

NC Medicaid Billing Changes in Response to COVID-19 Summary

Effective March 13, 2020

NC Medicaid is implementing a phased approach in responding to the COVID-19 outbreak in North Carolina. The priority in Phase 1 is to maintain access to care for all beneficiaries while prioritizing safety for providers and patients by reducing unnecessary exposure through social distancing efforts. Please refer to <https://medicaid.ncdhhs.gov/about-us/coronavirus-disease-2019-covid-19-and-nc-medicaid> for details and up-to-date information on COVID-19.

ICD-10 Diagnosis Code

ICD-10 Dx Code	Criteria for Use
Z20.828	Visit for COVID-19 symptoms, contact with and (suspected) exposure to other viral communicable disease

Telephonic Visit Codes

- ***Modifier CR must be used.*** This bypasses time limitations (7 day and 24 hour) and ensures payment and compliance with Medicaid auditing requirements.
- These codes are intended for telephonic/audio visits. However, providers may use these codes when using more advanced, video-enabled technology until telehealth service provision is approved. More specific guidance is forthcoming.
- Provider may be remote (not in the office) while patient is home-based instead of another healthcare facility.
- Patients are not subject to copays or out of pocket costs.
- These may not be used with new patients.

Visits with established patients actively experiencing mild COVID-19 symptoms (fever, cough, shortness of breath):

Medicaid Billing Code	Criteria for Use	Who Can Bill?
G2012	5-10 minutes of telephonic medical discussion	Physician or Advanced Care Provider who can report E/M services. Not for use in FQHCs or RHCs.

Routine, uncomplicated follow-up visits with established patients for chronic disease management (no COVID-19 symptoms):

Medicaid Billing Code	Criteria for Use	Who Can Bill?
99441	5-10 minutes of telephonic medical discussion	Physician or Advanced Care Provider who can report E/M services. Not for use in FQHCs or RHCs.
99442	11-20 minutes of telephonic medical discussion	
99443	21-30 minutes of telephonic medical discussion	

Visits with established patients for behavioral health assessment management:

Medicaid Billing Code	Criteria for Use	Who Can Bill?
98966	5-10 minutes of telephonic medical discussion	Licensed non-physician behavioral health professionals (LCSW, LCSW-A, LPC, LPC-A, LMFT, LMFT-A, LCAS, LCAS-A, LPA, Ph.D.). Not for use in FQHCs or RHCs.
98967	11-20 minutes of telephonic medical discussion	
98968	21-30 minutes of telephonic medical discussion	

Visits with established patients by FQHC and RHC providers:

Medicaid Billing Code	When to Use	Criteria for Use	Who Can Bill?
G0071	Used for established patients actively experiencing mild COVID-19 symptoms prior to going to ED, urgent care, etc. <u>or</u> Used for established patients needing routine, uncomplicated follow-up for chronic disease who are <u>not</u> experiencing COVID-19 symptoms.	5+ minutes of a virtual (not face-to-face) communication between an RHC or FQHC practitioner and RHC or FQHC patient	Physician or other qualified health care professional who can report E/M services, as well as PhD Psychologists and LCSWs. For use in FQHCs and RHCs only.

Laboratory Testing

Medicaid Billing Code	Criteria for Use
U0001	CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19)
U0002	non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19)

Pharmacy

- Providers should prescribe 90-day supplies on generic and brand medications (non-controlled substances only).
- There is no longer a requirement for a 30-day prescription prior to 90-day prescription.
- Providers may want to follow up with pharmacists to ensure 90-day supplies are filled.
- Copay requirements still apply to pharmacy claims - \$3 for 90-day supply.

Prior Authorization Code	Level of Service	When to Use
09	03	Fill up to a 14-day emergency supply for any pharmacy claim requiring prior approval when no active prior approval is showing in NCTracks <u>or</u> Fill up to a 14-day emergency supply for beneficiaries in the Pharmacy Lock-in Program needing emergency supplies of Lock-In program-related medications

In cases of early denial: resubmit claims with “09” (Emergency Preparedness) in the PA Type Code field and a valid value for an E.R. override in the Reason for Service, Professional Service and Result of Service fields to override a denial for an early refill. Do not place any values in the Submission Clarification Code field.

Durable Medical Equipment

- Prior authorization will no longer be required for specific respiratory equipment and supplies including oxygen tanks and equipment, oximeter devices, home ventilators, BiPAP and CPAP machines, and nebulizers.
- Quantity limits may be exceeded with no prior authorization on gloves and incontinence supplies for beneficiaries with respiratory infections.
- Providers can use HCPCS code **A4928 - surgical mask, per 20** if needed for beneficiaries and caregivers requiring frequent transportation/public presences with no prior authorization.
- Providers must maintain proper documentation of medical necessity for all DME orders.