COVID-19 Pandemic
Frequently Asked Questions for Providers

March 2, 2022
Changes affect all HAP members unless otherwise notified.

We appreciate your partnership during this unprecedented time. We are grateful to your health care teams who are on the front lines ensuring the safety and well-being of our community.

This document provides an overview of the changes HAP has made to policies and processes so you can quickly and easily provide care to your HAP patients. It also highlights the support we've provided to our members and employer groups.

You can select a link below to go directly to that section in the document.

Topics

Vaccine Information

- Information for members can be found here.
- Our vaccine policy can be found when you log in at **hap.org,** select *More*, *Benefit Admin Manual,* then search for *Immunizations & Vaccine*.

COVID-19 Testing and Treatment

1. **Does HAP waive cost sharing for COVID-19 testing and treatment?**
   Yes. Please details below.
   - **Testing:** HAP will waive member cost-sharing for COVID-19 diagnostic tests and test-related visits, including virtual/telehealth visits, during the public health emergency according to state and federal guidelines. This cost-sharing waiver applies to testing from in-network or out-of-network providers. Member cost-sharing for all other diagnostic tests will continue to apply. Self-insured employer group customers control their own health benefits; employees of self-funded employer groups should confirm cost-sharing when seeking services.

   - **Antibody testing:** HAP will waive member cost-sharing for the COVID-19 antibody test during the public health emergency if the test is FDA approved and is ordered by a qualified health professional according to CDC recommendations.

   - **Rapid testing:** HAP will waive member cost-sharing for a rapid COVID-19 test during the public health emergency if the test is FDA approved and is ordered by a qualified health professional according to CDC recommendations.

   - **Home test kits:** HAP will waive member cost-sharing for at-home COVID-19 diagnostic tests during the public health emergency if the test is FDA approved and is ordered by a qualified health professional who has determined that the test is medically appropriate for the individual according to CDC recommendations. The accuracy of at-home testing is still uncertain, and these are not widely available.

   - **Treatment:** HAP will waive member cost-sharing (which includes deductibles, copays and co-insurance) for treatment related to an acute diagnosis of COVID-19 infection. This cost-sharing waiver is for inpatient or outpatient treatment from an in-network provider and is currently in effect for services rendered through September 30, 2021. Beginning October 1, 2021, coverage for the treatment of COVID-19 will return to the standard benefit. HAP does not waive cost sharing for treatment of ongoing complications stemming from a previous COVID-19 diagnosis.

   Self-insured employer group customers control their own health benefits; employees of self-funded employer groups should confirm cost-sharing when seeking services.

   Also, **testing required by employers**, such as tests necessary to allow employees to return to work, is not a covered benefit. The employer and/or member is responsible for the cost of these tests.

Telehealth and Virtual Visits

1. **How does HAP define telehealth and virtual visits?**
   Telehealth is defined as real time audio/visual visit. Virtual visit is defined as a phone visit. with provider. CMS guidelines have changed due to COVID-19; therefore, if a provider can do any kind of HIPAA compliant video or audio call such as FaceTime or Skype, that is considered a telehealth visit.

2. **How is HAP covering virtual visits and telehealth?**
   Cost-sharing is waived for HAP individual, fully-insured group, Medicare, Medicaid and MI Health Link members using telehealth services related to a COVID-19 diagnosis through September 30, 2021. Member cost share will apply for telehealth services that are not related to an acute diagnosis of COVID-19 infection. Self-insured employer group customers control their own health benefits and HAP is working with its self-insured customers to determine how they will cover telehealth services.

   Eligible members who have an established relationship with a behavioral health provider can reach out directly to the provider's office to confirm their telehealth capabilities. All members with questions related to behavioral health can call customer service or the mental health services number on the back of their HAP ID card.

   Beginning Oct. 1, 2021, coverage for the treatment of COVID-19 will return to the standard benefit.

3. **Are wellness services (G0438 and G0439) covered via telehealth?**
   Yes, wellness visits (G0438 and G0439) are covered when provided via telehealth. Please refer to our Benefit Administration Manual for the Telemedicine, Telehealth & Virtual Care Services policy. The policy also contains links to CMS resources for codes.

4. **Are preventive visits covered via telehealth?**
   Preventive visits (99381-9939) are not covered via telehealth, consistent with CMS guidelines. These service codes include expectations or aspects of care that are not feasible by audio/visual telemedicine technology (listening to breath sounds, heart sounds, palpitation of the abdomen, etc.). We're reevaluating if this could be covered in the future.

5. **Do you cover PT/OT/ST therapy via telehealth?**
   Yes. Please refer to our Benefit Administration Manual for the Telemedicine, Telehealth & Virtual Care Services policy for more information. Applies to all Medicare Advantage, HAP/AHL Commercial and Individual product members. HAP Empowered Medicaid members continue to follow MDHHS directives.

6. **Do you cover autism via telehealth?**
   Yes. Please refer to our Benefit Administration Manual for the Autism Spectrum Disorders, Evaluation and Treatment policy for coverage criteria.

Prior Authorizations and Referrals

1. **Is prior authorization required for skilled nursing facility admissions from an acute care facility?**
   On January 21, 2022, we extended the temporary prior authorization waiver for skilled nursing facility admissions through March 6, 2022.

   Effective March 7, 2022 prior authorization will be required for admission to or continued stay at:
   - Skilled nursing facilities (SNF)
   - Inpatient rehab facilities (IRF)
   - Long-term acute care at hospitals (LTACH)

   Hospitals and skilled nursing facilities should follow the process below.

For	Process
HAP Medicare Advantage members	Contracted hospitals and skilled nursing facilities submit prior authorization requests to naviHealth via: • Online via nHAccess on naviHealth's portal • Fax at **(888) 927-0718** For resources, visit: **https://navihealth.com/partners/hap/resources**
Other HAP members HAP Empowered Medicaid members HAP Empowered MI Health Link members HAP Empowered Duals (HMO SNP) members	We have facilities designated as a Highly Preferred Skilled Nursing Facility for HAP. **Highly Preferred SNFs** • Do not submit prior authorization requests when admitting these members. • Within 3 business days of the admission date, submit the following information: – Patient medical history and physical – Therapy evaluation – Proof of medical necessity (only if therapy isn't required) – Face sheet You can fax it to **(313) 664-5820**. All members will undergo a clinical review within seven to 10 days of admission. **Skilled nursing facilities without the highly preferred designation, IRF and LTAC** Submit prior authorization requests via fax at **(313) 664-5820** or Allscripts

2. **Have effective dates of existing and new pre-service authorizations been extended?**
   Yes. We've extended effective dates of existing and new pre-service authorizations to 365 days; 180 days now for high-tech imaging, sleep studies and ZOLL LifeVests.

3. **Has HAP removed authorizations for out of plan/out of network services for any members?**
   Yes. We've removed authorizations for out of plan/out of network services for all Medicare, MMP and DSNP. No PCP referrals required for HAP Primary Choice Medicare (HMO) and HAP Choice Medicare (HMO) plans.

4. **Has HAP removed referral requirements for any plans requiring them?**
   Yes. Referrals are not required for HAP Primary Choice Medicare (HMO) plans, HAP Choice Medicare (HMO) plans, tiered network plans. This is effective March 10 through end of the PHE.

5. **Will HAP waive authorization for outpatient testing with a suspected or confirmed COVID diagnosis, i.e. high-tech imaging, DME?**
   Yes.

6. **Does HAP temporarily allow speech therapy for children with a diagnosis other than autism at medical facilities since services are not available at schools now due to state of emergency?**
   Yes. However, effective July 15, 2021, requests for speech therapy at medical facilities will not be approved for children 18 or younger with a diagnosis other than:
   - Autism
   - Acute illness
   - Medical indication such as surgery

   These members will be directed to their school district for speech therapy services.

7. **Do you cover out of network care for COVID-19 for Medicare members?**
   Yes. We cover all medically necessary covered Medicare Advantage plan benefits provided at non-contracted providers. The provider must participate with original Medicare. This is effective March 10 through end of State declared emergency.

Financial

1. **What is HAP doing to offer financial relief for providers?**
   We pay claims quickly and have experienced no operational barriers to our work. Additionally, we're providing cash flow relief by expediting our 2019 Best Practice payments. We're evaluating other opportunities for financial relief.

2. **How is HAP handling sequestration?**
   HAP will follow the Centers for Medicare and Medicaid Services and restrict sequestration temporarily beginning May 1, 2020. Per CMS, section 3709 of the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), temporarily suspends sequestration of Medicare programs between May 1, 2020, and December 31, 2020, which we will refer to as the "sequestration suspension period."

3. **What other financial relief are you offering HAP members?**
   Monthly premium changes for individual members and small group customers
   HAP will decrease monthly premiums by 5 percent through the end of the year. These decreases will be reflected in monthly premium bills beginning July 1 and will be in effect through December 2020.

Billing Guidelines

1. **What are your Billing Guidelines for COVID-19 Related Services and Telehealth Services during the Public Health Emergency?**

Updated Billing Guidelines for Outpatient Services for COVID-19 Cost Share Waiver

To ensure accurate claims payment, please follow the updated billing guidelines below for all HAP Commercial, ASO and Medicare products for outpatient services.

Important! For services provided through the end of the Public Health Emergency (PHE), you should use the CS modifier on applicable outpatient claim lines to show the service is subject to the cost-share waiver for COVID-19 testing-related services that result in an order for and are related to providing or administering a COVID-19 test.

Cost share will be waived when a provider:

- Submits a claim line with a CS modifier (professional, facility and telehealth) with a specific outpatient E&M or HCPCS code and if billed with suspected or likely exposure to COVID-19: Z20.822, as the primary diagnosis, as appropriate.

- Submits a claim line with procedure code S9083 with a CS modifier for Urgent Care services and if billed with suspected or likely exposure to COVID-19: Z20.822, as the primary diagnosis, as appropriate.

- Submits COVID-19 CPT/HCPCS testing codes on an outpatient claim if billed with suspected or likely exposure to COVID-19: Z20.822, as the primary diagnosis, as appropriate.

- Submits a claim line for COVID-19 specimen collection with a CS modifier on an outpatient claim and if billed with suspected or likely exposure to COVID-19: Z20.822, as the primary diagnosis, as appropriate. HAP continues to reimburse only when billed alone. We consider this service inclusive when billed with an E&M code.

- Submits each claim line with CS modifier appended for each additional lab other than COVID-19 diagnostic test when ordered specifically to determine a diagnosis of COVID-19 and if billed with suspected or likely exposure to COVID-19: Z20.822, as the primary diagnosis, as appropriate.

- Submits a claim line for COVID-19 CPT/HCPCS testing for pre-operative procedures. HAP supports correct coding guidelines and as such should be submitted with the following, as appropriate:
  - Z01.810 – Encounter for preprocedural cardiovascular examination
  - Z01.811 – Encounter for preprocedural respiratory examination
  - Z01.812 – Encounter for preprocedural laboratory examination
  - Z01.818 – Encounter for other preprocedural examination

COVID-19 testing for public health surveillance, employment purposes, and other testing not intended for individualized diagnosis or treatment of Covid-19:

- Submits a claim line for testing required for public health surveillance/screening, employment purposes or travel use Z11.52 as the primary diagnosis, as appropriate. This claim line will be denied as this is not a covered benefit.

Billing Guidelines for Telehealth Services During the Public Health Emergency

Our billing requirements for telehealth services are aligned with CMS.

For	Billing Guidelines
Dates of service on or after March 1, 2020, and for the duration of the PHE	• Bill with Place of Service (POS) equal to what it would have been had the service been furnished in-person and use modifier 95, indicating the service rendered was performed via telehealth • Traditional telehealth services professional claims should reflect the designated POS code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site. **Effective January 1, 2022** The POS 02 description was revised and a new code, POS 10, was developed. The place of service billed is dependent on where the patient is located during the telehealth service. When billing for telehealth services, use: • **POS 02: Telehealth Provided Other than in Patient's Home** Patient is not located in their home when receiving health services or health related services through telecommunication technology • **POS 10: Telehealth Provided in Patient's Home** Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.
• The CR modifier is not required on telehealth services. However, consistent with current rules for telehealth services, there are two scenarios where modifiers are required on Medicare telehealth professional claims: – Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier – Furnished for diagnosis and treatment of an acute stroke, use G0 modifier • There are no billing changes for institutional claims. • Critical access hospital method II claims should continue to bill with modifier GT.	

Billing Guidelines for COVID-19 Vaccine Administration Only

To ensure accurate claims payment, please follow the vaccine administration and billing guidelines below for all HAP and HAP Empowered lines of business.

Providers cannot bill for vaccines supplied by the government under the CARES Act.

Vaccine Administration Billing Guidelines for Commercial and Medicaid Members

You can submit claims for administration of COVID-19 vaccines for commercial and Medicaid members. Please use the codes below.

<table>
<tr><th colspan="3">Manufacturer and Administration codes</th></tr>
<tr><td>Pfizer
0001A (1st dose)
0002A (2nd dose)
0003A (3rd dose)
0004A (booster)
0051A (1st dose)
0052A (2nd dose)
0053A (3rd dose)
0054A (booster)
0071A (Pediatric – 1st dose)
0072A (Pediatric – 2nd dose)</td><td>Moderna
0011A (1st dose)
0012A (2nd dose)
0013A (3rd dose)
0064A (booster)</td><td>Janssen
0031A
0034A (booster)</td></tr>
<tr><td colspan="3">M0201
Covid-19 vaccine administration inside a patient's home; reported only once per individual home per date of service when only covid-19 vaccine administration is performed at the patient's home</td></tr>
</table>

Important! You can always find the most up-to-date codes in our policy. Log in at **hap.org**; select *Benefit Admin Manual* under *More*, then search for *Immunizations & Vaccines*.

Vaccine Administration Billing Guidelines for Medicare Advantage Members

For 2020 and 2021 Dates of Service	For 2022 Dates of Service
We're aligned with CMS guidelines. Per CMS, submit claims for administration of all COVID-19 vaccines for MA members to the CMS Medicare Administrative Contractor (MAC) for payment. Claims will deny if submitted to HAP with direction to bill CMS.	For administration of all COVID-19 vaccines on or after January 1, 2022, submit claims to HAP using the codes outlined in the table above.
For more information, visit: Medicare Billing for COVID-19 Vaccine Shot Administration | CMS)	

Urgent Care Centers-Reimbursement for COVID 19 Vaccine Administration

Below are the covered codes for administration of COVID-19 vaccines.

Manufacturer and Administration codes		
Pfizer • 0001A (1st dose) • 0002A (2nd dose) • 0003A (3rd dose) • 0004A (booster) • 0051A (1st dose) • 0052A (2nd dose) • 0053A (3rd dose) • 0054A (booster) • 0071A (Pediatric – 1st dose) • 0072A (Pediatric – 2nd dose)	**Moderna** • 0011A (1st dose) • 0012A (2nd dose) • 0013A (3rd dose) • 0064A (booster)	**Janssen** • 0031A • 0034A (booster)

Reimbursement

For dates of service November 1, 2020, and forward, we'll follow the guidelines below to reimburse urgent care centers for COVID-19 vaccine administration.

Claims submitted for	Reimbursement	Lines of Business
COVID-19 vaccine administration only and **without** S9083	HAP fee schedule rate based on appropriate HAP line of business	All HAP and HAP Empowered
COVID-19 vaccine administration and **with** S9083	Considered bundled and will be reimbursed with urgent care case rate	HAP Commercial and HAP Medicare plans only

Appeals

1. **What are the provider appeals timelines during the COVID-19 crisis?**
   HAP is waiving appeals timelines during the emergency timeframe.

Prescription Coverage

1. **What is HAP doing for prescriptions?**
   HAP is offering free in-home medication delivery service to ensure our members have adequate drug supply on hand. The delivery cost is free for members to get medications sent to their homes through Pharmacy Advantage. HAP members can request all their drugs from Pharmacy Advantage. This service is available for all of our HAP members - Medicare, Medicaid, Dual Medicare/Medicaid, and Commercial population.

2. **What if members can't get prescriptions from in network pharmacies?**
   HAP will reimburse members for prescriptions obtained from out of network pharmacies when the member cannot reasonably obtain medications from in network pharmacies

Durable Medical Equipment Provider Specific Questions

1. **What prior authorization requirements are you following during this time?**
   HAP will follow the MDHHS and CMS guidance below.

2. **What documentation can be used for hospital discharges that require oxygen treatment?**
   DME suppliers can use provider's documentation of COVID-19 rationale for O2 equipment with a qualifying oxygen sat. DME script can be written for up to 60 days if medically necessary from date of discharge. Discretion of provider to determine allowable timeframe. After prescription expires, the patient will require a reevaluation.

3. **With an increase in oxygen orders with the primary diagnosis of COVID-19, is the diagnosis COVID-19 enough on its own? If sufficient, how long can oxygen be provided to patients with the primary (only) diagnosis of COVID-19?**
   COVID-19 diagnosis with a qualifying oxygen sat. qualifies for up to first 60 days or length of script and then patient needs to be re-evaluated. DME supplier should check at 30 days to assess if patient requires oxygen beyond the initial 30 days or when patient no longer needs oxygen any longer. Use new diagnosis code U07.1, COVID-19, effective from April 1, 2020. Use CDC codes for COVID-19 conditions before the new COVID-19 code is available.

4. **With members fearing they will run out of supplies; can we ship orders early?**
   HAP will follow CMS billing rules for refills which allows to process well in advance. This will minimize unintended consequence of DME shortages due to stockpiling. DME can be delivered as early as 10 calendar days earlier than refill date which HAP follows for Medicare, Medicaid and Commercial.

5. **Will HAP offer subsidies to members or suppliers who have out-of-pocket expenses for DME/medical supplies, if the member can't make payments due to COVID-19 impacts?**
   HAP will follow CMS and MDHHS guidelines for member cost share which at this time does not include the scope of DME and supplies. HAP will continue to assess the environment for additional changes.

6. **Will HAP waive requirements on the prescription (date of birth, ID number, diagnosis, gender, times testing, etc.)?**
   HAP will follow MDHHS and CMS guidance below.

7. **Will HAP waive medical record documentation, if required for a supply or order if we're unable to obtain it during this time?**
   HAP will follow MDHHS and CMS guidance below.

8. **Will HAP waive expired documentation or prescription renewals for existing members?**
   HAP will follow MDHHS and CMS guidance below.

MDHHS Guidance

Bulletin MSA 20-14: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Providers, Hospitals, Physicians, Pharmacies, Medicaid Health Plans (MHPs), Integrated Care Organizations (ICOs)

Start Date: March 26, 2020

End Date: 30 days following the termination of the Governor's Declaration of a State Emergency Order (2020-04, COVID-19) or the first of the following month, whichever is later

Applies to: MMP, Medicaid, HMP, CSHCS **Excludes:** Commercial and Medicare

Here are the guidelines from the MDHHS:

- Waive quantity limits, prior authorization and documentation requirements for:
  - Respiratory equipment/supplies (e.g. ventilators, suction catheters, oxygen, etc.)
  - Medical supplies the member typically receives through home delivery (e.g. diabetic supplies, incontinence supplies, enteral formulas, etc.)
- Ordering provider must establish medical necessity for specified equipment/supplies and quantities on order.
- Physician order must be kept in the member file and be available upon request.
- All other documentation requirements (timeliness, medical records, tests results, etc) are waived during emergency.
- Waive POA and need for new medical documentation for the replacement of medical equipment/supplies that have been lost, destroyed, damaged or otherwise rendered unusable or unavailable during emergency.

CMS Guidance

COVID-19 Emergency Declaration Health Care Provider Fact Sheet (3/13/2020)

Start date: March 13, 2020

End date: Continue up to the termination of the Governor's Declaration of a State Emergency Order

Applies to: Medicare, MMP, DSNP, Commercial **Excludes**: Medicaid, ASO

Here are the guideline from CMS:

For Durable Medical Equipment Where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable:

- Contractors have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required.
- Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced.
- Suppliers need to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise rendered unusable or unavailable as a result of the emergency.

HAP will continue to assess the situation and revise policies as needed or if government rulings require changes.

Communicating with Members, Employers and Providers

1. **How have you communicated with members, employers, and providers?**
   Below is an outline of the ways we've communicated.

Members

- We've posted the following information on **hap.org:**
  - COVID-19 testing and treatment
  - Getting care (virtual visits on telehealth)
  - Prescription coverage
  - Travel and quarantine
  - Scam and fraud protection
  - Helpful resources on the latest health and wellness news, tips and answers to questions by HAP experts, as well as helpful ideas to improve well-being
- We've sent direct mail to members about in-home prescription delivery
- We've called members at highest risk of food insecurity and social isolation. Actions range from assessing care management needs to offering free meals for up to two weeks. This will be offered through the State declared emergency.

Employers

- Employers have access to the online information available for members, as well as the following specific employer information **hap.org:**
  - Legislative information
  - Premium payment
  - Temporary staff changes
  - Special enrollment periods
  - Other coverage options
  - Business resources with information on recent legislation, available resources, and answers to questions about their HAP plan. There is also a hotline:
    Business Information Hotline
    (248) 776-4000
    Hours: 8:30 a.m. – 4:30 p.m.

Providers

- Providers have access to the online information available for members, as well as the following specific provider information **hap.org:**

  - HAP policy updates related to COVID-19 (in the newsroom)
  - Business resources with information on recent legislation, available resources, and answers to questions about their HAP plan. There is also a hotline:
    Business Information Hotline
    (248) 776-4000
    Hours: 8:30 a.m. – 4:30 p.m.

Pharmacies

- We've worked directly with our pharmacies on early medication refills and prescription home deliveries.