



GENERATIONS ADVANTAGE AND THE US FAMILY HEALTH PLANS: COVID-19 FREQUENTLY ASKED QUESTIONS

Updated 03/09/2023

A Message to Our Network Providers

Thank you for the extraordinary work you are doing to keep our communities as safe and healthy as possible during these challenging times.

Martin's Point is committed to working with our provider partners to remove barriers during the COVID-19 pandemic so you can focus on caring for your patients.

These FAQs are a quick source of information intended to ease the administrative burden associated with patient care during the COVID-19 pandemic. **Our phone lines remain open to respond to any additional questions you may have regarding billing guidelines, testing, and benefit changes implemented during this time.**

THIS FAQ WILL BE UPDATED REGULARLY. THE INFORMATION CONTAINED IN THIS DOCUMENT IS ACCURATE AS OF THE DATE OF THE LATEST UPDATE. Martin's Point will continue monitoring updates and guidance received from regulatory agencies and comply accordingly.

PLEASE NOTE: Unless otherwise indicated, answers apply to both the Martin's Point US Family Health Plan and the Martin's Point Generations Advantage plan.

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CODING GUIDELINES

WHAT DIAGNOSIS CODES SHOULD BE USED FOR COVID-19?

- U07.1 should only be used for confirmed cases of COVID-19 with positive or presumptive-positive test results.
 - U07.1 should be sequenced first, followed by the appropriate codes for associated manifestations, *except in the case of obstetrics patients*
 - Obstetric patients with confirmed COVID-19 during pregnancy, childbirth, or the puerperium should have O98.5-, Other viral diseases, as the primary diagnosis, followed by code U07.1 and any codes for associated manifestation(s).
- If COVID-19 is not confirmed or if testing is negative, the following Encounter Codes should be used:
 - Z11.59: Encounter for screening for other viral diseases
Asymptomatic, no known exposure, results unknown or negative
 - Z03.818: Encounter for observation for suspected exposure to other biological agents ruled out
Possible exposure to COVID-19, infection ruled out
 - Z20.828: Contact with and (suspected) exposure to other viral communicable diseases
Contact with COVID-19, Suspected exposure

PUBLIC HEALTH EMERGENCY WAIVERS 1135

WHEN IS THE PUBLIC HEALTH EMERGENCY SCHEDULED TO END?

On February 9, 2023, the Department of Health and Human Services (HHS) announced the Public Health Emergency (PHE) for COVID-19 will end on May, 11, 2023.

Please go to <https://www.phe.gov/emergency/pages/default.aspx> for status of the Public Health Emergency related to the Coronavirus Disease. Please note TRICARE plans such as the US Family Health Plan are not subject to 1135 waivers.

COVID-19 VACCINATIONS

WILL GENERATIONS ADVANTAGE REIMBURSE COVID-19 VACCINATIONS AND ADMINISTRATIONS?

- According to CMS, “For calendar years 2020 and 2021, [FFS] Medicare will pay directly for the COVID-19 vaccine and its administration for beneficiaries enrolled in MA plans. MA plans would not be responsible for reimbursing providers to administer the vaccine during this time. Medicare Advantage beneficiaries also pay nothing for COVID-19 vaccines and their copayment/coinsurance and deductible are waived.” All COVID-19 vaccinations provided for dates of service 2022 and after can be submitted directly to Martin’s Point Health Care.

WHAT ARE THE PAYMENT ALLOWANCES AND EFFECTIVE DATES FOR COVID-19 VACCINES AND THEIR ADMINISTRATION DURING THE PUBLIC HEALTH EMERGENCY?

- CMS publishes rates and effective dates at the following location [Covid-19-vaccines-and-monoclonal-antibodies](#).
- The US Family Health Plan will utilize CMAC rates. CMS rates will be used in the absence of a published TRICARE rate.

Payment after the end of the PHE: CMS will continue to pay approximately \$40 per dose for administering COVID-19 vaccines in outpatient settings for beneficiaries through the end of the calendar year that the PHE ends.

Effective January 1, 2024, the payment rate for administering COVID-19 vaccines will align with the payment rate for administering other Part B preventive vaccines. Monoclonal antibodies will be reimbursed through similar applicable payment methodology for complex biological products.

WILL THE US FAMILY HEALTH PLAN REIMBURSE COVID-19 VACCINATIONS AND ADMINISTRATIONS?

- TRICARE covers COVID-19 vaccines and their administration approved by the FDA (including if on an exception basis). Claims can be submitted directly to Martin’s Point Health Care.

COST SHARE CHANGES

WHAT WILL THE COST SHARE BE FOR LABS UTILIZED TO TEST FOR COVID-19?

- **Generations Advantage:** The lab test 86328, 87635, 86769, U0001, U0002, U0003, U0004, and **U0005** will be covered with no cost share for the member.
- **US Family Health Plan:** The lab test 86328, 87635, 86769, U0001, U0002, U0003, U0004, and **U0005** will be covered with no cost share for the member.

WILL IN-NETWORK COST SHARES APPLY TO OUT-OF-NETWORK SERVICES?

- **Generation Advantage:** All plan-covered, out-of-network services will process with in-network member cost shares effective 3/10/2020 to correspond with guidance from The Centers for Medicare and Medicaid Services (CMS). The out-of-network maximum out of pocket (MOOP) still applies.
 - **Generations Advantage only:** Are in-network cost shares being applied only to services related to COVID-19 or to all services?

For dates of service from 03/10/2020 to 05/11/2023, during the declared Public Health Emergency, all plan-covered, out-of-network services will be processed at the in-network member cost shares to follow guidance from The Centers for Medicare and Medicaid Services (CMS). Once the Public Health Emergency has officially ended, members receiving covered out-of-network services will be subject to out-of-network cost shares.

The current Public Health Emergency is due to end on May 11, 2023. To align with CMS guidance, after this date, services provided by out-of-network specialists will process with the out-of-network cost share. Contracted providers per contract requirements should only refer beneficiaries to participating specialists.

- **US Family Health Plan:** DHA has confirmed that only claims billed with COVID-19 lab codes, or urgent or emergent in nature, will process as in network unless the Health Management Department has determined Point of Service (POS) exception criteria has been met. Please see Martin's Point Health Care's [USFHP POS Payment Policy](#)

WILL COST SHARES BE WAIVED FOR ANY SERVICES?

- **Generations Advantage:**

- **Detection of COVID-19:** In accordance with the Families First Corona Virus Response Act cost shares will be waived for the following service that result in an order for or administration of a COVID-19 test*:
 - Office and other outpatient services
 - Hospital observation services
 - Emergency department services
 - Nursing facility services
 - Domiciliary, rest home, or custodial care services
 - Home services
 - Online digital evaluation and management services

*Eligible providers must submit modifier CS on the claim lines eligible under the waiver. The waiving of cost share is limited to the following providers:

- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
- Physicians and other professionals under the Physician Fee Schedule
- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

- **Treatment of COVID-19:** Cost shares will be waived for the following services (dates of service 3/10/2020 until the federal declaration ends**) if billed with diagnosis code B97.29 or U07.1:

- Emergency Room
- Urgent Care
- Office Visits
- Telehealth

*Please note Inpatient cost shares **will not** be waived.

* Waiving of cost share **will not** expand to include influenza.

* Urgent and emergency care services are always covered with in-network cost shares, even if received out of network.

**Effective for dates of service on or after 05/12/2023, cost shares will only be waived for the following COVID-19 treatments:

- COVID-19 Oral Antivirals
- COVID-19 Monoclonal Antibodies

For all other services, cost sharing will apply based on plan benefit and provider participation status.

- **US Family Health Plan:**
 - In accordance with the “Families First Coronavirus Response Act,” the US Family Health Plan is currently waiving copays for lab test used to detect COVID-19 and for the following services that result in an order for a lab or diagnostic used to detect COVID-19.
 - [Emergency Room](#)
 - [Urgent Care](#)
 - [Office Visits](#)
 - [Telehealth](#)
 - In accordance with the interim final rule titled, “TRICARE Coverage and Payment for Certain Services in Response to the COVID-19 Pandemic,” the US Family Health Plan will waive copayments and cost shares for all covered services delivered via telemedicine if provided by an in-network provider. **This temporary waiver provision terminated on July 1, 2022.**

HOW WILL COVID-19 RELATED SERVICES BE REIMBURSED?

- **Generations Advantage:**
 - **COVID-19 Specific Labs:** These will be reimbursed at the CMS Regional Carriers current allowed amount if one exists. Otherwise, it will be reimbursed under the Prevailing Rate Policy.
 - **All other services:** All other services will follow standard FFS/prevailing process.
- **US Family Health Plan:**
 - **COVID-19 Specific Labs** These currently do not have a published rate. The prevailing charge policy would be utilized in lieu of rate being published.

All other services: All other services will follow standard TRICARE CMAC/prevailing process.

WILL MARTIN’S POINT HEALTH CARE WAIVE SEQUESTRATION REDUCTIONS IN ACCORDANCE WITH THE CARES ACT?

Yes, Generations Advantage will be waiving sequestration in accordance with the Coronavirus Aid, Relief and Economic Security Act (CARES Act) sections 3709 for dates of service prior to 1/1/2022. Sequestration will be phased back in accordance with ‘The Protection Medicare and American Farmers from Sequester Cuts Act’:

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

https://www.cms.gov/outreach-and-education/outreach/ffsprovpartprog/provider-partnership-email-archive/2021-12-16-mlnc#_Toc90391082

WILL MARTIN'S POINT HEALTH CARE BE APPLYING THE CARES ACT'S INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS) FOR HOSPITALS ADD-ON PAYMENT OF 20%?

Yes, Generations Advantage will follow guidance indicated in the Coronavirus Aid, Relief and Economic Security Act (CARES Act) section 3710.

In accordance with the end of the COVID-19 PHE guidance from CMS, the 20% add-on increase to the hospital inpatient prospective payment system will expire effective 05/11/2023.

DURABLE MEDICAL EQUIPMENT

WILL MARTIN'S POINT HEALTH CARE BE ADDING ADDITIONAL COVERAGE FOR GLOVES AND MASKS NOT COVERED UNDER THE ORIGINAL BENEFITS?

No, Martin's Point Health Care is not providing additional coverage for gloves and masks at this time.

WILL MARTIN'S POINT HEALTH CARE COVER HOME RESPIRATORY SERVICES, SUCH AS OXYGEN, CPAP, BIPAP, AND VENTILATOR FOR THE ACUTE TREATMENT OF COVID-19?

Yes, Martin's Point Health Care will consider waiving the chronic coverage requirement for home respiratory services. The determination of coverage will be made by the Health Management Department utilizing current clinical criteria.

WILL GENERATIONS ADVANTAGE ALLOW CMS'S DME FACE TO FACE REQUIREMENT (BOTH INITIAL AND RENEWAL) TO BE COMPLETED TELEPHONICALLY OR VIA TELEHEALTH TECHNOLOGY?

Yes, Generations Advantage will allow face to face to be completed via interactive telehealth to reduce exposure to members and staff.

However, if an item is lost, damaged, irreparable or otherwise unusable as a result of the coronavirus emergency the face-to-face requirement will be waived in accordance with CMS's Section 1135 and Section 1812(f) 'Blanket Waivers.'

Effective May 12, 2023, if you use a telehealth encounter to satisfy the face-to-face encounter requirement for a DMEPOS item(s), it also must meet the requirements of 42 CFR 410.78 and 42 CFR 414.65

WILL GENERATIONS ADVANTAGE FOLLOW CMS'S SECTION 1135 AND SECTION 1812(F) 'BLANKET WAIVERS' THAT REDUCE REQUIREMENTS FOR DME REPLACEMENT IF AN ITEM IS LOST, DAMAGED, IRREPARABLE OR OTHERWISE UNUSABLE AS A RESULT OF THE EMERGENCY?

Yes, Generations Advantage is waiving the following requirements in accordance with the 'Blanket Waiver' when replacing DME:

- face-to-face requirement
- new physician's order requirement
- new medical necessity documentation requirements

As indicated by CMS, "suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable as a result of the emergency."

WILL GENERATIONS ADVANTAGE WAIVE SIGNATURE AND PROOF OF DELIVERY REQUIREMENTS IN ACCORDANCE WITH CMS GUIDELINES?

Yes, Generations Advantage in accordance with CMS guidance is waiving signature and proof of delivery requirements when a signature cannot be obtained because of the inability to collect signatures. Suppliers should document in the medical record the appropriate date of delivery and that a signature was not able to be obtained because of COVID-19. <https://www.cms.gov/files/document/covid-dme.pdf>

Effective for claims with dates of service on or after 05/12/2023, signature and proof of delivery requirements will be reinstated.

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HOME HEALTH CARE

WILL MARTIN'S POINT HEALTH CARE WAIVE THE REQUIREMENT IN 42 CFR §484.55(A) TO ALLOW HHAS TO PERFORM MEDICARE-COVERED INITIAL ASSESSMENTS AND DETERMINE PATIENTS' HOMEBOUND STATUS REMOTELY OR BY RECORD REVIEW?

Yes, Martin's Point Health Care will follow CMS guidance and allow home health agencies to perform Medicare-covered initial assessments and determine patients' homebound status remotely or by record review. **This waiver is set to expire at the end of the COVID-19 PHE which is May 11, 2023.**

WILL MARTIN'S POINT HEALTH CARE WAIVE THE REQUIREMENT FOR ONSITE VISITS FOR HHA AID SUPERVISION?

Yes, Martin's Point Health Care will follow CMS guidance: "CMS is waiving the requirements at 42 CFR§484.80(h), which require a nurse to conduct an onsite visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time. This waiver is also temporarily suspending the 2-week aide supervision by a registered nurse for home health agencies requirement at §484.80(h)(1), but virtual supervision is encouraged during the period of the waiver." **CMS will end this waiver at the conclusion of the PHE which is May 11, 2023. Of note, as a part of the CY 2022 Home Health Prospective Payment System Final Rule (CMS 1747-F), CMS finalized the provision for aide supervision for patients receiving skilled care every 14 days to now allow for one virtual visit per 60-day episode per patient and only in rare circumstances. For patients receiving non-skilled care, the registered nurse must make an onsite, in-person visit every 60 days to assess the quality of care and services provided by the home health aide and to ensure that services meet the patient's needs; semi-annually the nurse will make a supervisory direct observation visit for each patient to which the aide is providing services."**

WILL MARTIN'S POINT HEALTH CARE WAIVE THE REQUIREMENT IN 42 CFR § 484.55(A)(2) AND § 484.55(B)(3) THAT REHABILITATION SKILLED PROFESSIONALS MAY ONLY PERFORM THE INITIAL AND COMPREHENSIVE ASSESSMENT WHEN ONLY THERAPY SERVICES ARE ORDERED?

Yes, Martin's Point Health Care will follow CMS guidance: "This temporary blanket modification allows any rehabilitation professional (OT, PT, or SLP) to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether or not the service establishes eligibility for the patient to be receiving home care. The existing regulations at § 484.55(a) and (b)(2) would continue to apply; rehabilitation skilled professionals would not be permitted to perform assessments in nursing-only cases. We would continue to expect HHAs to match the appropriate discipline that performs the assessment to the needs of the patient to the greatest extent possible. Therapists must act within their state scope of practice laws when performing initial and comprehensive assessments and access a registered nurse or other professional to complete sections of the assessment that are beyond their scope of practice. Expanding the category of therapists who may perform initial and comprehensive assessments provides HHAs with additional flexibility that may decrease patient wait times for the initiation of home health services."

As a part of the CY 2022 Home Health Prospective Payment System Final Rule (CMS 1747-F), CMS finalized changes to § 484.55(a) and (b)(2) to permanently allow occupational therapists to complete the initial and comprehensive assessments for patients, in accordance with Division CC, section 115 of CAA 2021. Medicare appeals in Traditional Medicare, Medicare Advantage.

WILL MARTIN’S POINT HEALTH CARE ALLOW NURSE PRACTITIONER, CLINICAL NURSE SPECIALIST, OR A PHYSICIAN ASSISTANT TO ORDER HOME HEALTH SERVICES, ESTABLISH AND PERIODICALLY REVIEW A PLAN OF CARE, AND CERTIFY THAT THE PATIENT IS ELIGIBLE FOR MEDICARE HOME HEALTH SERVICES?

Yes, Martin’s Point Health Care will follow CMS guidance: “In addition to a physician, section 3708 of the CARES Act allows a Medicare-eligible home health patient to be under the care of a nurse practitioner, clinical nurse specialist, or a physician assistant who is working in accordance with State law. These physicians/practitioners can: (1) order home health services; (2) establish and periodically review a plan of care for home health services (e.g., sign the plan of care), (3) certify and re-certify that the patient is eligible for Medicare home health services. These changes, effective March 1, 2020, provide the flexibility needed for more timely initiation of services for home health patients, while allowing providers and patients to practice social distancing. Specifically, for Medicare, these changes are effective for Medicare claims with a “claim through date” on or after March 1, 2020.”

This provision has been made permanent beyond the COVID-19 Public Health Emergency and is codified in the regulations at 42 CFR 409.43.”

SKILLED NURSING FACILITY

WILL MARTIN'S POINT HEALTH CARE WAIVE THE REQUIREMENT AT SECTION 1812(F) OF THE SOCIAL SECURITY ACT FOR 3-DAY PRIOR HOSPITALIZATIONS FOR COVERAGE OF A SNF STAY?

- **Generations Advantage:** Generations Advantage does not require a 3-day inpatient hospitalization stay prior to a skilled nursing stay.
- **US Family Health Plan:** The US Family Health Plan has waived requirement of a qualify staying of three consecutive days for dates of admission Sept 3, 2020, and after. Per the interim final rule [TRICARE Coverage of Certain Medical Benefits in Response to the COVID-19 Pandemic](#). This temporary waiver is only in effect for the duration of the Public Health Emergency for the COVID-19 outbreak which is set to expire on May 11, 2023.

IF A MEMBER HAS EXHAUSTED THEIR SNF BENEFIT DURING THE COVID-19 EMERGENCY WILL GENERATIONS ADVANTAGE PLANS RENEW SNF COVERAGE WITHOUT FIRST HAVE TO START A NEW BENEFIT PERIOD?

Yes, Martin's Point Health Care will follow CMS guidance, "In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period." This waiver will terminate at the end of the COVID-19 Public Health Emergency which is May 11, 2023.

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TELEHEALTH AND TELEMEDICINE

WHICH SPECIFIC SERVICES ARE COVERED UNDER THE TELEHEALTH BENEFIT?

- **Generations Advantage:** Please reference the table below. Please see additional questions in this FAQ for interactive requirements.

Telemedicine Service	HCPC/CPT CODE	Patient Relationship with the provider
Telehealth Services*	<p>Common Telehealth Services include:</p> <ul style="list-style-type: none"> • 99201-99215 (Office or other outpatient Visit) • G0425- G0427 (Telehealth consultation, emergency departments or initial inpatient) • G0406-G0408 (Follow-up inpatient telehealth consultation furnished to beneficiaries in hospital or SNF) <p>For a comprehensive list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes</p> <p>*Please review the comprehensive list to confirm if the service requires a video component.</p>	<p>For new* or established patients:</p> <p>*To the extent the 1135 waiver requires and established relationship, HHD will not conduct audits to ensure that such a prior relationship existed for claims</p>
Virtual Check-In	<ul style="list-style-type: none"> • G2010 • G2012 	For established patient
E-Visits	<ul style="list-style-type: none"> • 99421 • 99422 • 99423 • G2061 • G2063 	For established patient
Telephonic Evaluation Codes (covered only under 1135 waiver during the Public Health Emergency)	<ul style="list-style-type: none"> • 98966 • 98967 • 98968 • 99441 • 99442 • 99443 	<p>For new* or established patients:</p> <p>*To the extent the 1135 waiver requires and established relationship, HHD will not conduct audits</p>

		to ensure that such a prior relationship existed for claims
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- **US Family Health Plan:** Please reference the table below.

Telemedicine Service	HCPC/CPT CODE	Patient Relationship with the provider
Telehealth Services*	<p>Common Telehealth Services include:</p> <ul style="list-style-type: none"> • 99201-99215 (Office or other outpatient Visit) • 99307-99310 (subsequent nursing facility care) • 99354-99357 (prolonged service) • 99495-99498 (transitional care Management services) • G0508-G0509 <p>In accordance with the TRICARE Policy Chapter 7 section 22.1, “The use of interactive telecommunications systems may be used to provide diagnostic and treatment services for otherwise covered TRICARE benefits when such services are medically or psychologically necessary and appropriate medical care.”</p> <p>Please see the Billing Section of this document for important information</p> <p><i>Effective for dates of service 05/12/2020 and until further notice, telehealth may be provided via an audio-only connection where a visual connection would not be required to ensure appropriate medical care.</i></p>	For new or established patients
Virtual Check-In	<ul style="list-style-type: none"> • G2010 • G2012 	For established patient
E-Visits	<ul style="list-style-type: none"> • 99421 • 99422 • 99423 • G2061 • G2063 	For established patient

Telephonic Evaluation Codes	<p><i>Covered for dates of service 05/12/2020 and until further notice:</i></p> <ul style="list-style-type: none"> • 98966 • 98967 • 98968 • 99441 • 99442 • 99443 • G2012 	For new or established patients.
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HAS CMS OR DHA LIFTED ITS INTERACTIVE REQUIREMENTS FOR ALL TELEHEALTH SERVICES?

- **Generations Advantage:** Yes, the HHS Office for Civil Rights (OCR) has relaxed the following requirements:
 - i. **Everyday Communication Technology:** Everyday communications technologies, such as Facetime or Skype is now allowed. Members must be made aware there may be a risk in utilizing some of these technologies if they don't meet HIPPA Security requirements. For more information: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html>
 - ii. **Location Restrictions:** Additionally, CMS has indicated, "The Coronavirus Preparedness and Response Supplemental Appropriations Act, as signed into law by the President on March 6, 2020, includes a provision allowing the Secretary of the Department of Health and Human Services to waive certain Medicare telehealth payment requirements during the Public Health Emergency (PHE) declared by the Secretary of Health and Human Services January 31, 2020 to allow beneficiaries in all areas of the country to receive telehealth services, including at their home. "
 - iii. **Telephone Evaluation:** On March 30, 2020 the President authorized coverage and payment for the following services during the Public Health Emergency: CPT codes 98966-98968 and CPT codes 99441-99443. Specific CMS coverage requirements can be found here: <https://www.cms.gov/files/document/covid-final-ifc.pdf>

- **US Family Health Plan:**
 - i. In accordance with the interim final rule titled, "*TRICARE Coverage and Payment for Certain Services in Response to the COVID-19 Pandemic,*" audio-only health care visits will be temporarily allowed. Please see the following question for details.

CAN PROVIDERS DELIVER TELEMEDICINE SERVICES VIA AUDIO-ONLY CONNECTION DURING THE PUBLIC HEALTH EMERGENCY?

- **Generations Advantage:** On April 30, 2020, CMS updated its [‘List of Medicare Telehealth Services’](#) to indicate services that may be provided utilizing an audio-only connection. Generations Advantage will allow audio-only telehealth services if approved by CMS. Additionally, telephonic evaluations (CPT codes 98966-98968 and CPT codes 99441-99443) can be provided via audio-only connections.

Please note that the CMS Memo ‘Applicability of diagnosis from telehealth services for risk adjustment’, stipulates only interactive audio and video telecommunications system are permitted for the purpose of risk adjustment. Thus, audio-only approved telehealth visits and telephonic evaluations (CPT codes 98966-98968 and CPT codes 99441-99443) are not risk adjustable.

- **US Family Health Plan:** In accordance with the interim final rule titled, [“TRICARE Coverage and Payment for Certain Services in Response to the COVID-19 Pandemic,”](#) audio-only health care visits will be temporarily allowed. These provisions are effective May 12, 2020 and expire upon expiration of the President’s national emergency for the COVID-19 outbreak.

The use of audio-only telehealth should be for the purpose of providing assessment, diagnosis, clinical care, or formal patient education from an authorized provider to a patient, or for providing clinical consultation between providers that directly impacts upon a patient’s care. Care that normally requires a physical examination (including a remote physical examination requiring a tele-presenter such as a nurse) or a visual evaluation is not appropriate for audio-only telehealth encounters. Administrative services (for example, making appointments or verifying prescriptions) are not separately reimbursed services.

Audio-only telemedicine is inappropriate where a visual connection would be required to ensure appropriate medical care, e.g., evaluation of a skin lesion by a dermatologist or intensive outpatient programs.

The reason for using the telephone, in lieu of HIPAA-compliant audiovisual requirements as required in TRICARE’s telemedicine policy, must be documented in the medical record.

WILL MARTIN’S POINT HEALTH CARE WAIVE THE REQUIREMENT THAT PROVIDERS MUST HAVE A PRE-EXISTING RELATIONSHIP WITH PATIENTS IN ORDER TO PROVIDE TELEHEALTH SERVICES?

Yes, in accordance with the Coronavirus Aid, Relief and Economic Security Act (CARES Act), Martin’s Point Generations Advantage plans will waive the pre-existing relationship requirement.

WHAT COST SHARE IS APPLIED TO TELEHEALTH SERVICES DURING THE COVID-19 NATIONAL EMERGENCY?

- **Generations Advantage:**

- The office visit copay will be applied during the COVID-19 National Emergency*. If the provider can hold a PCP panel, the PCP copay will apply, otherwise the specialty copay will apply.

*The telehealth copay will be waived (dates of service 3/10/2020 and after until the federal declaration ends on May 12th, 2023) if the claim is billed with diagnosis code B97.29 or U07.1.

Effective for dates of services on or after May 12, 2023, cost shares will apply based on member's plan benefit.

- **US Family Health Plan**

- **For dates of service prior to 5/12/2020:** The office visit copay will be applied during the COVID-19 National Emergency*. If the provider can hold a PCP panel, the PCP copay will apply, otherwise the specialty copay will apply.

* In accordance with the "Families First Coronavirus Response Act," the US Family Health Plan will waive the telehealth copay if the visit results in a lab test for COVID-19.

- **For dates of service 5/12/2020 and after:** Copays and coinsurance will be waived for all covered services delivered via telehealth if provided by an in-network provider. This provision will be in effect until the expiration of the President's national emergency for the COVID-19 outbreak. Telehealth services provided by out-of-network providers will be subject to applicable cost shares unless the visit results in lab test for COVID-19.

WILL MARTIN'S POINT HEALTH CARE ALLOW FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) AND RURAL HEALTH CLINICS (RHC) AS SITES OF CARE FOR TELEHEALTH SERVICES?

Yes, in accordance with the Coronavirus Aid, Relief and Economic Security Act (CARES Act), Martin's Point Generations Advantage plans recognize FQHC and RHC as sites of care for telehealth services.

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BILLING GUIDANCE

HOW DO I BILL FOR TELEHEALTH/TELEMEDICINE SERVICES*?

- **Generations Advantage:** In accordance with CMS guidance, “When billing professional claims for all telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with:
 - i. Place of Service (POS) equal to what it would have been had the service been furnished in-person
 - ii. Modifier 95, indicating the service rendered was actually performed via telehealth”

Additional references:

- [Medicare Claims Processing Manual Chapter 12](#)
- [CMS's MLN BOOKLET TELEHEALTH SERVICES](#)
- [CMS Covered Telehealth Services](#)
- [CMS Telehealth FAQ](#)

- **US Family Health Plan:**

Effective March 20th, 2020, until the end of the COVID-19 PHE the billing requirements will be as follows*:

- i. When billing for synchronous **telehealth** services, providers will use CPT or **Healthcare Common Procedure Coding System (HCPCS)** codes with a **GT or 95** modifiers for distant site and Q3014 for originating site to distinguish **telehealth** services.
- ii. For billing asynchronous **telehealth** services, providers will use CPT or HCPCS codes with a **GQ** modifier. In addition, **POS 02 may** be reported in conjunction with the **GQ** modifier. **CMS is allowing the provider to bill the place of service that would have been billed had the service been provided in person to allow for higher non-site-of-service rate reimbursement. Once, the PHE has ended the provider will be required to bill the place of Service (POS) 02 or 10 and will no longer receive the higher non-site-of-service rate.**

*As indicated in the TRICARE Policy Manual Update 89 effective October 15, 2021. Providers looking to submit a corrected/disputed claim will have 120 days from the October 15, 2021, date to submit.

WHERE CAN I FIND THE CDC'S CURRENT BILLING GUIDELINES?

<https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf>

ARE ANY BILLING ISSUES EXPECTED WHEN BILLING FOR SERVICES FOR A PROVIDER AT A LOCATION OTHER THAN THE ONE(S) ON THEIR ENROLLMENT FILE?

Billing issues are not expected; however, this is an unprecedented situation. Please contact Martin's Point Provider Inquiry should issues arise.

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COVERING PROVIDERS

IF A PROVIDER IS QUARANTINED IS THE BILLING ENTITY ABLE TO SEND ANOTHER PROVIDER TO SEE PATIENTS AT THAT OFFICE IN THEIR ABSENCE?

In the absence of a particular provider due to quarantine, another provider may see patients at that office.

IF PROVIDER HAS MULTIPLE LOCATIONS WILL THE MEMBER BE ABLE TO SEE A COVERING PROVIDER AT ANOTHER LOCATION?

Yes, additionally all covered services will be subject to the in-network cost share.

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GENERAL INFORMATION

WILL MARTIN'S POINT HEALTH CARE WAIVE TIMELY FILING REQUIREMENTS DURING THE COVID-19 NATIONAL EMERGENCY?

Martin's Point Health Care's timely filing requirements have not changed.

WHERE CAN I GET ADDITIONAL INFORMATION FROM CMS ON THE COVID-19 NATIONAL EMERGENCY?

<https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>

WILL GENERATIONS ADVANTAGE ALLOW AMBULATORY SURGICAL CENTERS TEMPORARILY TO ENROLL AS A HOSPITAL DURING THE PUBLIC HEALTH EMERGENCY (PHE)?

Ambulatory Surgical Centers (ASC) will be allowed to operate as a hospital to the extent allowed by waiver 1135, if they meet conditions of participation and other requirements not waived by CMS. The provider must submit an attestation that the MAC approved enrollment with the effective date of enrollment.

Effective 05/12/2023, Ambulatory Surgical Centers (ASC) must meet the certification standards requirement to operate as a hospital under the 42 C.F.R. part 482, or return to ASC status.

WHAT ADDITIONAL COVID-19 RESOURCES ARE AVAILABLE TO PROVIDERS?

- Per the CMS website, *"CMS has released a set of toolkits for providers, states and insurers to help the health care system prepare and assist in swiftly administering these products once they become available. These resources are designed to increase the number of providers that can administer the products and ensure adequate reimbursement for administration in Medicare, while making it clear to private insurers and Medicaid programs their responsibility to cover these products at no charge to beneficiaries. This webpage provides the payment allowances and other related information for these products. For information specific to pricing [COVID-19 provider toolkit](#).*

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OPERATIONS UPDATES

ARE YOUR CALL CENTERS OPEN?

Yes, our call centers are open. Provider inquiry is available Monday through Friday from 8 am to 5 pm at 888-732-7364. Additionally, providers can utilize the [Provider Portal](#) to access remits, check eligibility and claim status.

CAN I CHECK MEMBER ELIGIBILITY AND CLAIMS STATUS AND REMITS ONLINE?

Yes, during and after the crises, providers can utilize the [Provider Portal](#) to access remits, check eligibility and claim status.

WILL CLAIMS PROCESSING STILL OCCUR?

Yes, currently there are no plans to stop the processing of claims.

WILL CLAIM PAYMENTS STILL OCCUR?

Yes, currently there are no plans to stop payment of claims.

WILL PROVIDERS BE ALLOWED TO SEND INFORMATION ELECTRONICALLY THAT MARTIN'S POINT HEALTH CARE NORMALLY WOULD REQUIRE TO BE SENT VIA MAIL, E.G. DISPUTES?

Currently, there are no changes to the dispute process. Providers should continue to submit disputes via U.S. Mail.

DO YOU ANTICIPATE ANY DELAYS OR CHANGE IN PROCESS (EX. CALL CENTER STAFFING OR CONTACT METHOD) IN PROVIDING AUTHORIZATION FOR ELECTIVE OR SCHEDULED SERVICES?

Martin's Point authorization processes have not changed. We do not anticipate any delays or change in process.

HAVE THERE BEEN ANY CHANGES TO MARTIN'S POINT HEALTH CARE'S UTILIZATION MANAGEMENT TEAM'S CONTACT INFORMATION?

No, there have been no changes to Martin's Point Health Care's Utilization Management team's contact information.

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CLINICAL REVIEW AND UTILIZATION MANAGEMENT

DOES MARTIN'S POINT HEALTH CARE UTILIZE INFOCLIQUE FOR NOTICE OF ADMISSION?

No, Martin's Point does not utilize Infoclique.

WILL MARTIN'S POINT HEALTH CARE BE ADJUSTING ITS NOTICE OF ADMISSION TIMEFRAMES?

Martin's Point will not be adjusting our current Notice of Admission process at this time.

SHOULD A POST-ACUTE AUTHORIZATION (E.G. SNF OR MED REHAB) BE NEEDED, DO YOU ANTICIPATE ANY DELAYS?

Martin's Point Health Care does not anticipate any delays to the post-acute authorization process. The only delays that we anticipate would be in the availability of open beds for members to be transferred to.

WILL MARTIN'S POINT HEALTH CARE TEMPORARILY SUSPEND OR MODIFY ANY ADMISSION PROTOCOLS FOR ADMISSIONS TO POST-ACUTE CARE FACILITIES?

Covered Services: Admission protocols have not changed for covered services.

Non-Covered Services: Non-skilled care is not covered under Original Medicare and TRICARE. Martin's Point Health Care recognizes that due to the COVID-19 emergency, there may be situations in which the member is unable to leave the post-acute care facility. If this situation occurs, please contact the Martin's Point Health Management Department.

ARE PROVIDERS STILL ABLE TO ESCALATE AUTHORIZATION SHOULD THE NEED ARISE FOR FAST TURNOVER OF ACUTE BEDS?

Martin's Point Health Care's escalation process has not changed. If a provider needs to escalate an authorization, they must submit it as "urgent."

WILL MARTIN'S POINT HEALTH CARE'S UTILIZATION MANAGEMENT STAFF CONTINUE TO BE AVAILABLE FOR NEEDED CASE REVIEW INCLUDING RN TO RN REVIEW AND MD PEER TO PEER REVIEW IF NEEDED?

Martin's Point Health Care review process will remain the same including the peer-to-peer process.

DOES MARTIN'S POINT HEALTH CARE ANTICIPATE ANY DELAYS IN AUTHORIZING INPATIENT OR OBSERVATION CARE?

Martin's Point Health Care does not anticipate any delays to the prior-authorization process. Please note authorization is not required for observation.

DOES MARTIN'S POINT HEALTH CARE HAVE THE ABILITY SEND LEVEL OF CARE AUTHORIZATIONS AND DENIALS ELECTRONICALLY, E.G. EMAIL?

Authorization requests can be submitted to Martin's Point online, via fax/mail, or phone. Approval and denial letters will still be sent via mail. Providers can check the status of their authorizations through our Portal or by calling us.

Martin's Point Health Care does not have the ability to send notifications via email.

WILL MARTIN'S POINT HEALTH CARE WAIVE AUTHORIZATION/MEDICAL REVIEW REQUIREMENTS FOR HOME RESPIRATORY SERVICES?

Martin's Point authorization processes have not changed. If a provider needs to escalate an authorization, they must submit it as "urgent."

WILL MARTIN'S POINT HEALTH CARE WAIVE MEDICAL NECESSITY REVIEW FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES THAT EXCEED QUANTITY LIMITS E.G. MUE?

No, medical necessity reviews will still be required when services exceed the quantity limit for durable medical equipment and supplies.

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PHARMACY UPDATES

IS MARTIN'S POINT HEALTH CARE WAIVING PHARMACY REFILLS FOR BEING TOO SOON OR WAIVING ANY FORMULARY REQUIREMENTS?

In accordance with the section 3714 of the CARES Act, Martin's Point Health Care has allowed the CVS Caremark's SCC 13 override process for prescriptions fill requests to be covered up to a 90-day supply in one fill or refill. This waiver will end on 05/11/2023.

○ **Generations Advantage**

- Martin's Point Health Care has authorized enrollment in CVS Caremark's SCC 13 Override process, which was moved into production effective Friday, March 13, 2020. The SCC 13 Override early fill program includes:
 - Maximum day supply of 90 days for maintenance medications
 - Max number of early fills is ONE in 90 days
 - Members can receive a 30-day early fill, but the claims editing software will only allow One early fill per medication.
 - Does NOT exclude any specialty medications
 - Excludes OPIOID prescriptions only (this includes tramadol).

In-network pharmacies will be able to place the override using the proper SCC 13 code. Pharmacies do not have to call the help desk to assist with overrides.

- Generations Advantage Over-The-Counter supplemental benefit, provided by CVS'OTC Health Solutions, has placed the following limits on select products:
 - Hand sanitizer – limit of 2 per quarter
 - Disposable Nitrile gloves – limit of 1 per quarter
 - Alcohol & disinfectant wipes – limit of 1 per quarter
 - First Aid kits – limit of 1 per quarter
 - Digital Thermometer – Limit 1 per quarter
 - Unscented Wipes – Item B33 – Limit 1 per quarter

○ **US Family Health Plan**

- Martin's Point Health Care has authorized enrollment in CVS Caremark's SCC 13 Override process for maintenance medications only*.
- The SCC 13 Override early fill program includes the following:
 - Max day supply of 30 days for early fills
 - Max number of fills 3 in 90 days for SCC 13 claims

- Excludes ALL controlled substances (DEA 2-5)
- HIV and transplant medications **are** eligible for 30-day overrides.

*Please note that 30-day overrides are not available for most specialty medications or controlled substances.

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IS MARTIN'S POINT HEALTH CARE MAKING CHANGES TO QUANTITY LIMIT RESTRICTIONS DUE TO THE DEMAND ON SUPPLY FOR MEDICATIONS USED IN THE TREATMENT OF COVID-19?

- Generations Advantage- Currently there are no changes to quantity limits for the Generations Advantage members. Conversations continue with CMS for guidance on any ability to assist with the shortage of medications used in the treatment of COVID-19.
- USFHP- Due to COVID-19, the demand for albuterol inhalers (Proair, Ventolin, Proventil) and levalbuterol (Xopenex) inhalers is much higher than normal. Martins Point Health Care has followed the TRICARE decision to implemented quantity limits on USFHP for these medications to help balance the demand with supply to ensure all patients have access to these medications. The limit for members is **one inhaler per 30 days** (one full copayment applies). Martins Point Health Care will remove these temporary quantity limits in place for USFHP members as the supply becomes available. Members can get a refill starting on or after the 22nd day after they last filled their prescription. For additional information go to:
https://www.tricare.mil/CoveredServices/BenefitUpdates/Archives/04_10_2020_TRICARE_Asthma_Inhaler_limits

STATE MANDATES

DO STATE BUREAU OF INSURANCE EMERGENCY RESPONSE ORDERS APPLY TO THE US FAMILY HEALTH PLAN OR GENERATIONS ADVANTAGE?

The Generations Advantage and the US Family Health Plan are federal contracts in which federal preemption applies and Martin's Point Health Care is prohibited from changing benefits coverage and cost unless permitted to do so by The Centers for Medicare and Medicaid Services and/or Defense Health Agency.

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