriber ID (407-D7): 5123456787
    - Prescriber last name: OTC PRODUCT

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Specimen collection

Coverage

HCA covers the following procedure codes when collecting a specimen to test for COVID-19 that is not associated with an E/M visit.

Procedure code	Short description	Professional claims	Facility claims	Effective	FQHCs	RHCs	IHS
CPT® 99211	Office specimen collection	Modifier CR	Modifier CR and Condition code DR	See COVID-19 Fee Schedule	**	**	** ***
HCPCS C9803*	Hopd covid-19 spec collect	Modifier CR	Modifier CR and Condition code DR	See COVID-19 Fee Schedule	No	No	***
HCPCS G2023*	Specimen collect covid-19	Modifier CR	Modifier CR and Condition code DR	See COVID-19 Fee Schedule	No	No	***
HCPCS G2024*	Spec coll snf/lab covid-19	Modifier CR	Modifier CR and Condition code DR	See COVID-19 Fee Schedule	No	No	Yes

Notes:

- * HCPCS codes G2023, G2024, and C9803 include drive-through testing. If you billed using these three procedure codes before their effective date and were denied, resubmit the claim.
- ** Encounter eligible when performed by an encounter-eligible provider in an eligible place of service.
- *** Eligible for IHS encounter rate if rendered by a health care professional at a direct IHS clinic, tribal clinic, or tribal FQHC.

Payment

See the COVID-19 fee schedule for maximum allowable fees.

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Antibody Testing for SARS-CoV-2

Antibody testing currently has clinical applicability only in specific circumstances and is not recommended for the general public on a broad scale. Per the Centers for Disease Control (CDC) Interim Guidelines for COVID-19, antibody testing should not be used to determine immune status in individuals until the presence, durability, and duration of immunity is established.

Coverage

Based on above information, **retroactive to dates of service on and after April 10, 2020**, HCA only covers COVID-19 antibody testing when the following criteria are met:

- Must be performed by a Clinical Laboratory Improvement Amendments (CLIA)-certified lab unless the test is designated by the FDA as a CLIA-waived test
- Must meet medical necessity criteria, specifically that the results from the antibody test will be used by a clinician to initiate or change the management of a client's care. A representative example of this occurs in cases where a client has late complications of COVID-19 illness, such as multisystem inflammatory syndrome in children

Limitations

HCA limits the following COVID-19 antibody tests to 1 per calendar year, per client:

CPT® code	Short description	Professional claims	Facility claims
86328	Ia nfct ab sarscov2 covid19	Modifier CR	Modifier CR and Condition code DR
86408	Neutrlzg antb sarscov2 scr	Modifier CR	Modifier CR and Condition code DR
86409	Neutrlzg antb sarscov2 titer	Modifier CR	Modifier CR and Condition code DR
86413	Sars-cov-2 antb quantitative	Modifier CR	Modifier CR and Condition code DR
86769	Sars-cov-2 covid-19 antibody	Modifier CR	Modifier CR and Condition code DR

Note:

- If additional tests are needed, providers can submit a limitation extension request to HCA. See the Physician-related services/health care professional services billing guide for information regarding limitation extensions.

- HCA is aware there are other, nonspecific procedure codes that could be used to gain the same information as the procedures codes in the preceding table. If you bill those procedure codes, HCA will apply the same criteria applied to the procedure codes in the preceding table.

Payment

See the COVID-19 fee schedule for maximum allowable fees.

Note: HCA may update this policy as new information becomes available. HCA may perform a post-pay review on any claim and supporting physician's documentation to ensure compliance with this policy.

Pharmacists/pharmacies

During the PHE, a pharmacist may prescribe, administer, and bill for COVID-19 testing as follows:

- Pharmacies may bill for COVID testing if the performing provider is a pharmacist and the test is performed in the pharmacy.
- Claims must be billed as a HIPPA 837 transaction using the pharmacy billing taxonomy of 193200000X.
- Pharmacies and pharmacists may bill HCA for PCR tests and antigen tests.
- Pharmacies and pharmacists may bill HCPCS codes C9803 and G2023 for specimen collection.

Note: Pharmacies may bill for OTC COVID-19 tests with or without a prescription. See Over-the Counter (OTC) Testing for more information.

This policy applies to HCA-contracted managed care organizations.

Dentists

During the PHE, before an aerosol generating procedure, a dentist may prescribe, administer, and bill for COVID-19 antigen testing and bill for specimen collection using the following CDT® codes. Dentists may bill these codes separately or together.

CDT® code	Short description	FQHCs	RHCs	IHS*
D0604	Antigen test pub hlth pathog	No	No	Yes
D0415	Collection of microorganisms	No	No	No

Note: See the COVID-19 fee schedule for maximum allowable fees.

*Direct IHS Clinics, Tribal Clinics, or Tribal FQHCs