Summary of NC Medicaid Billing Changes in Response to COVID-19

Effective March 13, 2020

NC Medicaid (DHHS) 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-only visits.
- 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.
- These codes will pay 80% parity of in-person visits, retroactive to March 10th.

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.). FQHC/RHCs may bill for services provided by licensed clinical addiction specialists, licensed
98967	11-20 minutes of telephonic medical discussion	

Revised: 05/16/20

98968	21-30 minutes of telephonic medical discussion	clinical mental health counselors, licensed psychologists, licensed psychological associates, licensed clinical social workers and licensed marriage and family therapists.

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. or Used for established patients needing routine, uncomplicated follow-up for *chronic disease* who are not 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 or 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.