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## **CMS Releases Medicare Fee-For-Service and Medicare Advantage Plan Guidance**

In the past days, CMS has released COVID-19 Medicare fee-for-service (FFS) and third party payer guidance, specifically, guidance to Medicare Advantage plans. A summary of each is below as well as hyperlinks to the CMS materials. Additionally, America's Health Insurance Plans (AHIP) and the Association for Community Affiliated Plans (ACAP) both have posted plan by plan information on their members' COVID coverage changes.

### **Medicare Fee-for-Service Coverage of COVID-19 Testing**

#### **Testing will be Paid for by Medicare Part B**

Medicare Part B covers medically necessary clinical diagnostic laboratory tests when a doctor or other practitioner orders them. Medically necessary clinical diagnostic laboratory tests are generally not subject to coinsurance or deductible. Medicare Part B also covers medically necessary imaging tests, such as computed tomography (CT) scans, as needed for treatment purposes for lung infections (not for screening asymptomatic patients). For those imaging tests paid by Part B, beneficiary coinsurance and deductible would apply.

If the Part B deductible (\$198 in 2020) applies to the Part B services, such as imaging tests, beneficiaries must pay all costs (up to the Medicare-approved amount) until the beneficiary meets the yearly Part B deductible. After the beneficiary's deductible is met, Medicare pays its share and beneficiaries typically pay 20% of the Medicare-approved amount of the service (except laboratory tests), if the doctor or other health care provider accepts assignment. There's no yearly limit for what a beneficiary pays out-of-pocket.

#### **COVID-19 Specific Billing Guidance**

In the past weeks, CMS has released COVID-19 billing guidance in several waves [NOTE: In the CMS materials, COVID-19 is called SARS-CoV-2]. CMS is using the Healthcare Common Procedure Coding System (HCPCS), the standardized coding system that Medicare and other health insurers use, to submit claims for COVID-19 tests.

Last month, CMS developed the first HCPCS code (**U0001**) to bill for tests and track new cases of the virus. This code initially is being used for CDC testing laboratories to test patients for COVID-19. Later, CMS announced a second HCPCS billing code (**U0002**) to bill for non-CDC COVID-19.

**Medicare Billing.** The Medicare claims processing systems will be able to accept both of the codes, above, starting on April 1, 2020, for dates of service on or after February 4, 2020. It is important to note that Local Medicare Administrative Contractors (MACs) are responsible for



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developing the payment amount for claims they receive for these newly created HCPCS codes in their respective jurisdictions until Medicare establishes national payment rates. Laboratories may seek guidance from their MAC on payment for these tests prior to billing for them. As with other laboratory tests, there is generally no beneficiary cost sharing under Original Medicare.

To view a map of CMS MAC coverage go to <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/AB-Jurisdiction-Map-Jun-2019.pdf> Recommend members contact their MACs on where they are with developing rates for these codes while CMS Central Office develops national payment rates. AHCA is in contact with the CMS Institutional Billing staff so they can direct us to the Part B billing leads to find out what the MAC interim rates will be for the testing.

The relevant CMS guidance is Medicare Coverage and Payment Related to COVID-19 and is located here <https://www.cms.gov/files/document/03052020-medicare-covid-19-fact-sheet.pdf>

### **CMS Guidance to Medicare Advantage Plan Guidance**

On March 11, CMS issued guidance to Medicare Advantage and Part D plans outlining plan options and plan requirements. New and current flexibilities available to plans are intended to break down barriers to beneficiary access to care:

1. Plans *may* offer access to Medicare Part B services via telehealth in any geographic location and from a variety of places including a beneficiaries' home; and
2. Plans *may* choose to waive plan prior authorization requirements that otherwise would apply to test or services related to COVID-19 at any time.

The memorandum also reviews the special *requirements* Medicare Advantage plans must adhere to in a disaster or emergency:

1. Cover plan benefits furnished at non-contracted facilities (e.g., out of network providers);
2. Waive, in full, requirements for gatekeeper referrals where applicable;
3. Provide same cost sharing for the enrollee as if services were received in a contracted facility; and
4. Make changes that benefit the beneficiary without the 30-day notification requirement (such changes could include reductions in cost).

Lastly, CMS reminded MA Plans that under a specific emergency waiver authority, called a [Katrina Waiver](#), the Agency may authorize Medicare Administrative Contractors (MACs) to pay for Part C covered services furnished to beneficiaries enrolled in Medicare Advantage plans and retrospectively seek reimbursement from the Medicare Advantage plan for those services.



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Providers should check with their participating Medicare Advantage plans to understand which flexibilities the plan is offering. To view the CMS Guidance Memo, click [here](#).

### **Health Plan Information**

On Tuesday America's Health Insurance Plans (AHIP) issued a [COVID response statement](#) on their industry response to COVID-19: Additionally, AHIP also has compiled a helpful list of specific health insurance plans' responses to COVID-19 regarding services and benefits: [Health Insurance Providers Respond to Coronavirus \(COVID-19\) - AHIP](#). The responses, which may differ among health plans, include measures such as:

- Waiving co-pays for diagnostic testing related to COVID-19;
- Waiving co-pays and out of pocket costs for emergency and urgent care services;
- No-cost telemedicine visits;
- Waiving some prior authorization requirements;
- Waiving prescription refill limits; and
- Providing additional stress and anxiety support services.

Also, available at AHIP's website is a [AHIP COVID-19 Resource Center](#). AHCA recommends providers contact each of their health insurance plans for policies and procedures, or changes to existing policies and procedures, for COVID-19 related as well as non-related admissions and residents.

Finally, the Association for Community Affiliate Plans (ACAP), the not-for-profit Medicaid and Medicare-Medicaid health plan association, also has posted an array of [COVID resources](#) on plan coverage. To-date, no other health plan associations have posted coverage information.

AHCA will provide COVID reimbursement and market coverage information weekly. If you have questions, suggestion or concerns, contact us at [COVID19@ahca.org](mailto:COVID19@ahca.org).