MNS
MANAGEMENT & NETWORK SERVICES

COVID-19 MCO and Private Insurance Process Updates

January 31, 2022

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Payor updates that have occurred since the last version are highlighted in orange.

January 31, 2022

The information included in this document is effective as of January 31, 2022. This document will be updated regularly as new information is released by the payor.

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COVID-19 Communications Update: Temporary Changes in Prior Authorization/Precertification for Skilled Nursing Facility (SNF) admissions

Please check back for any new updates to this important information

Original notification: January 6, 2022
Updated: January 24, 2022

Aetna understands that health care systems are experiencing increased demand and urgency due to the difficult circumstances created by COVID-19. For this reason, Aetna, a CVS Health company, is applying temporary measures to help members access care and reduce administrative burden for physicians and facilities.

For all states, Aetna is temporarily applying the following changes, effective through February 28, 2022:

Skilled Nursing Facility admissions from Acute Hospitals

- Initial Precertification/Prior Authorization for admission from acute care hospitals to Skilled Nursing Facilities (SNF) are **waived** for all Commercial and Medicare Advantage (MA) Part C plans.
- The SNFs will be required to **notify** Aetna of admissions within 48 hours. Providers may submit their request electronically though our provider portal on Availity or their preferred EDI vendor using the existing Precertification Request transaction. Providers can also submit their request by calling Aetna directly (refer to the back of the member's ID cards for the correct telephone number).
- The Post-Acute care facility would also be required to send medical records for concurrent review within **three days** of the initial admission. Medical records can be uploaded directly through Aetna's provider portal on Availity or sent to Aetna by fax to 1-833-596-0339. Please include the patient's name and Member ID# on the cover sheet.
- Aetna Requires:
  - Hospital history and last two to three days of progress notes.
  - Any information that demonstrates a need for Post-Acute Care.
  - Anticipated Discharge Plan with estimated length of stay.

Regulations regarding post-acute care precertification and admissions protocols for Aetna Medicaid members varies by state and, in some cases, may change in light of the current situation. Providers are encouraged to call their provider services representative for additional information.

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- This change **does not apply** to transfer between facilities or level of care changes within a SNF.
- In addition, Aetna will continue to waive the three-day prior hospitalization requirements for skilled nursing facility stays, as part of our normal course of business.
- Our current policy for Home Health does **not** require precertification. Aetna plans to continue that process for contracted providers. Refer to Aetna DocFind for our contracted Home Agencies.
- **Long-Term Care Hospital Admissions (LTACH) and Inpatient Acute Rehabilitation** admissions still **require a prior authorization** for admission unless prohibited by state regulation.
- Temporary changes to reduce prior authorizations protocols for SNF admissions are effective through February 28, 2022.

Regulations regarding post-acute care precertification and admissions protocols for Aetna Medicaid members varies by state and, in some cases, may change in light of the current situation. Providers are encouraged to call their provider services representative for additional information.

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aetna®
Aetna Better Health®

COVID-19 Update
Aetna Better Health of Florida
Policy Update – Revised 08/26/20201

Effective August 1, 2021, The SNF Waiver was instituted for Aetna Better Health of Florida in response to the rising COVID-19cases in Florida. Included below is the SN F Waiver summary:

- Initial Precertification/Prior Authorization for admission from acute care hospitals to Skilled Nursing Facilities (SNF) are **waived** for ABH Florida Medicaid and Healthy Kids plans.
- The SNFs will be required to **notify** Aetna of admissions within 48 hours. Providers may submit their request electronically though our provider portal on Availity or using the existing Precertification Request transaction. Providers can also submit their request by calling Aetna directly (refer to the back of the member's ID cards for the correct telephone number).
- The Post-Acute care facility would also be required to send medical records for concurrent review within **three days** of the initial admission. Medical records can be uploaded directly through Aetna's provider portal on Availity or sent to Aetna by fax to 1-860-607-8056. Please include the patient's name and Member ID# on the cover sheet.

Aetna requires:

- Hospital history and last two to three days of progress notes.
- Any information that demonstrates a need for Post-Acute care.
- Anticipated Discharge Plan with estimated length of stay.

- This change **does not apply** to transfer between facilities or level of care changes within a SNF.
- Any DME or HHA requested from an acute care facility as part of physician discharge orders will be approved without clinical review.
- Aetna plans to continue regular process for all other Home Health precertification requests not related to an acute facility discharge request.
- **Long-Term Care Hospital Admissions (LTACH) and Inpatient Acute Rehabilitation** admissions still **require a prior authorization** for admission unless prohibited by state regulation. If a prior authorization is not completed, the admission will be reviewed retrospectively at claims submission.

We will provide 14 calendar days' notice to all providers regarding any change to the tentative end date of these flexibilities.

We appreciate the excellent care you provide to our members. If you have any questions, please feel free to contact us via e-mail: FLMedicaidProviderRelations@Aetna.com. You can also fax us at 1-844-235-1340 or call us through our Provider Relations telephone line: 1-844-528-5815.

Amerigroup

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Important COVID-19 update: prior authorization and other policy adjustments (updated September 3, 2021)

Please note: This notice applies to Arizona, New Jersey, New Mexico, Tennessee, Texas, Washington.

Amerigroup recognizes the intense demands facing doctors, hospitals, and all healthcare providers in the face of the COVID-19 pandemic. Today, unless otherwise required under state and federal mandates as detailed below, Amerigroup is making adjustments to assist providers in caring for members. These adjustments apply to members of all lines of business except as noted below, including self-insured plan members and in-network and out-of-network providers, where permissible. We encourage our self-funded customers to participate, although these plans may have an opportunity to opt out.

Medicare adjustments and suspensions may have different time frames or changes where required by federal law.

Inpatient and respiratory care

- **For Texas only:** Prior authorization requirements are suspended for patient transfers from acute inpatient (IP) hospitals to skilled nursing facilities effective August 23, 2021, through September 6, 2021. These adjustments apply to Medicare plan members receiving care from in-network providers. While prior authorization is not required, we continue to require notification of the admission via the usual channels and clinical records on day two of admission to aid in our members' care coordination and management. Amerigroup reserves the right to audit patient transfers.
- **For Arizona, New Jersey, New Mexico, Tennessee, and Washington:** Prior authorization requirements were suspended for patient transfers from acute IP hospitals to skilled nursing facilities effective December 21, 2020, through January 31, 2021. These adjustments apply for our Medicare plan members receiving care from in-network providers. While prior authorization is not required, we continue to require notification of the admission via the usual channels and clinical records on day two of admission to aid in our members' care coordination and management. Amerigroup reserves the right to audit patient transfers.
- **Concurrent review for discharge planning** will continue unless required to change by federal or state directive.
- **Prior authorization requirements are suspended for COVD-19 durable medical equipment** including oxygen supplies, respiratory devices, continuous positive airway pressure (CPAP) devices, noninvasive ventilators, and multi-function ventilators for patients who need these devices for any medical reason as determined by a provider, along with the requirement for authorization to exceed quantity limits on gloves and masks.

Amerigroup

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- **Respiratory services** for acute treatment of COVID-19 will be covered. Prior authorization requirements are suspended where previously required.

COVID-19 testing

Laboratory tests for COVID-19 at both in-network and out-of-network laboratories will be covered with no cost sharing for members.

Claims audits, retrospective review, peer-to-peer review, and policy changes

Amerigroup will adjust the way we handle and monitor claims to ease administrative demands on providers:

- **Hospital claims audits** requiring additional clinical documentation was limited through June 24, 2020, though Amerigroup reserves the right to conduct retrospective reviews on these findings with expanded lookback recovery periods for all lines of business except Medicare. To assist providers, Amerigroup can offer electronic submission of clinical documents through the provider portal.
- **Retrospective utilization management review** was suspended through June 24, 2020, and Amerigroup reserves the right to conduct retrospective utilization management review of these claims when this period ends and adjust claims as required.
- **Suspended peer to peer reviews** through June 24, 2020, except where required pre-denial per operational workflow or where required by the state during this time period for all lines of business except Medicare.
- **Our Special Investigation programs** targeting provider fraud will continue, as well as other program integrity functions that help ensure payment accuracy.
- **New payment and utilization management policies and policy updates** will be minimized unless helpful in the management of the COVID-19 pandemic.

Otherwise, Amerigroup will continue to administer claims adjudication and payment in line with our benefit plans and state and federal regulations, including claims denials where applicable. Our timely filing requirements remain in place, but Amerigroup is aware of limitations and heightened demands that may hinder prompt claims submission.

Provider credentialing

Through June 24, 2020, Amerigroup will continue to process provider credentialing within the standard 15 to 18 days even if we are unable to verify provider application data due to disruptions to licensing boards and other agencies. We will verify this information when available.

If Amerigroup finds that a practitioner fails to meet our minimum criteria because of sanctions, disciplinary action, etc., we will follow the normal process of sending these applications to committee review, which will add to the expected 15- to 18-day average timeline. We are monitoring and will comply with state and federal directives regarding provider credentialing.

Providers should watch the Provider News page for any future administrative changes or policy adjustments we may make in response to the COVID-19 pandemic.

Anthem

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OHIO Provider Communications
Important COVID-19 update: Prior authorization and other policy adjustments
(Updated January 28, 2022)

Please note that the following information applies to Anthem's Commercial health plans. Please review the Medicare specific site noted below for details about Medicare plans.

Commercial: Provider News Home
Medicare: COVID-19 Bulletins for Medicare Advantage Providers

COVID-19 update: Anthem updates guidance on prior authorization requirements and other policy adjustments in response to unprecedented demands on health care providers

Anthem recognizes the intense demands facing doctors, hospitals and health care providers in the face of the COVID-19 crisis. Unless otherwise required under State and Federal mandates, Anthem health plans is making adjustments to assist providers in caring for members. These adjustments apply to members of all lines of business except as noted below, including self-insured plan members and in-network and out-of-network providers, where permissible.

Medicare adjustments and suspensions may have different timeframes or changes where required by federal law. Where permissible, these guidelines apply to Federal Employee Plan (FEP) members. For the most up-to-date information about the changes FEP is making, go to https://www.fepblue.org/coronavirus.

Inpatient and respiratory care

- Prior authorization requirements are suspended for patient transfers from acute inpatient hospitals to skilled nursing, acute rehabilitation and long term acute care hospital facilities effective January 5, 2022 through February 7, 2022. These adjustments apply for our fully-insured and self-funded employer, individual and Medicare ® Important COVID-19 update: Prior authorization and other policy adjustments (updated January 7, 2022) Page 2 of 5 plan members receiving care from in-network providers. While prior authorization is not required, we require notification of the admission via the usual channels and clinical records on day two of admission to aid in our members' care coordination and management. Anthem reserves the right to audit patient transfers.

Anthem – COVID-19 Updates

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- **Prior authorization requirements were suspended for patient transfers from acute IP hospitals to skilled nursing facilities effective December 7, 2021, through January 4, 2022**. These adjustments applied for our fully-insured and self-funded employer, individual and Medicare plan members receiving care from in-network providers. While prior authorization was not required, we required notification of the admission via the usual channels and clinical records on day two of admission to aid in our members' care coordination and management. Anthem reserves the right to audit patient transfers.

- **Prior authorization requirements were suspended for patient transfers from acute IP hospitals to skilled nursing facilities effective September 17, 2021, through October 31, 2021**.These adjustments applied for our fully-insured and self-funded employer, individual and Medicare plan members receiving care from in-network providers. While prior authorization was not required, we required notification of the admission via the usual channels and clinical records on day two of admission to aid in our members' care coordination and management. Anthem reserves the right to audit patient transfers.

- **Prior authorization requirements were suspended for patient transfers from acute IP hospitals to skilled nursing facilities effective November 23, 2020, through January 31, 2021**.These adjustments applied for our fully-insured and self-funded employer, individual and Medicare plan members receiving care from in-network providers. While prior authorization was not required, we required notification of the admission via the usual channels and clinical records on day two of admission to aid in our members' care coordination and management. Anthem reserves the right to audit patient transfers.

- **Prior authorization requirements were suspended for patient transfers from acute IP hospitals to skilled nursing facilities effective November 23, 2020, through January 31, 2021**.These adjustments applied for our fully-insured and self-funded employer, individual, Medicare and Medicaid plan members receiving care from in-network providers. While prior authorization was not required, we required notification of the admission via the usual channels and clinical records on day two of admission to aid in our members' care coordination and management. Anthem reserves the right to audit patient transfers.

- **Prior authorization requirements were suspended for patient transfers through May 30, 2020.** Prior authorization was waived for patient transfers from acute IP hospitals to skilled nursing facilities, rehabilitation hospitals, long-term acute care hospitals, and Behavioral Health residential/intensive outpatient/partial hospitalization programs, and to home health including ground transport in support of those transfers. Although prior authorization was not required, Anthem requested voluntary notification via the usual channels to aid in our members' care coordination and management.

Anthem – COVID-19 Updates

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- **Extended the length of time a prior authorization issued on or before May 30, 2020**, was in effect for elective inpatient and outpatient procedures to 180 days. This helped prevent the need for additional outreach to Anthem to adjust the date of service covered by the authorization.
- **Concurrent review for discharge planning** will continue unless required to change by federal or state directive.
- **Prior authorization requirements are suspended for COVD-19 Durable Medical Equipment** including oxygen supplies, respiratory devices, continuous positive airway pressure (CPAP) devices, non-invasive ventilators, and multi-function ventilators for patients who need these devices for COVID-19 treatment, along with the requirement for authorization to exceed quantity limits on gloves and masks.
- **Respiratory services** for acute treatment of COVID-19 will be covered. Prior authorization requirements are suspended where previously required.

COVID-19 testing

Laboratory tests for COVID-19 at both in-network and out-of-network laboratories will be covered with no cost sharing for members.

Claims audits, retrospective review, peer to peer review and policy changes

Anthem will adjust the way we handle and monitor claims to ease administrative demands on providers:

- **Hospital claims audits** requiring additional clinical documentation were limited through June 24, 2020, though Anthem reserves the right to conduct retrospective reviews on these findings with expanded lookback recovery periods for all lines of business except Medicare. To assist providers, Anthem can offer electronic submission of clinical documents through the provider portal.
- **Retrospective utilization management review** was suspended through June 24, 2020, and Anthem reserves the right to conduct retrospective utilization management review of these claims when this period ends and adjust claims as required.
- **Suspended peer-to-peer reviews** through June 24, 2020, except where required pre-denial per operational workflow or where required by State during this time period for all lines of business except Medicare.
- **Our Special Investigation programs** targeting provider fraud will continue, as well as other program integrity functions that help ensure payment accuracy.

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Otherwise, Anthem will continue to administer claims adjudication and payment in line with our benefit plans and state and federal regulations, including claims denials where applicable. Our timely filing requirements remain in place, but Anthem is aware of limitations and heightened demands that may hinder prompt claims submission.

Provider credentialing

Through June 24, 2020, Anthem processed provider credentialing within the standard 15-18 days even if we were unable to verify provider application data due to disruptions to licensing boards and other agencies. We will verify this information when available.

If Anthem finds that a practitioner fails to meet our minimum criteria because of sanctions, disciplinary action etc., we will follow the normal process of sending these applications to committee review, which will add to the expected 15–18-day average timeline. We are monitoring and will comply with state and federal directives regarding provider credentialing.

Please note that the above information applies to Anthem's Commercial health plans. Please review the Medicare specific site noted below for future administrative or policy adjustments we may make in response to the COVID-19 changes pandemic.

Anthem

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Important COVID-19 update: prior authorization and other policy adjustments (updated January 24, 2022)

Please note: This notice applies to Medicare Advantage in Connecticut, Colorado, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio, Virginia, and Wisconsin.

Anthem Blue Cross and Blue Shield (Anthem) recognizes the intense demands facing doctors, hospitals and all healthcare providers in the face of the COVID-19 pandemic. Today, unless otherwise required under state and federal mandates as detailed below, Anthem is making adjustments to assist providers in caring for members. These adjustments apply to members of all lines of business except as noted below, including self-insured plan members and in-network and out-of-network providers, where permissible. We encourage our self-funded customers to participate, although these plans may have an opportunity to opt out.

Medicare adjustments and suspensions may have different time frames or changes where required by federal law.

Where permissible, these guidelines apply to Federal Employee Plan (FEP) members. For the most up-to-date information about the changes FEP is making, go to https://www.fepblue.org/coronavirus.

Inpatient and respiratory care

- Updated January 24, 2022: Prior authorization requirements are suspended for patient transfers from acute inpatient (IP) hospitals to skilled nursing and acute rehabilitation facilities effective according to the following dates by state:

State	Dates
Connecticut	December 30, 2021, through January 31, 2022
Virginia	January 10, 2022, through January 31, 2022

Prior authorization requirements are suspended for patient transfers from acute IP hospitals to skilled nursing, acute rehabilitation and long-term acute care hospital facilities effective according to the following dates by state:

State	Dates
Kentucky	January 5, 2022, through January 31, 2022
Missouri	January 5, 2022, through January 31, 2022
Ohio	January 5, 2022, through January 31, 2022
Wisconsin	January 5, 2022, through January 31, 2022

Anthem – COVID-19 Updates

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Prior authorization requirements are suspended for patient transfers from acute inpatient hospitals to skilled nursing facilities according to the following dates by state:

State	Dates
Colorado	September 10, 2021, through September 24, 2021
Indiana	September 7, 2021, through October 31, 2021
Kentucky	December 13, 2021 through January 4, 2022
Maine	December 17, 2021, through January 31, 2022
Missouri	August 23, 2021, through September 6, 2021
Nevada	January 10, 2022, through January 31, 2022
New Hampshire	December 9, 2021, through January 31, 2022
Ohio	December 7, 2021, through January 4, 2022
Wisconsin	December 17, 2021, through January 4, 2022

These adjustments apply for our Medicare plan members receiving care from in-network providers. While prior authorization is not required, we continue to require notification of the admission via the usual channels and clinical records on day two of admission to aid in our members' care coordination and management. Anthem reserves the right to audit patient transfers.

- Concurrent review for discharge planning will continue unless required to change by federal or state directive.
- Prior authorization requirements are suspended for COVD-19 DME including oxygen supplies, respiratory devices, continuous positive airway pressure (CPAP) devices noninvasive ventilators, and multi-function ventilators for patients who need these devices for any medical reason as determined by a provider, along with the requirement for authorization to exceed quantity limits on gloves and masks.
- Respiratory services for acute treatment of COVID-19 will be covered. Prior authorization requirements are suspended where previously required.

COVID-19 testing
Laboratory tests for COVID-19 at both in-network and out-of-network laboratories will be covered with no cost sharing for members.

Anthem – COVID-19 Updates

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Claims audits, retrospective review, peer-to-peer review and policy changes
Anthem will adjust the way we handle and monitor claims to ease administrative demands on providers:

- Hospital claims audits requiring additional clinical documentation will be limited through June 24, 2020, though Anthem reserves the right to conduct retrospective reviews on these findings with expanded lookback recovery periods for all lines of business except Medicare. To assist providers, Anthem can offer electronic submission of clinical documents through the provider portal.
- Retrospective utilization management review will also be suspended through June 24, 2020, and Anthem reserves the right to conduct retrospective utilization management review of these claims when this period ends and adjust claims as required.
- Suspend peer-to-peer reviews through June 24, 2020, except where required predenial per operational workflow or where required by the state during this time period for all lines of business except Medicare.
- Our Special Investigation programs targeting provider fraud will continue, as well as other program integrity functions that help ensure payment accuracy
- New payment and utilization management policies and policy updates will be minimized, unless helpful in the management of the COVID-19 pandemic.

Otherwise, Anthem will continue to administer claims adjudication and payment in line with our benefit plans and state and federal regulations, including claims denials where applicable. Our timely filing requirements remain in place, but Anthem is aware of limitations and heightened demands that may hinder prompt claims submission.

Provider credentialing
Through June 24, 2020, Anthem processed provider credentialing within the standard 15 to 18 days even if we were unable to verify provider application data due to disruptions to licensing boards and other agencies. We verified this information when available.

If Anthem finds that a practitioner fails to meet our minimum criteria because of sanctions, disciplinary action etc., we will follow the normal process of sending these applications to committee review, which will add to the expected 15 to 18 day average timeline. We are monitoring and will comply with state and federal directives regarding provider credentialing

BlueCross BlueShield of Texas

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BCBSTX Making It Easier to Transfer Members to Post-Acute Care

This accommodation ended October 31, 2021. We will continue to evaluate and update, if needed.

Blue Cross and Blue Shield of Texas (BCBSTX) is making it easier to transfer our members from acute-care facilities to in-network, medically necessary alternative post-acute facilities **through Oct. 31, 2021.**
We will no longer require a post-acute care facility to obtain prior authorization to transfer our members from an inpatient hospital to an in-network medically appropriate, post-acute site of care such as long-term acute care hospitals, skilled nursing facilities, rehabilitation facilities and in-patient hospice. The receiving facility must call and inform us of the transfer **within two business days**. This will help promote availability of acute care capacity for COVID-19 patients during this Public Health Emergency. It also allows our members to continue to access medically necessary care. **Coverage is based on the members' benefits.**

If the transfer is for a **behavioral health** facility, it **will** require prior authorization.

Which members will benefit?
This applies to the following members:
•Fully-insured
•Self-funded group
•Medicaid
•Medicare Advantage

How to Transfer a Member
You can move members who are medically stable for transfer to the safest, most appropriate in-network place of care. You do not need our approval for transfer to any **Texas in-network, post-acute care facility** that is:
•In-network consistent with the member's plan (e.g. a PPO member could be transferred to an in-network PPO facility)
•Medically appropriate for the member and medically necessary
•Available and accepting transferred members

BlueCross BlueShield of Texas

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The receiving facility should notify us within two business days. Once our member is transferred, our standard utilization management processes will apply as described in more detail below.

Standard Utilization Management Process
After the post-acute care facility notifies us, our utilization management care manager will **not** review the admission for medical necessity. They **will** work with the post-acute care facility to:
•Approve the admission without records for the first two days
•Manage the ongoing stay for concurrent review
•Work with the facility for discharge planning

Post-acute care facilities must notify us of the admission, but they do not have to send records or wait for authorization before admitting our members.

How long is this process in effect?
The utilization management process modification will be in effect through Oct. 31, 2021. We will then determine if it needs to be extended to best serve our members.

Important Reminders
•State and federal laws and regulatory requirements will supersede these guidelines.
•We maintain the right to retrospectively review health care services submitted for claims payment for accuracy and appropriateness.
•This change to member prior authorization requirements is subject to in-network facility access.
Because this is a rapidly evolving situation, you should continue to use the Centers for Disease Control Guidance (CDC) on COVID-19, as the CDC has the most up-to-date information and recommendations. Additionally, watch for updates on BCBSTX News and Updates and our COVID-19 Preparedness pages.

Have questions?
If you have any questions or if you need additional information, please contact your BCBSTX Network Management Representative.

Bright HealthCare™

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Bright Health Utilization Management Program

Submitting Authorizations for Skilled Nursing Care and Home Health Services

Bright Health Authorization Guidelines – Skilled Nursing Care and Home Health Services

	Individual and Family (IFP)	Medicare Advantage (MA)
Skilled Nursing Services (SNF)	Contracted (in-network) providers are required to submit an authorization request for SNF admissions. Automatic approval will occur for days 1 through 7. Medical necessity must be met by day 8 of SNF admission for payment of services.	Contracted (in-network) providers are required to submit an authorization request for SNF admissions. Automatic approval will occur for days 1 through 7. Medical necessity must be met by day 8 of SNF admission for payment of services.
Home Health Services	Contracted (in-network) providers are required to submit an authorization request for Home Health Services. Automatic approval will occur for first 6 visits, including initial assessment. Medical necessity must be met by seventh home health visit.	Contracted (in-network) providers are required to submit an authorization request for Home Health Services. Automatic approval will occur for days 1 through 7. Medical necessity must be met by day 8 for.

Note: ALL non-contracted (out-of-network) SNF and Home Health Service providers need to submit an authorization prior to admission and/or initiation of service.

Definitions

Skilled Nursing Facilities (SNF) provide individualized, skilled nursing care, and related services for patients recovering from illness or injury. Services may include rehabilitation services (e.g., physical therapy, occupational therapy, speech therapy.)

Home Health Services are provided in the home to improve or maintain a member's functioning. Home care therapies include physical, occupational, speech-language pathology and respiratory care, etc.

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Coronavirus Waiver For Medicare Products Extended

Update: PA waiver for SNF, LTACH and Inpatient Rehab admission reviews continue through January 31, 2022 for our Medicare products.

Buckeye Health Plan will continue our Waiver for Medicare products through admissions on December 31, 2021. The Waiver will end for the Medicare lines of business effective January 1, 2022.

The Waiver will continue for our Medicaid and Ambetter products until we receive official notification of rescinding the Waiver from ODM.

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CarePlus HEALTH PLANS

An important message regarding CarePlus' COVID-19 response:
ADMINISTRATIVE UPDATE September 22, 2021

As we continue to monitor the status of COVID-19 cases and review procedure data, CarePlus is implementing changes to authorization requirements in our service area.

CarePlus is reinstating authorization requirements for skilled nursing facilities (SNFs) and long-term acute care (LTAC) for CarePlus members discharging from hospitals in all CarePlus counties with a date of service on or after Oct. 1, 2021.

a) This return to our standard authorization policy applies to participating/in-network providers.
b) You will need to submit supporting documentation for your authorization and can expect responses to be provided in normal processing timeframes; please plan accordingly.

We are here to support you as you care for your CarePlus-covered patients, particularly during this difficult time. CarePlus leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your designated Provider Services Executive or call our Provider Operations inquiry line at 1-866-220-5448, Monday through Friday from 8:00 a.m. to 5 p.m.

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COVID-19: Temporary Change to Prior Authorization for Transition to PostAcute Care

Effective Date: August 27, 2021

Summary
CareSource is committed to assisting providers and members during the pandemic. To further partner with the provider community and help mitigate obstacles to care, CareSource is modifying the prior authorization process to allow movement of members from the acute to the post-acute environments in order to reduce barriers and increase timeliness of member admissions and discharge.

Impact
Effective Aug. 27, 2021, prior authorization requirements for long term acute care facilities (LTACH), skilled nursing facilities (SNF) and inpatient rehabilitation facilities (IRF/hospitals) have been lifted. CareSource will still need notifications from providers related to the start of care, admissions and discharge planning in order to ensure tracking referrals to case management as well as claims processing. Prior authorization waivers for admission to LTACHs, SNFs and IRFs will be in place until further direction from the Ohio Department of Medicaid (ODM) (refer to memo below).

Importance
During the COVID-19 pandemic, CareSource continues to partner with the provider community as changes occur to reduce unnecessary burden and improve member transition across the continuum of care. As a result, CareSource is temporarily relaxing the prior authorization requirement for members seeking admission to the post-acute environment.

Questions?
If you have questions regarding this notice, please contact Provider Services at 1-800-488-0134 (Monday through Friday, 8 a.m. to 6 p.m. Eastern Standard Time).

Cigna

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COVID-19 Update – Ohio Cleveland Clinic Care Management ECF Precerts

January 5, 2022

Effective December 29, 2021 through March 31, 2022, Cigna will waive the authorization requirement for direct emergent or urgent transfers from an acute inpatient facility to a second acute inpatient facility, skilled nursing facility (SNF), acute rehabilitation facility (AR), or long-term acute care hospital (LTACH) for the expressed purpose of freeing up emergently needed bed space.

This authorization waiver applies to all patients with Cigna commercial and Cigna Medicare Advantage plans.

Additional important notes

The receiving facility (e.g., second acute facility, SNF, AR, or LTACH) is responsible for notifying Cigna of admissions the next business day.

Concurrent review will start the next business day with no retrospective denials.

Coverage reviews for appropriate levels of care and medical necessity still apply to SNF, AR, and LTACH admissions.

For patients already hospitalized, neither Cigna Commercial nor Cigna Medicare Advantage require three days of inpatient care prior to transfer to a SNF. Direct admission to a SNF can occur at any time.

If a hospital does not have an urgent or emergent need to free up bed space, transfers will require precertification.

For routine and non-emergent transfers, precertification is required to ensure coverage.

Q: Does the transferring facility still need to notify Cigna in advance before they begin to transfer patients without authorization?

A: No. While Cigna greatly appreciates any notification by the transferring facility that a patient was or will be emergently transferred before an authorization can be arranged, Cigna will not require that the transferring facility provide any formal notice or documentation attesting as to why they are referring without authorization.

Cigna simply asks that the post-acute care facility attest to the reason for the urgent transfer without authorization when they notify Cigna the next business day of the admission. No other official documentation is required at the time of transfer.

Cigna – COVID-19 Updates

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Q: Will Cigna extend the window for prior authorization approvals?

A: Yes. Considering the pressure facilities are under, Cigna will extend the authorization approval window from three months to six months on request.

Q: Does Cigna remain staffed to review precertification requests and process and pay claims in a timely manner?

A: Yes. Cigna remains fully staffed, and is committed to ensuring that precertification requests are reviewed in a timely manner and that there is no interruption of claims processing or claims payments.

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Devoted HEALTH PLANS

COVID-19 State of Emergency guidance

Referrals and Prior Authorizations

Referrals:

Referrals are not required due to state of emergency guidance, but are encouraged to support coordination of care.

Prior authorizations:

Services, procedures, and items that normally require authorization will still need an authorization. For emergency inpatient admissions related to the treatment of COVID-19, we require only notification. CT scans of the chest do not require a prior authorization per existing policies.
As our knowledge of COVID-19 evolves and treatment patterns become more clear, we will continue to monitor our prior authorization list to ensure timely access to care for members.

Florida Blue

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COVID-19 Update as of November 1, 2021

As we move forward during the COVID-19 pandemic, we support the work of providers, and the guidelines set forth by the Florida Department of Health and the Centers for Disease Control and Prevention (CDC). As information changes, we continue to make process updates for our Florida Blue Commercial, Affordable Care Act (ACA), Medicare Advantage, Federal Employee Program® (FEP) and Truli for Health lines of business.

During the COVID-19 pandemic, the processes noted below remain in effect until further notice. We will keep you informed as information changes. **For easy reference, new updates are noted in "red" throughout the communication.**

The Federal Public Health Emergency has been extended through Jan. 16, 2022.

The temporary prior authorization waivers put in place to help hospitals with bed capacity during the COVID-19 surge this summer and early fall will end Dec.31, 2021, with normal processes resuming Jan. 1, 2022. This includes waivers for:

- **Patients being transferred from inpatient acute hospital settings to post-acute care skilled nursing facilities**
- **Supplemental oxygen for patients being discharged with a COVID-19 diagnosis**

COVID-19 Provider Billing Guidelines

To help you, we have created billing guidelines in response to COVID-19. To ensure proper, timely reimbursement, please submit claims using these guidelines. All claims billed by a provider must effectively meet the accepted standard of care for the condition being treated.
Note: Please check these guidelines often as they will be updated as needed. These remain in effect until further notice. Click here and scroll down to **COVID-19 Provider Billing Guidelines.**

COVID-19 Provider Information Web Page

Click here to find coronavirus information for providers on floridablue.com including current and past communications, billing guidelines, frequently asked questions, forms, support resources, additional resources and more.

Florida Blue

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Service/Benefit	Description	Dates
Authorization/ Prior Approvals	**Post-Acute Care** To help hospitals accelerate appropriate discharges and support bed capacity, Florida Blue is waiving prior authorization requirements for patients being transferred from inpatient acute hospital settings to post-acute care skilled nursing facilities. (This is for in-network skilled nursing facilities and does not include long-term acute care facilities or inpatient rehabilitation.) • The first five days of post-acute facility admission to a skilled nursing facility will be automatically approved. Skilled nursing facilities are still required to notify Florida Blue of a patient being transferred from an inpatient acute hospital setting to their facility by the end of the following business day. This timely notification and review are still required to determine medical necessity of continued stay and ensure Florida Blue can assist with discharge planning for its members. • Normal business processes for notification apply: • Notifications can be entered and verified electronically through Availity® 1 at availity.com. • Fax any available clinical records including history and physical, labs, current medications, prior level of function, therapy notes and discharge plans to 305-716- 2731. Supplemental Oxygen We are also waiving the prior authorization requirements for supplemental oxygen for patients being discharged with a COVID-19 diagnosis. This change only waives the authorization requirements for the first 30 days of supplemental oxygen. You are required to submit a reauthorization request following the standard process for additional oxygen the patient may need.	12/31/21

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Dear Health Care Providers,

We here at Friday Health Plans (FHP) want to ensure you that we are doing everything in our power to assist you during this time. It is our priority to ensure that both our members who experience the effects of COVID-19 and require testing or medical care, as well as the providers who provide that care, are taken care of.

We feel it is important to let you know what changes to our normal operations we have put into effect during this time of COVID-19:

COVID-19 Claims and Pre-Auths
Effective March 1, 2020 through the duration of the public health emergency, FHP will pay COVID-19 related claims for testing and treatments without any question. If a member is transferred to an out-of-network provider/facility due to COVID-19, FHP will pay the claims at an in-network rate based on the rates of in-network facilities in the area. All COVID-19 related transfers to out-of-network locations will not require prior authorization, however notification via phone is imperative to ensure the prompt payment of services. Please Note: All other non-COVID-19 related transfers to out-of-network facilities still must follow the prior authorization process or claims will be denied.

Inpatient Notification Calls Required
Inpatient notification calls are still required at the time of admission for ALL patients. As an Insurer, FHP is required to report the number of COVID-19 members and claims to our regulatory bodies, so it is imperative that this notification process stays in place.

Authorization Date Ranges
Authorizations are being approved with extended date ranges due to possible cancellations or postponements of procedures. If you are in need of making changes to an existing authorization, please email the changes to medical@fridayhealthplans.com.

Approved Pre-Auths
As a provider, FHP would like to assure you that any authorization that is already approved will not change and you do not need to resubmit. Please notify us of a new date once you have that information.

Pre-Auths for Diagnostics Services
FHP will waive the need for Prior-Authorizations for the diagnostic services related to COVID-19 testing, any transfers for both COVID-19 and non-COVID-19 members as well as for post-acute care settings.

friday health plans

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Authorization Form Requirements
If a provider's authorization staff does not have access to the authorization form we are currently accepting any form of communications and should include the following:
- Member name, date of birth and ID number
- Ordering providers tax ID number and phone number
- Place of service where the services are being renderer's tax ID number and phone number
- ICD-10 diagnosis code(s)
- CPT Code(s)
- Is procedure inpatient or outpatient or in office
- Appropriate clinical documentation

One-Time Early Refills
FHP, to the extent consistent with clinical guidelines, will cover an additional one-time early refill of any necessary prescriptions to ensure individuals have access to their necessary medications should they need to limit close contact with others. FHP will not apply a different cost-sharing amount to an early refill of a prescription due to concerns about COVID-19. However, this does not apply to drugs with a high likelihood of abuse such as opioids.

Telehealth Appointments
Providers who have not been set up to bill telehealth visits in the past can now provide services via telehealth without any prior approvals. Telehealth visits can be billed at the same rate as in-person visits. Telehealth visits include emergency department visits, initial nursing, facility, discharge visits, home visits, and therapy services.

When billing for these nontraditional telehealth services during dates of service from March 1, 2020 through the duration of the public health emergency, providers will bill with the place of service equal to what it would have been in the absence of the public health emergency along with the modifier 95 indicating services were rendered via telehealth. Normal practices will resume at the end of the public health emergency.

We also have zero cost to our Teledoc partner for our members to call in and speak to a healthcare professional. Members should use or create a Teledoc account here:
https://member.teladoc.com/fridayhealthplans

In-Home Medical Treatment Equipment
For patients who, as determined by a medical provider, can be monitored and treated at home outside of a health care facility setting, carriers are reminded that they must provide coverage for necessary medical equipment and medications for in-home treatment. This may include the following durable medical equipment and medications as deemed medically necessary by the treating provider:

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- Pulse oximeter
- Oxygen
- Any medications determined to be medically appropriate for the treatment of COVID-19
- Home infusion therapy
- Electrocardiographs and cardiac monitors

FHP will eliminate any prior authorization requirements and otherwise expedite requests for these home health services.

For our members, all cost-sharing will be waved which includes co-payments, deductibles, and cost sharing for those members needing testing or treatment for COVID-19 from March 1, 2020, through the duration of the public health emergency.

We appreciate all of the work that is being done on the front lines of this pandemic and we want to make sure that we are doing all we can here at Friday Health Plans to make things easier for you.

Thank you for your continued work in treating, not only FHP members but all the members in our communities.

Sincerely,
Friday Health Plans

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Gateway Health℠

COVID-19 Medicare Authorization Update
July 2021

Impacts to Prior Authorizations:

Medicare-Centers for Medicare & Medicaid Services (CMS):

"Prior Authorization. Moreover, consistent with flexibilities available to Medicare Advantage Organizations absent a disaster, declaration of a state of emergency, or public health emergency, Medicare Advantage Organizations may choose to waive or relax plan prior authorization requirements at any time in order to facilitate access to services with less burden on beneficiaries, plans, and providers. Any such relaxation or waiver must be uniformly provided to similarly situated enrollees who are affected by the disaster or emergency. We encourage plans to consider utilizing this flexibility."

As part of Gateway Health's response to the COVID-19 pandemic, clinical reviews (via Navihealth) for post-acute authorizations (SNFs IRFs and LTACs) for its Medicare members were relaxed to alleviate provider burden and ensure access to post-acute care for our members. This was implemented during the height of the pandemic when there were significant barriers to post-acute placement due to uncertainty around testing protocols as well as the lack of vaccine availability. With the availability of the vaccine and as more information has become available around treatment, isolation precautions, etc., barriers that existed earlier in the pandemic are no longer present.

Therefore:

Effective August 15, 2021 Gateway Health will reinstate clinical reviews for post-acute services through the prior authorization process. Clinical reviews will ensure that members are in the most appropriate and least restrictive level of care.

If you have any questions regarding this update, please contact Gateway Health's Provider Services team

- Medicare Assured 1-800-685-5209

Gateway Health℠

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COVID-19 Medicaid Authorization Update
June 2021

Impacts to Prior Authorizations:

Medicaid – Pennsylvania Department of Human Services (PA DHS)
The Pennsylvania Department of Human Services has issued the following guidance regarding suspension of authorizations:

- Effective July 30, 2021 – PA Medicaid beneficiaries will be required to obtain an authorization for outpatient CT scans of the chest. Impacted procedure codes include: 71250, 71260 and 71270.
- Effective July 30, 2021, PA DHS has suspended Provider Quick Tip 241. Prior authorization requirements for all diagnosis that were altered during the COVID-19 emergency disaster declaration will be reinstated for participating and non-participating providers. Gateway Heath will reinstate prior authorization requirements on 7/30/2021 as follows:
- As of 7/30/2021, prior authorization requirements will be reinstated for the following types of care:
    - Inpatient Hospital Admissions
    - Inpatient Rehabilitation Admissions, include ongoing care
    - New Authorization Requests for Initial and Continuing Home Health Visits
    - New Authorization Requests for Initial and Continuing Hospice Services
    - Medical Supplies and Durable Medical Equipment, including codes A7000, A7001, E0470 and E0471
    - Skilled Nursing Facility Stays for any dates as of 7/30/2021
- As of 7/30/2021, timeframes for retrospective reviews will be followed for all services that require authorization.
- If you have any questions regarding this update, please contact Gateway's Provider Services Team.
    - Inpatient Hospital Admission Requests should be made no later than four (4) business days of the admission
    - Outpatient Service Requests should be made no later than one (1) business day of the care being provided
- Medicaid 1-800-392-1147
- Medicare Assured 1-800-685-5209

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Alabama)

October 6, 2021

As we continue to monitor the status of COVID-19 cases and review procedure data, Humana is implementing changes to authorization requirements in Alabama.

Humana is reinstating authorization requirements for the Medicare Advantage and commercial fully insured lines of business for skilled nursing facilities (SNFs) and long-term acute care (LTAC) with a date of service on or after Oct. 12, 2021.

a) This return to our standard authorization policy applies to participating/in-network providers.
b) You will need to submit supporting documentation for your authorization and can expect responses to be provided in normal processing timeframes; please plan accordingly.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Arizona)

January 19, 2022

Given the recent rise of COVID-19 infection rates in Arizona, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, **Humana is suspending authorization requirements for skilled nursing facilities (SNFs)and long-term acute care (LTAC) for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Arizona through Feb. 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning.**

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important Details:

- Authorization suspension, as outlined herein, will continue through February 6, 2022.
- This suspension applies to participating/in-network providers only.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Arkansas)

January 26, 2022

Given the recent rise of COVID-19 infection rates in Arkansas, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, Humana is **suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Arkansas through Feb 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning.**

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important details:

- Authorization suspension, as outlined herein, will continue through Feb 6, 2022.
- This suspension applies to participating/in-network providers only.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Colorado)

January 19, 2022

We know you have been working tirelessly to battle COVID-19, and hope to see an end to the pandemic soon. Given the recent rise in infection rates, we must continue to remain vigilant and take necessary precautions for the safety of our community. We are here to help support our providers and will continue to monitor the situation in Colorado and determine how we can help.

In response, Humana is **suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage members discharging from hospitals in the state of Colorado through Feb 6, 2022.**

Humana is also suspending authorization requirements for skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term acute care (LTAC) and home health for commercial fully insured members discharging from hospitals in the state of Colorado through at least Feb 6, 2022.

NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning.

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. The suspension affecting Medicare Advantage members applies to participating/in-network providers only. The suspensions affecting commercial fully insured members apply to both in- and out-of-network providers.

Important details:

- Authorization suspension for Medicare Advantage members, as outlined herein, will continue through Feb 6, 2022.
- Authorization suspension for commercial fully insured members, as outlined herein, will continue until such time as Emergency Regulation 21-E-15 is no longer effective, which is currently through at Feb 6, 2022.
    - Emergency Regulation 21-E-15 became effective Nov. 5, 2021
- The suspension affecting Medicare Advantage members applies to participating/in-network providers only. The suspensions affecting commercial fully insured members apply to both in- and out-of-network providers.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

Humana

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An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Delaware)

January 26, 2022

As we continue to monitor the status of COVID-19 cases and review procedure data, Humana is implementing changes to authorization requirements in the state of Delaware.

Humana is reinstating authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Delaware for dates of service on or after Jan. 31, 2022.

a. This return to our standard authorization policy applies to participating/in-network providers.

b. You will need to submit supporting documentation for your authorization and can expect responses to be provided in normal processing timeframes; please plan accordingly.

We are here to support you as you care for your Humana-covered patients. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Florida)

September 22, 2021

As we continue to monitor the status of COVID-19 cases and review procedure data, Humana is implementing changes to authorization requirements in Florida.

Humana is reinstating authorization requirements for skilled nursing facilities (SNFs) and long-term acute care (LTAC) for Medicare Advantage, Medicaid and commercial members discharging from hospitals in the state of Florida with a date of service on or after Oct. 1, 2021. Medicaid will continue to follow state mandates as published by the Agency for Health Care Administration (AHCA).

a. This return to our standard authorization policy applies to participating/in-network providers.
b. b. You will need to submit supporting documentation for your authorization and can expect responses to be provided in normal processing timeframes; please plan accordingly.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Georgia)

October 1, 2021

As we continue to monitor the status of COVID-19 cases and review procedure data, Humana is implementing changes to authorization requirements in Georgia.

Humana is reinstating authorization requirements for skilled nursing facilities (SNFs) for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Georgia with a date of service on or after Oct. 1, 2021. Also, for commercial fully insured members, Humana is reinstating authorization requirements for inpatient rehabilitation facilities (IRFs), long-term acute care (LTAC), home health as well as participating acute inpatient hospitalizations and scheduled surgeries (performed in Georgia hospitals).

a) This return to our standard authorization policy applies to participating/in-network and nonparticipating/out-of-network providers.
b) You will need to submit supporting documentation for your authorization and can expect responses to be provided in normal processing timeframes; please plan accordingly.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Idaho)

December 1, 2021

We know you have been working tirelessly to battle COVID-19, and hope to see an end to the pandemic soon. Given the recent rise in infection rates, we must continue to remain vigilant and take necessary precautions for the safety of our community. We are here to help support our providers and will continue to monitor the situation in Idaho and determine how we can help.

In response, Humana is suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in Kootenai County in the state of Idaho through Dec. 12, 2021.

Humana is reinstating authorization requirements for skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs) and long-term acute care (LTAC) for Medicare Advantage and commercial fully insured members discharging from hospitals in all counties—except SNFs in Kootenai County—in the state of Idaho for dates of service on or after Dec. 6, 2021.

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important details:

- Authorization suspension, as outlined herein, will continue through Dec. 12, 2021
    - This suspension applies to participating/in-network providers only.
    - Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
    - No other services requiring prior authorization are included in this suspension.
- The reinstated authorization requirement as outlined herein will be for dates of service on or after Dec. 6, 2021.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Indiana)

January 26, 2022

Given the recent rise of COVID-19 infection rates in Indiana, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, Humana is **suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Indiana through Feb. 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning.**

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important details:

- Authorization suspension, as outlined herein, will continue through Feb. 6, 2022.
- This suspension applies to participating/in-network providers only.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Iowa)

January 26, 2022

Given the recent rise of COVID-19 infection rates in Iowa, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, **Humana is suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Iowa through Feb. 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning.**

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important Details:

- Authorization suspension, as outlined herein, will continue through Feb. 6, 2022
- This suspension applies to participating/in-network providers only.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Kansas)

January 26, 2022

Given the recent rise of COVID-19 infection rates in Indiana, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, Humana **is suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Kansas through Feb. 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning.**

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important details:

- Authorization suspension, as outlined herein, will continue through Feb 6, 2022.
    - This suspension applies to participating/in-network providers only.
    - Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Kentucky)

January 26, 2022

Given the recent rise of COVID-19 infection rates in Kentucky, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, **Humana is suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Kentucky through Feb. 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning. Medicaid will continue to follow state mandates as published by the Kentucky Cabinet for Health and Family Services.**

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important Details:

- Authorization suspension, as outlined herein, will continue through Feb 6, 2022.
- This suspension applies to participating/in-network providers only.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Louisiana)

October 6, 2021

As we continue to monitor the status of COVID-19 cases and review procedure data, Humana is implementing changes to authorization requirements in Louisiana.

Humana is **reinstating authorization requirements for the Medicare Advantage and commercial fully insured lines of business for skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term acute care (LTAC) and home health with a date of service on or after Oct. 18, 2021.**

a. This return to our standard authorization policy applies to participating/in-network and nonparticipating/out-of-network providers.
b. You will need to submit supporting documentation for your authorization and can expect responses to be provided in normal processing timeframes; please plan accordingly.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Maryland)

January 26, 2022

As we continue to monitor the status of COVID-19 cases and review procedure data, Humana is implementing changes to authorization requirements in the state of Maryland.

Humana is reinstating authorization requirements for skilled nursing facilities (SNFs) for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Maryland for dates of service on or after Jan. 31, 2022.

a. This return to our standard authorization policy applies to participating/in-network providers.

b. You will need to submit supporting documentation for your authorization and can expect responses to be provided in normal processing timeframes; please plan accordingly.

We are here to support you as you care for your Humana-covered patients. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Michigan)

January 26, 2022

Given the recent rise of COVID-19 infection rates in Michigan, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, **Humana is suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Michigan through Feb 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning.**

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important Details

- Authorization suspension, as outlined herein, will continue through Feb. 6, 2022.
- This suspension applies to participating/in-network providers only.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Minnesota)

January 12, 2022

As we continue to monitor the status of COVID-19 cases and review procedure data, Humana is implementing changes to authorization requirements in the state of Minnesota.

Humana is reinstating authorization requirements for skilled nursing facilities (SNFs) for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Minnesota for dates of service on or after Jan. 17, 2022.

a. This return to our standard authorization policy applies to participating/in-network providers.
b. You will need to submit supporting documentation for your authorization and can expect responses to be provided in normal processing timeframes; please plan accordingly.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Mississippi)

October 6, 2021

As we continue to monitor the status of COVID-19 cases and review procedure data, Humana is implementing changes to authorization requirements in Mississippi.

Humana **is reinstating authorization requirements for the Medicare Advantage and commercial fully insured lines of business for skilled nursing facilities (SNFs) and long-term acute care (LTAC) with a date of service on or after Oct. 18, 2021.**

a. This return to our standard authorization policy applies to participating/in-network providers.
b. You will need to submit supporting documentation for your authorization and can expect responses to be provided in normal processing timeframes; please plan accordingly. We are here to support you as you care for your Humana-covered patients, particularly during this difficult time.

Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Missouri)

January 26, 2022

Given the recent rise of COVID-19 infection rates in Missouri, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, Humana is **suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Missouri through Feb 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning.**

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important Details:

- Authorization suspension, as outlined herein, will continue through Feb. 6, 2022.
- This suspension applies to participating/in-network providers only.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Montana)

December 8, 2021

As we continue to monitor the status of COVID-19 cases and review procedure data, Humana is implementing changes to authorization requirements in the state of Montana.

Humana is reinstating authorization requirements for skilled nursing facilities (SNFs) for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Montana for dates of service on or after Dec. 13, 2021.

a. This return to our standard authorization policy applies to participating/in-network providers.
b. You will need to submit supporting documentation for your authorization and can expect responses to be provided in normal processing timeframes; please plan accordingly.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Nebraska)

January 19, 2022

Given the recent rise of COVID-19 infection rates in Nebraska, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, **Humana is suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Nebraska through Feb. 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning.**

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important Details:

- Authorization suspension, as outlined herein, will continue through Feb. 6, 2022.
- This suspension applies to participating/in-network providers only.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (New Mexico)

January 19, 2022

Given the recent rise of COVID-19 infection rates in New Mexico, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, **suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of New Mexico through Feb. 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning.**

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important details:
• Authorization suspension, as outlined herein, will continue through Feb. 6, 2021.
• This suspension applies to participating/in-network providers only.
• Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
• No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (New York)

December 23, 2021

Thank you for your continued participation with Humana and the exceptional service you provide to our Dental Members. We recently received notification from the State of New York regarding the compliance of N.Y. Insurance Law §§ 2601, 3217-a, 3221, 4305, and 4324; N.Y. Public Health Law § 4408; 11 NYCRR 52 (Insurance Regulation 62), and the state of New York has stated:

"The Department of Financial Services has been made aware that participating providers, particularly under dental insurance policies or contracts, are charging insureds fees at the time of in-person visits for Personal Protective Equipment (PPE) or other charges related to increased costs due to COVID-19 that are in addition to the insureds' cost-sharing for such covered services. A provider who participates with an issuer's provider network has agreed to accept a reimbursement amount from the issuer for covered services, with the insured responsible for the cost-sharing set forth in the insured's health or dental insurance policy or contract. A participating provider should not charge the insured fees or other charges in addition to the insured's financial responsibility for covered services. In addition, the Department does not approve policy or contract provisions that hold the insured responsible for the cost of a participating provider's PPE." 2

To assist you with additional operational costs due to COVID, Humana was providing additional compensation per patient claim from June through August. Per the New York Department of Financial Services communication, any payment that you have received from the insured should be reimbursed per your contract, and this Circular Letter prohibits adding these fees going forward. Please contact us at 800-833-2233, Monday through Friday, 8:00 a.m. until 6:00 p.m. for any questions you may have.

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An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (North Carolina)

January 26, 2022

Given the recent rise of COVID-19 infection rates in North Carolina, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, **Humana is suspending authorization requirements for skilled nursing facilities (SNFs) for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of North Carolina through Feb. 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning.**

Humana is also suspending authorization requirements for inpatient rehabilitation facilities (IRFs), long -term acute care (LTAC) and home health for Medicare Advantage and commercial fully insured members for facilities in Beaufort, Bertie, Chowan, Dare, Duplin, Edgecombe, Halifax, Hertford, Martin, Northampton and Pitt counties in the state of North Carolina through Feb. 6, 2022.

Humana is reinstating authorization requirements for acute inpatient hospitalizations and scheduled surgeries (performed at in-network/participating hospitals) for Medicare Advantage and commercial fully insured members for facilities in Beaufort, Bertie, Chowan, Dare, Duplin, Edgecombe, Halifax, Hertford, Martin, Northampton and Pitt counties in the state of North Carolina for dates of service on or after Jan. 26, 2022.

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important details:

- Authorization suspension, as outlined herein, will continue through Jan. 30, 2022
- This suspension applies to participating/in-network providers only.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Ohio)

January 26, 2022

Given the recent rise of COVID-19 infection rates in Ohio, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, Humana is **suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Ohio through Feb. 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning.**

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important details:

- Authorization suspension, as outlined herein, will continue through Feb. 6, 2022.
- This suspension applies to participating/in-network providers only.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves

If you have any questions about these new procedures, please contact your Humana representative

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Oklahoma)

January 26 2022

Given the recent rise of COVID-19 infection rates in Oklahoma, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, **Humana is suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Oklahoma through Feb 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning.**

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important Details:

- Authorization suspension, as outlined herein, will continue through Feb. 6, 2022.
- This suspension applies to participating/in-network providers only.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Oregon)

October 6, 2021

We know you have been working tirelessly to battle COVID-19, and hope to see an end to the pandemic soon. Given the recent rise in infection rates, we must continue to remain vigilant and take necessary precautions for the safety of our community. We are here to help support our providers and will continue to monitor the situation in Oregon and determine how we can help.

In response, Humana is suspending authorization requirements for skilled nursing facilities (SNFs) for Medicare Advantage and fully insured commercial members discharging from hospitals in the state of Oregon through Oct. 24, 2021.

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important details:

- Authorization suspension, as outlined herein, will continue through Oct. 24, 2021.
- This suspension applies to participating/in-network providers only.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (South Carolina)

September 29, 2021

As we continue to monitor the status of COVID-19 cases and review procedure data, Humana is implementing changes to authorization requirements in South Carolina.

Humana is reinstating authorization requirements for the Medicare Advantage, commercial fully insured and Medicaid lines of business for skilled nursing facilities (SNFs) with a date of service on or after Oct. 1, 2021.

a) This return to our standard authorization policy applies to participating/in-network providers

b) You will need to submit supporting documentation for your authorization and can expect responses to be provided in normal processing timeframes; please plan accordingly.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Tennessee)

October 6, 2021

As we continue to monitor the status of COVID-19 cases and review procedure data, Humana is implementing changes to authorization requirements in Tennessee.

Humana is reinstating authorization requirements for the Medicare Advantage and commercial fully insured lines of business for skilled nursing facilities (SNFs) and long-term acute care (LTAC) with a date of service on or after Oct. 12, 2021.

a. This return to our standard authorization policy applies to participating/in-network providers.
b. You will need to submit supporting documentation for your authorization and can expect responses to be provided in normal processing timeframes; please plan accordingly.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Texas)

January 19, 2022

Given the recent rise of COVID-19 infection rates in Texas, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, **Humana is suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Texas through Feb. 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning.**

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important Details:

- Authorization suspension, as outlined herein, will continue through Feb. 6, 2022.
- This suspension applies to participating/in-network providers only.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Utah)

January 5, 2022

As we continue to monitor the status of COVID-19 cases and review procedure data, Humana is implementing changes to authorization requirements in the state of Utah.

Humana is reinstating authorization requirements for skilled nursing facilities (SNFs) for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Utah for dates of service on or after Jan. 10, 2022.

a. This return to our standard authorization policy applies to participating/in-network providers**.**

b. You will need to submit supporting documentation for your authorization and can expect responses to be provided in normal processing timeframes; please plan accordingly.

We are here to support you as you care for your Humana-covered patients. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Virginia)

January 26, 2022

Given the recent rise of COVID-19 infection rates in Virginia, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, **Humana is suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Virginia through Feb. 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning.**

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important Details:

- Authorization suspension, as outlined herein, will continue through Feb. 6, 2022.
- This suspension applies to participating/in-network providers only.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Washington)

January 19, 2022

Given the recent rise of COVID-19 infection rates in Washington, we must continue to remain vigilant and take necessary precautions for the safety of our community.

In response, **Humana is suspending authorization requirements for skilled nursing facilities (SNFs)for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of Washington through Feb. 6, 2022. NaviHealth will continue to work with SNF facility-based teams on concurrent review for length of stay and appropriate level of care, including discharge planning**.

Please provide notification of admission within 24 hours to allow us to track our members' progress and provide assistance with discharge planning. You will receive an approval when you submit the notification. This suspension applies to participating/in-network providers only.

Important Details:

- Authorization suspension, as outlined herein, will continue through Jan. 30, 2022.
- This suspension applies to participating/in-network providers only.
- Please provide notification of admission within 24 hours to allow us to track our members' progress. You will receive an approval when you submit the notification.
- No other services requiring prior authorization are included in this suspension.

We are here to support you as you care for your Humana-covered patients. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (West Virginia)

November 17, 2021

As we continue to monitor the status of COVID-19 cases and review procedure data, Humana is implementing changes to authorization requirements in the state of West Virginia.

Humana is reinstating authorization requirements for skilled nursing facilities (SNFs) for Medicare Advantage and commercial fully insured members discharging from hospitals in the state of West Virginia for dates of service on or after Nov. 22, 2021.

a. This return to our standard authorization policy applies to participating/in-network providers.
b. You will need to submit supporting documentation for your authorization and can expect responses to be provided in normal processing timeframes; please plan accordingly.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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Humana

An important message regarding Humana's COVID-19 response:
ADMINISTRATIVE UPDATE (Wisconsin)

September 9, 2021

As we continue to monitor the status of COVID-19 cases and review procedure data, Humana is implementing changes to authorization requirements in Wisconsin.

Humana is reinstating authorization requirements for skilled nursing facilities (SNFs) for Medicare Advantage and commercial members discharging from hospitals in the state of Wisconsin with a date of service on or after Oct. 2, 2021.

a. This return to our standard authorization policy applies to participating/in-networkproviders.

b. You will need to submit supporting documentation for your authorization and can expect responses to be provided in normal processing timeframes; please plan accordingly.

We are here to support you as you care for your Humana-covered patients, particularly during this difficult time. Humana leaders will continue to monitor service volumes as well as the progression of the COVID-19 curve and recovery. We will update you on policies and processes that affect your practices and organizations as this crisis evolves.

If you have any questions about these new procedures, please contact your Humana representative.

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COVID-19 Frequently Asked Questions for Providers

Updated: Jan. 25, 2022 With the changes that have taken place for health insurance providers in response to the COVID-19 crisis, Medical Mutual has received many questions from providers regarding our policies and coverage. To assist you, we have prepared the following FAQ. These responses apply to all lines of business.

Updates to this FAQ will be made as more guidance from local and federal governments and other agencies is made available. New information is highlighted in yellow.

UTILIZATION MANAGEMENT PROCESSES
Medical Mutual's utilization management processes are evolving with state and federal regulatory guidance issued in response to the COVID-19 spread throughout Ohio and the nation. The answers to the questions below are accurate as of the date of this document and our current understanding of hospital bed capacity constraints. We are reaching out to our hospital partners requesting up-to-date information on bed capacity in their regions, so that our policies and processes can yield in parallel with surges in hospitalizations and any related capacity concerns. Information on capacity at your facilities can be sent via email to hospitalcapacity@medmutual.com. Please note the contact list included in this FAQ should a patient situation arise that requires immediate attention.

CASE MANAGEMENT REFERRALS Medical Mutual's Case Management team is here to assist our members that may be struggling with isolation and the inability to meet basic needs. We encourage you to use the email addresses below to refer such members to our Case Management team.
Medicare Advantage Members: CaseMgmt-MedAdv@medmutual.com
Commercial Members: CaseMgmt-Triage@medmutual.com
Inpatient Hospital Stays
Q1. Is prior authorization required for acute-care hospital admissions through the emergency room?
A. No. Prior authorization is not required for patients admitted through the emergency room.
Q2. Is Medical Mutual suspending admission and concurrent medical necessity review for acute inpatient stays?
A. No. However, utilization management processes will evolve as hospitals experience surges in acute care admissions and capacity constraints.
Q3. Will Medical Mutual agree to pay for inpatient admissions if the admission notification is delayed or not performed?
A. While Medical Mutual does not require prior authorization for emergency inpatient admissions, our policy does require notification of hospital admission within 24 hours. However, we are modifying our policy during the current state of emergency in Ohio to allow notification at any time while the patient is hospitalized. Admission and discharge date notification is critical to ensuring accurate and prompt payment for the inpatient stay

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In addition, it is critical Medical Mutual receives notification as early as possible so we can support transitions to alternate care levels, including assisting hospitals in finding beds and/or arranging other post-discharge needs as benefits and coverage vary from health plan to health plan. This effort will help prevent patients from experiencing avoidable out-of-pocket expenses for noncovered benefits unrelated to COVID-19 coverage.

Q4. Will Medical Mutual approve and reimburse a sub-acute/SNF-level of care provided in a hospital acute care setting if there is no sub-acute/SNF capacity and the patient is unable to be discharged from the hospital inpatient setting? An example of this is if a patient requires ventilator care and a ventilator or ventilator care is not available in a sub-acute setting.

A. Yes, when there is a documented need. Please note that Medical Mutual's staff is available to assist in locating beds, so your valuable resources can be utilized to provide patient care.

Q5. Will Medical Mutual suspend current appeal and peer-to-peer request timeframes?

A. No. However, our utilization management processes will evolve as hospitals experience surges in acute care admissions and capacity constraints.

Transition to Alternate Levels of Care

Q6. Will prior authorizations continue to be required for elective hospital admissions and postacute care, including long-term acute care (LTAC), inpatient rehabilitation (IRF) and skilled nursing facility (SNF) admissions?

A. Effective immediately, please be advised that Medical Mutual is temporarily suspending and/or modifying our utilization management processes in response to the recent surge in Covid admissions. We hope that these changes will assist our hospital partners in managing acute inpatient bed capacity. These changes apply to our commercial and Medicare Advantage lines of business and will be in effect through Feb. 28, 2022.

- Authorization Suspension
  - o Suspension of LTAC prior authorization for patients transferring from an acute inpatient critical care unit
  - o Suspension of Acute Rehab prior authorizations o Suspension of SNF prior authorizations remains in place
  - o The following conditions of this authorization suspension apply:
    - ▪ LTACs, Acute Rehabs and SNFs are responsible for notifying Medical Mutual of admissions by the next business day, including admitting clinical information.
    - ▪ Discharge planning staff must notify Medical Mutual of patients discharging to a LTAC, Acute Rehab and SNF.
    - ▪ All patients must meet the requisite admission level of care criteria.
    - ▪ Patients must be admitted to a Medical Mutual contracted provider.
    - ▪ Complete clinical information must be provided to the LTAC, Acute Rehab and SNF to facilitate continuity and coordination of care.

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Changes to Acute Care Inpatient Utilization Management Processes for Ohio Contracted Providers

- All medical and behavioral health acute care hospitals admissions (excluding psychiatric and substance abuse residential level of care) may suspend submitting additional clinical information following the initial admission notification and medical necessity review
- The following conditions of this authorization suspension apply:
  - All acute care hospitals will continue to notify Medical Mutual of hospital notifications per normal procedures
  - Medical Mutual will review the admission per normal procedures including requesting additional information if not provided on the initial admission review
  - All acute care hospitals will continue to collaborate on discharge planning
  - All acute care hospitals will continue to notify Medical Mutual of patient discharge date

Medical Mutual will continue to monitor healthcare delivery system constraints and will update this policy as appropriate. Please contact your provider representative if you have any questions. You may also continue to communicate information regarding your capacity constraints at hospitalcapacity@medmutual.com.

Q7. CMS has removed the three-day waiver for transfers to nursing facilities. Is there a waiver for commercial pre-certification?

A. The three-day waiver applied only to traditional Medicare fee for service. Medical Mutual has never required a three-day acute length of stay for any line of business.

Ambulatory Services

Q8. Many elective procedures and surgeries that have been approved with prior authorizations in place are being postponed because of COVID-19. In these cases, will Medical Mutual honor the current prior authorizations when procedures are rescheduled, or will additional approvals be needed?

A. Medical Mutual will honor any prior authorizations for currently approved, elective admissions or procedures through Dec. 31, 2020 without additional provider administrative burden. Effective May 12, 2021, high-tech imaging approvals through EviCore are changing back to the prior 45 day timeframe from the date of authorization. This had been extended to 180 days due to the COVID-19 pandemic. Given the numerous businesses being interrupted because of COVID-19, providers should check to make sure their patients remain covered by Medical Mutual at the time the surgery is rescheduled.

Q9. The administration of many medical drugs that have been approved with prior authorizations in place are being postponed because of COVID-19. Will Medical Mutual honor the current prior authorizations when infusions are rescheduled, or will additional approvals be needed?

A. We have already extended prior authorization without additional provider administrative burden for many of the medical drugs that require approval. For prior approvals issued by Magellan Rx, providers may view the updated authorization period on the Magellan Rx Provider Portal under View Authorizations. To check the authorization period for prior approvals issued by Medical Mutual prior to Jan. 1, 2020, please contact Magellan Rx at 1-800-424-7698.

Given the numerous businesses being interrupted because of COVID-19, providers should check to make sure their patients remain covered by Medical Mutual at the time the infusion is rescheduled.

MEDICAL MUTUAL®

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Q10. Will Medical Mutual suspend referral restrictions?

A. Medical Mutual does not require specialty referral authorization. Q11. Will Medical Mutual suspend current appeal and peer-to-peer request timeframes? A. No. However, our utilization management processes will evolve as hospitals experience surges in acute care admissions and capacity constraints.

PAYMENT AND COVERAGE

Q12. How is treatment for COVID-19 being covered?

A. For our fully insured plans, Medical Mutual has extended the period during which cost sharing for all treatment related to COVID-19 will be waived to now go through Dec. 31, 2020. Treatment includes hospitalizations and ground ambulance transfers for individuals with a positive COVID-19 diagnosis. In addition, Medical Mutual will permanently cover FDA-approved medications and vaccines when they become available. This is effective retroactively to the beginning of the COVID-19 national public health emergency declared by the US Department of Health and Human Services that started on Jan. 27, 2020.

For plans subject to the jurisdiction of the Ohio Department of Insurance (ODI), the bulletin released on March 20, 2020, states that testing and treatment for COVID-19 are included in the definition of an emergency medical condition. For these plans, Medical Mutual will follow member cost sharing for services related to the treatment of COVID-19 received from an out-of-network provider the same as if the member received treatment from an in-network provider.

If a member is covered by a self-funded or labor plan, he/she should check with their employer to confirm coverage.

At this time, there are no FDA-approved prescription treatments for COVID-19. If members are prescribed medications on an outpatient basis following a COVID-19 diagnosis, those medications would be covered at the member benefit cost share level. Medications to treat COVID-19 on an inpatient basis would be covered at 100% with no member cost share, through Dec. 31, 2020.

Q13. Are prescriptions for COVID-19 treatment covered?

A. Any medication(s) prescribed in the hospital to treat COVID-19 would be covered per a group's COVID-19 treatment coverage. At this time there are no FDA-approved outpatient prescription treatments for COVID-19. If members are prescribed medications on an outpatient basis following a COVID-19 diagnosis, those medications would be covered at the member benefit cost share level. We will continue to monitor and adjust coverage if/when FDA-approved COVID-19 treatments become available.

Q14. Are emergency room copays waived for COVID-19 treatment (treat and release)?

A. Yes. Emergency room copays are being waived following the guidelines within, and to ensure compliance with, the Families First Coronavirus Response Act (H.R. 6201).

MEDICAL MUTUAL®

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Q15. Are copays being waived for COVID-19 testing?

A. Yes. Copays are being waived for all Medical Mutual fully insured and self-funded customers. This also covers the cost of the provider visit, which could include a telehealth (telemedicine) visit, urgent care, or emergency room visit, to determine whether the COVID-19 testing is required and to administer the test.

Q16. If a facility fee is charged for a visit that results in an order for, or administration of, a COVID19 diagnostic test, will Medical Mutual cover the facility fee without cost-sharing?

A. Yes. Per section 6001(a)(2) of the Families First Coronavirus Response Act, the facility fee will be covered without imposing any cost-sharing requirements, prior authorization or other medical management requirements as long as it relates to the furnishing or administration of a COVID-19 test, or the evaluation to determine an individual's need for testing.

Q17. What coding does Medical Mutual need to see on claims to designate a service as being related to COVID-19 and excluded from cost sharing, specifically, in cases where a patient's visit was related to COVID-19 testing, but the patient ended up not being COVID-19 positive?

A. Medical Mutual is following coding guidelines provided by CMS. For more information from CMS, please review these guidelines.

Q18. Will Medical Mutual cover the serological (antibodies) test for COVID-19 with no member cost sharing?

A. Yes. Per the guidance from the Department of Labor, HHS and the IRS, Medical Mutual will cover FDA-approved serological (antibodies) tests for COVID-19 with no member cost sharing. The associated codes are 86328 and 86769.

Q19. How will Medical Mutual communicate that your system is prepared to accept claims for COVID-19 testing?

A. Our systems are able to accept and process claims for COVID-19 testing.

Q20. What are the requirements in order for providers to receive the CMS mandated 20% increase in claim payment when a Medicare Advantage member tests positive for COVID-19?

A. According to CMS, effective Sept. 1, 2020, Medicare Advantage members must have a positive COVID-19 test within 14 days of hospital admission in order for you to receive the mandated 20% increase in claim payment. Please submit COVID-19 test results with clinical information to ensure prompt payment. Medical Mutual will be issuing post pay audits to ensure this regulation is met.

Q21. Will your plans follow Medicare guidelines for essential health benefits around COVID-19 care and quarantine?

A. We are treating testing and treatment of COVID-19 as essential health benefits for all our plans. We are following other Medicare guidance for treatment of COVID-19, but some portions of the benefits are specific to traditional Medicare. Specifics are included in this FAQ.

Q22. If a member needs to have pre-op testing completed for a second time due to a procedure being delayed because of the COVID-19 crisis, will the second pre-op testing be covered by Medical Mutual?

A. Yes. If it has been more than one month since the initial pre-op testing was completed, then the second testing can be billed and will be covered by Medical Mutual per the member's benefit coverage.

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Q23. Providers will be open for surgeries and procedures starting May 1, 2020, as directed by Governor DeWine's Responsible RestartOhio program. Part of that next step will likely include screening/testing patients for COVID-19 before procedures are scheduled. Will Medical Mutual cover screening patients for COVID-19 as part of pre-admission testing?

A. Under the Families First Coronavirus Response Act, Medical Mutual must pay for COVID-19 testing from March 18, 2020, through the end of the national public health emergency declared by the U.S. Department of Health and Human Services. During this period, we will not require prior authorization for COVID-19 testing done as part of pre-admission testing. We will monitor guidance as to whether this is best practice post the national public health emergency and develop policies in accordance with clinical guidance.

Q24. Does Medical Mutual cover telehealth (telemedicine)?

A. For all insured members, visits between a Medical Mutual member and his/her provider via telehealth (telemedicine) are covered (use the Claims Edit System to verify billing codes), whether an on-demand or a scheduled visit, if the service would be covered when conducted in person. This includes initial visits with a provider. At this time, Medical Mutual is waiving the requirement that telehealth (telemedicine) visits have a visual encounter. Therefore, telephonic visits, in addition to web or app, will be covered. For members covered by self-funded plans, benefits may be different, and the patient should verify coverage.

Some Medical Mutual members covered by self-funded plans may have benefits for 24/7 on demand telehealth (telemedicine) services through national vendors or platforms offered through hospital systems. On-demand virtual visits are a subset of telehealth (telemedicine). These types of visits typically include 24/7 virtual access to licensed healthcare professionals with whom the patients do not have an established relationship. They are similar to visits to an urgent care facility and are typically needed due to an acute health issue.

- Visits are typically covered like primary care provider visits
- Visits are billed with these codes: 99421, 99422, 99423
- Behavioral health visits are not covered as on-demand virtual visits

On-demand telehealth (telemedicine) visits will be payable if they are used to determine the need for COVID testing. Patients covered by self-funded plans should check their benefits for coverage details.

Please note that any telemedicine visits not related to COVID-19 diagnosis are being covered at a member's benefit level. Cost sharing is applied according to benefits.

For all telehealth (telemedicine) visits, the patient must consent to this method of treatment. At this time, verbal consent is allowed and should be documented by the provider and retained permanently in the patient's record.

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Q25. How long will Medical Mutual allow the expanded telehealth (telemedicine) services and relaxed telehealth (telemedicine) requirements that are currently in place?

A. Medical Mutual is allowing the expanded telehealth services through Dec. 31, 2020, at which time we will begin to follow Ohio Revised Code Section 3902.30, effective Jan. 1, 2021.

Q26. Ohio Medicaid is expanding its coverage to include telephone calls, images transferred via fax and text messages. Will Medical Mutual consider expanding coverage of the services considered telehealth (telemedicine)?

A. At this time, Medical Mutual is waiving the requirement that telehealth (telemedicine) visits have a visual encounter. Therefore, telephonic visits with an audio-only connection will be covered.

Q27. Can a telehealth (telemedicine) visit be done through a phone call or through online portal communication with my health system?

A. At this time, Medical Mutual is waiving the requirement that telehealth (telemedicine) visits have a visual encounter. Therefore, telephonic visits with an audio-only connection will be covered.

Q28. Is Medical Mutual waiving the requirement that initial mental health visits be conducted in person before telehealth (telemedicine) visits are covered?

A. At this time, Medical Mutual is waiving the requirement that an initial behavioral health visit be done in person before visits can be conducted via telehealth (telemedicine). This applies only to scheduled visits and does not include on-demand telehealth (telemedicine) providers.

Q29. Is member cost sharing waived for behavioral health telehealth visits that are related to a COVID-19 diagnosis?

A. Behavioral health telehealth visits are covered at 100% with no member cost sharing if the member has been diagnosed with COVID-19. If members are experiencing conditions such as anxiety or depression as a result of the COVID-19 pandemic, but they do not have a COVID-19 diagnosis, then the telehealth visit would be covered at the member's benefit level and cost sharing would apply.

Q30. The telemedicine reimbursement policy has an effective date of April 2, 2020. Does that mean Medical Mutual isn't covering telehealth (telemedicine) until that date?

A. No. Medical Mutual has covered telehealth (telemedicine) prior to the COVID-19 crisis. Posting a reimbursement policy was the final step in documentation. We are revising the effective date to March 1, 2020.

Q31. Will Medical Mutual be implementing a special telehealth (telemedicine) policy during the COVID-19 pandemic?

A. At this time, the policies Medical Mutual put in place regarding telehealth (telemedicine) during the COVID-19 pandemic will remain in place. Details of those modifications are included in this FAQ.

Q32. Can a provider bill the surcharge they incur for using a telehealth (telemedicine) platform to the member or seek additional reimbursement from Medical Mutual for this charge?

A. No. Payment for the service would be considered payment in full. There is no additional reimbursement provided for the technology cost.

Q33. Can a provider bill a fee for a prescription refill via the phone?

A. No. Telephonic services alone are not a reimbursed service.

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Q34. Can occupational and physical therapy, as well as speech pathology, be billed as telehealth (telemedicine)?

A. At this time, Medical Mutual will allow occupational and physical therapy, as well as speech pathology, visits to be conducted via telehealth (telemedicine) when an audio and visual encounter are included. Telephonic-only visits will NOT be covered. Chiropractic services are NOT included. Services performed by home health agencies are NOT included. Please check the Claims Edit System to verify the billing codes to use. Therapy services performed through telehealth (telemedicine) are subject to the same plan benefits, limitations and authorization requirements as if the services were performed in person.

Q35. Can mental health and substance abuse services be provided through telehealth (telemedicine)?

A. Yes. Individual therapy can be conducted by a provider to their patients. At this time, Medical Mutual is waiving the requirement that an initial behavioral health visit be done in person before visits can be conducted via telehealth (telemedicine). Also at this time, Medical Mutual is waiving the requirement that telehealth (telemedicine) visits have a visual encounter. Therefore, telephonic visits with an audio-only connection will be covered.

Q36. Will Medical Mutual suspend the face-to-face requirement for Medicare annual wellness visits and home health referrals?

A. CMS is not waiving the face-to-face requirement at this time. Therefore, Medical Mutual is keeping the requirement in place. The annual wellness visit can be conducted through telehealth (telemedicine) as long as a visual component is included, thus satisfying the face-to-face requirement.

Q37. Will Medical Mutual cover applied behavioral analysis (ABA) therapy conducted via telehealth (telemedicine)?

A. Yes. At this time, Medical Mutual will cover the ABA services outlined in the Claims Edit System as approved services when conducted via telehealth (telemedicine). The service must include both a visual and an audio component. ABA services will still be covered within benefits limits, authorization limits and within state and federal regulatory requirements and licensure, including HIPAA compliance.

Q38. Will Medical Mutual cover pediatric preventive (well child care) visits conducted via telehealth (telemedicine)?

A. Considering clinical guidance from the American Academy of Pediatrics, Medical Mutual will NOT cover pediatric preventive care (well child care) visits conducted via telehealth (telemedicine) These visits center around services that necessitate a face-to-face interaction, such as administering vaccines, checking height and weight, and performing vision and hearing screenings.

Q39. Will Medical Mutual cover adult preventive care visits (annual check-ups) conducted via telehealth (telemedicine)?

A. Medical Mutual will NOT cover adult preventive care visits (annual check-ups) conducted via telehealth (telemedicine) These visits center around services that necessitate a face-to-face interaction. For Medicare Advantage members, an annual check-up is different than the annual wellness visit CMS allows to be conducted via telehealth (telemedicine).

Q40. Is Medical Mutual implementing the temporary suspension of sequestration withholdings from Medicare Advantage payments?

A. Yes. Effective May 1, 2020, in compliance with CMS guidance, Medical Mutual will no longer be withholding sequestration amounts.

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Q41. Is COVID-19 testing covered under workers' compensation for first responders?

A. At this time, the Ohio Bureau of Workers' Compensation (BWC) has not issued guidance pertaining to whether testing due to work-related exposure to COVID-19 would be covered. Until we receive clear guidance from the BWC, Medical Mutual plans to cover COVID-19 testing at 100%, even if exposure occurs within the workplace. This may change retroactively if further guidance is released from the BWC.

Q42. If Medical Mutual receives a claim for COVID-19 testing that has the "work-related" box checked, will your system reject it or would it process and pay?

A. In this example, the COVID-19 test would pay at 100% even if the work-related box is checked based on the lack of guidance from the BWC and to be compliant with federal law. Should something change in the future we will adjust our processing practices retroactively.

Q43. If a first responder contracts COVID-19 is the treatment covered by workers' compensation?

A. The Ohio Bureau of Workers' Compensation (BWC) has issued guidance stating that claims can be filed in cases where jobs pose a special hazard or risk which results in employees contracting COVID-19 directly from the work exposure. First responders such as EMS, police, firefighters and healthcare workers are some examples of jobs that would fall into this category. If the work-related box is check on a COVID-19 treatment claim, Medical Mutual will NOT automatically process and pay these at 100%, but will refer these to the BWC for review.

CREDENTIALING

Q44. Does Medical Mutual have any way to bypass the normal credentialing process and grant an access needs waiver when needed to serve patients expeditiously?

A. Yes. Medical Mutual will grant an access needs waiver in this situation and would only need basic information for claim submission.

COVID-19 Hospital Contact List

First Name	Last Name	Title	Email	Work Telephone	Cell Phone
Robin	Bender	Clinical Coordinator, Acute and Post-Acute	Robin.Bender@medmutual.com	419-473-7198	419-654-2466
Josie	Valente	Manager, Prior Authorization	Josephine.Valente@medmutual.com	216-736-2419	216-533-3030
Annette	Ruby	VP, Clinical Population Health	Annette.Ruby@medmutual.com	216-687-7503	330-620-7240
Linda	Patterson	Medical Director	Linda.Patterson@medmutual.com	440-878-4171	216-780-8474
Philip	Rice	Medical Director	Philip.Rice@medmutual.com	216-687-6524	814-931-5966

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Updated 12/2021

SNF Waiver Extension

Due to the ongoing COVID-19 pandemic, MediGold will be waving the authorization requirement for skilled nursing admissions. This will be effective 8/30/2021 through 3/31/2022.

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MOLINA HEALTHCARE

Molina Healthcare of Texas
Prior Authorization Extensions – COVID-19

August 27, 2021

To alleviate any burden on our providers, and to ensure our members have access to necessary services, Molina has proactively implemented a system change to automatically extend all Medicaid acute, therapy, DME and LTSS authorizations expiring in April through December 31, 2020.

Additionally, we have directed our staff to extend all Medicaid authorizations currently being processed to at least December 31, 2020, or longer as clinically appropriate. For Medicaid HCBS waiver services expiring at the end of April through the end of December, Molina has extended services for 90 days to comply with HHSC's current guidance.

If the current authorization extension process does not meet the needs of a Molina member you serve, please let us know. Some examples include that the authorization needs to be adjusted differently to properly meet the needs of the patient or not extended at all. We will work with you to help with this process.

After December 31st, if providers encounter unexpected difficulties with obtaining needed clinical information due to physician office closure or other COVID-related challenges, please communicate with us. We want to be sure our members receive medically necessary and appropriate services and will work with you to meet those needs.

All services/tasks currently authorized remain the same. All authorizations that are being extended will be updated in the Molina Provider Portal to reflect the new expiration date.

EVV Providers: updated authorization information must be entered into the electronic visit verification (EVV) systems for EV-relevant services.

For an updated authorization, please refer to our provider portal.

If you have questions regarding any current authorizations or the authorization process, please contact Molina at (833) 322-4080, Monday to Friday, 8 a.m. – 5 p.m.

MOLINA HEALTHCARE

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Molina Healthcare of Ohio
COVID-19 Prior Authorization Update:

Post-Acute Authorization Requirement
Information for Medicare network providers

Molina has updated the Prior Authorization (PA) waivers grid since the December Provider Bulletin, posted on the Provider Website, under the "Communications" tab, on the "Provider Bulletin" page. Please see the updated table below summarizing the underlined changes for the Medicare LOB reinstating the Skilled Nursing Facility (SNF) PA waiver effective Jan. 10, 2022.

		Medicaid and MyCare Ohio (Medicaid Primary Payer Services)	Medicare	Marketplace
Provider Type	Long-term acute care hospital (LTACH)	PA is waived (notification only)	PA is not waived	PA is not waived
	SNF	PA is waived (notification only)	Update: PA is waived effective 1/10/22	PA is waived (notification only)
	Inpatient Rehabilitation Facility (IRF)	PA is waived (notification only)	PA is not waived	PA is not waived
Notification	Fax Number	(866) 449-6843	(844) 834-2152	(833) 322-1061
Key Dates: Temporary Auth Waivers	Auth Waiver Start Date	8/27/21	Update: Reinstated 1/10/22	9/1/21
	Auth Waiver End Date	Until further notice	Update: Until further notice	Until further notice

Note: Other PA waivers for other LOB's are still in place.

Molina – COVID-19 Updates

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The face sheet should also include the date of admission.

Molina will continue to determine member level of care upon admission.

Updates will be provided by Molina as additional information is received, including an end date to this temporary policy.

		Medicaid and MyCare Ohio (Medicaid Primary Payer Services)	Medicare	Marketplace
Provider Type	LTACH	PA is waived (notification only)	PA is not waived	PA is not waived
	SNF	PA is waived (notification only)	PA is waived (notification only)	PA is waived (notification only)
	IRF	PA is waived (notification only)	PA is not waived	PA is not waived
Notification	Fax Number	(866) 449-6843	(844) 834-2152	(833) 322-1061
Key Dates: Temporary Authorization (Auth) Waivers	Auth Waiver Start Date	8/27/21	8/30/21	9/1/21
	Auth Waiver End Date	Until further notice	Until further notice	Until further notice

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COVID-19 State Guidelines
to health carriers regarding cost-sharing and/or out-of-network services
This document summarizes bulletins and emergency orders issued by states in response to the COVID-19 virus. Updates will be made as quickly as possible upon issuance or revision; however, this should not be referred to as a definitive source of all current information.

Alaska
Pertinent information effective until April 30, 2020 regarding cost-sharing and/or out-of-network services: Health insurers regulated by the state shall waive cost-sharing for laboratory diagnostic testing for respiratory syncytial virus (RSV), influenza, respiratory panel tests, and COVID-19. Health insurers are asked to waive the cost-sharing for an office visit, urgent care center visit, emergency room visit for testing. Bulletin: https://www.commerce.alaska.gov/web/Portals/11/Pub/INS_B20-04.pdf

California
Pertinent information regarding cost-sharing and/or out-of-network services: California Department of Insurance (CDI) directs all insurers providing commercial health insurance coverage to immediately reduce cost-sharing (including, but not limited to, co-pays, deductibles, or coinsurance) to zero for all medically necessary screening and testing for COVID-19, including hospital, emergency department, urgent care, and provider office visits where the purpose of the visit is to be screened and/or tested for COVID-19. Bulletin: http://www.insurance.ca.gov/0250-insurers/0300-insurers/0200-bulletins/bulletin-notices-commissopinion/upload/COVID-19-Screening-and-Testing.pdf

Colorado
Pertinent information regarding cost-sharing and/or out-of-network services: The Division is directing carriers to ensure that coverage is provided for COVID-19 testing without the requirement that consumers pay co-pays, deductibles or co-insurance. Carriers are directed to waive cost-sharing for an in-network provider office visit, an in-network urgent care center visit, and an emergency room visit when a covered person is seeking testing for COVID-19. Carriers are reminded that if an in-network provider is unable to conduct testing for COVID-19, carriers must cover such testing if performed by an out-of-network provider. Bulletin: https://drive.google.com/file/d/1_9Z6CVhzAxNNxUWBKeAfVHgfr3mXQB_T/view

Georgia
Pertinent information regarding cost-sharing and/or out-of-network services: The Department is asking health insurers who provide coverage to Georgia residents to take the following immediate measures: • Consider options to reduce potential barriers of cost-sharing for testing and treatment of COVID-19 during the outbreak • Wave any cost-sharing for COVID-19 laboratory tests • Waive cost-sharing for an in-network provider office visit and an in-network urgent care center visit when testing for COVID-19, as well as for an emergency room visit when testing for COVID-19 Full Directive: https://www.oci.ga.gov/ExternalResources/Announcements/Directive-392020-943.pdf

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Kentucky
Pertinent information regarding cost-sharing and/or out-of-network services: All insurers shall waive all cost-sharing including copayments, coinsurance, and deductibles for screening and testing for COVID-19 as specified by the Centers for Disease Control and Prevention (CDC), including hospital, emergency department, urgent care, provider office visits, lab testing, telehealth, and any immunizations that are made available. Executive Order: https://governor.ky.gov/attachments/20200309_Executive-Order_2020-220.pdf

Louisiana
Emergency Rule 36 (3/11/2020) §3105. Waiver A. All health insurance issuers shall waive all cost-sharing including copayments, coinsurance, and deductibles for screening and testing for COVID-19 as specified by the CDC, including hospital, emergency department, urgent care, provider office visits, lab testing, telehealth, telemedicine, and any immunizations that are made available. §3111. Notice to Contracted Providers of Waiver A. All health insurance issuers shall provide notice to contracted providers that they are waiving the costsharing and prior authorization requirements, or any restrictions, and ensure that information regarding the waivers is provided to customer service centers, nurse advice lines, and others so that proper information is provided to insured citizens. Information: https://ldi.la.gov/docs/default-source/documents/legaldocs/rules/rule36-cur-patientprotections

Maine
Pertinent information effective until April 30, 2020 regarding cost-sharing and/or out-of-network services: Governor Janet T. Mills directs all health insurance carriers to make medically necessary screening and testing for COVID-19 services available with no deductible, copayment, or other cost sharing of any kind, or any prior authorization requirement, including all associated costs such as processing fees and clinical evaluations. The only situation in which carriers will be permitted to impose out-of-network charges is when the enrollee was offered the service in-network without additional delay but chose instead to visit an out-of network provider or be tested by an out-of-network laboratory. If and when an immunization becomes available for COVID-19, carriers shall immediately cover the cost of the vaccine and all associated costs of administration without cost sharing, on the same basis as screening and testing services. Bulletin: https://www.maine.gov/tools/whatsnew/index.php?id=2220066&topic=INSBulletins&utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=&v=boitemplate2017

Maryland
Pertinent information regarding cost-sharing and/or out-of-network services: The Commissioner will promulgate emergency regulations to require health carriers to: • Waive any cost-sharing, including co-payments, coinsurance and deductibles, for any visit to diagnose or test for COVID-19 regardless of the setting of the testing (for example emergency rooms, urgent care centers, and a primary physician's office). • Waive any cost-sharing, including co-payments, coinsurance, and deductibles, for laboratory fees to diagnose or test for COVID-19. • Waive any cost-sharing, including co-payments, coinsurance and deductibles, for vaccination for COVID-19. • Make a claims payment for treatment for COVID-19 that the health carrier has denied as experimental. • Evaluate a request to use an out of network provider to perform diagnostic testing of COVID-19 solely on the bas is of whether the use of the out of network provider is medically necessary or appropriate. Bulletin: https://insurance.maryland.gov/Insurer/Documents/bulletins/Bulletin-20-05-Covid-19.pdf

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Massachusetts
Pertinent information regarding cost-sharing and/or out-of-network services: Division of Insurance expects Carriers to: • Forego any cost-sharing (co-payments, deductibles, or coinsurance) for medically necessary Coronavirus testing, counseling, vaccinations at in- network doctors' offices, urgent care centers, or emergency rooms; and at out of network doctors' offices, urgent care centers, or emergency rooms when access to urgent testing or treatment, in accordance with DPH and CDC requirements is unavailable from in-network providers. • Forego any copayments for medically necessary Coronavirus treatment, in accordance with DPH and CDC guidelines, at in-network doctors' offices, urgent care centers, or emergency rooms; and at out-of-network doctors' offices, urgent care centers, or emergency rooms when in-network alternatives are not available. • Relax prior approval requirements and procedures so that members can get timely medically necessary testing or treatment, in accordance with DPH and CDC guidelines, if they are at risk of contracting the Coronavirus. Bulletin: https://www.mass.gov/doc/bulletin-2020-02-addressing-covid-19-coronavirus-testing-andtreatment-issued-362020/download

Michigan
Pertinent information regarding cost-sharing and/or out-of-network services: A number of insurers, including Blue Cross Blue Shield of Michigan, Blue Care Network of Michigan, Priority Health, CVS Health, McLaren, and Meridian announced they will fully cover the cost of medically-necessary COVID-19 tests for members. Governor's Announcement: https://www.michigan.gov/whitmer/0,9309,7-387-90487-521179--,00.htm

Mississippi
Pertinent information regarding cost-sharing and/or out-of-network services: Consumers with fully-insured individual and group health plans will not be charged co-payments, co-insurance, or deductibles related to COVID-19 laboratory testing administered consistent with guidelines issued by the United States Centers for Disease Control and Prevention. Consumer Alert: https://www.mid.ms.gov/consumers/covid.aspx#chi

Nevada
Pertinent information effective March 5 to July 3, 2020 regarding cost-sharing and/or out-of-network services: Health Insurers: • Shall not impose out-of-pocket cost for provider office, urgent care center or emergency room visits if the purpose is to test for COVID-19 • Shall not impost an out-of-pocket cost for COVID-19 testing, • Shall cover the costs of a COVID-19 vaccine should one become available If an in-network provider would prolong testing, then an out-of-network provider must be covered by your plan at no out-of-pocket cost. State of Emergency: http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/News-Notes/2020-03- 05.DOI_Emergency_Regulations_re_COVID-19.pdf

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New Hampshire
Pertinent information regarding cost-sharing and/or out-of-network services: Health carriers must provide coverage, prior to application of any deductible and without cost-sharing, of the initial health care provider visit for FDA-authorized COVID-19 testing for insureds who meet the CDC criteria for testing, as determined by the insured's health care provider. This includes in-network provider office visits, urgent care visits, or emergency services to test for COVID-19. If in-network providers are unavailable to conduct testing for COVID-19, insurers must cover out-of-network testing. Any prior authorization requirements that typically apply to covered diagnostic tests are suspended with regard to testing for COVID19. Full Order: https://www.governor.nh.gov/news-media/press-2020/documents/health-care-coronovirusorder.pdf

New Mexico
Pertinent information regarding cost-sharing and/or out-of-network services: In response to Governor Michelle Lujan Grisham's March 11 declaration of a public health emergency, Superintendent of Insurance Russell Toal has issued an emergency rule prohibiting health insurers from imposing cost sharing, including copays, coinsurance and deductibles, for testing and health care services related to COVID-19. The rule also covers pneumonia, influenza, or any disease or condition that is the subject of a public health emergency. The first order requires insurers providing major medical coverage and insurers providing limited benefits coverage to notify their members whether and to what extent their policies cover testing and health care services related to COVID-19. Additionally, if an insurer only offers limited coverage, they must notify their members of available full coverage options. The second order requires limited benefit plans (such as workers compensation and automobile medical payment insurance) to provide notice to their members that their plans do not provide comprehensive medical coverage and to give members information on where they should go to check on their eligibility to apply for and obtain such coverage. Press Release: https://www.osi.state.nm.us/wp-content/uploads/2020/03/Governor-Press-Release.pdf

New Jersey
Pertinent information regarding cost-sharing and/or out-of-network services: Governor Phil Murphy announced administrative actions to waive consumer cost sharing for all medically necessary COVID-19 testing, as well as services related to testing. This waiver includes emergency room, urgent care, and office visits related to COVID-19 testing. Bulletin: https://www.state.nj.us/dobi/bulletins/blt20_03.pdf

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New York

Pertinent information regarding cost-sharing and/or out-of-network services: An insurer shall provide written notification to its in-network providers that they shall not collect any deductible, copayment, or coinsurance in accordance with this subdivision. The Superintendent of Financial Services ("Superintendent") is advising issuers that they should waive any costsharing for COVID-19 laboratory tests so that cost-sharing does not serve as a barrier to access to this important testing. In addition, issuers should waive the cost-sharing, including through telehealth, for an in-network provider office visit and an in-network urgent care center visit any other in-network outpatient provider setting able to diagnose the novel coronavirus (COVID-19), or an emergency department of a hospital when testing for diagnosis and testing of COVID-19. The Superintendent will promulgate an emergency regulation to ensure that issuers do not impose cost-sharing for COVID-19 testing consistent with this circular letter. In addition, if in-network providers are unable to conduct testing for COVID-19, issuers are reminded that they must cover testing out-of-network. Circulars:
https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2020_03
https://www.dfs.ny.gov/system/files/documents/2020/11/re62_57_amendment_text.pdf

Fifty-Seventh Amendment to 11 NYCRR 52 (1/7/2021) An insurer shall provide written notification to its in-network providers that they shall not collect any deductible, copayment, or coinsurance in accordance with this subdivision. The Superintendent of Financial Services ("Superintendent") is advising issuers that they should waive any cost-sharing for COVID-19 laboratory tests so that cost-sharing does not serve as a barrier to access to this important testing. In addition, issuers should waive the cost-sharing for an in-network provider office visit and an in-network urgent care center visit when testing for COVID-19. Issuers should also waive the costsharing for an emergency room visit when testing for COVID-19. The Superintendent will promulgate an emergency regulation to ensure that issuers do not impose cost-sharing for COVID-19 testing consistent with this circular letter. In addition, if in-network laboratory tests to diagnose the novel coronavirus shall not be subject to cost-sharing. Information:
https://www.dfs.ny.gov/system/files/documents/2021/01/re62_a57_text.pdf

Fifty-Eighth Amendment to 11 NYCRR 52 (1/7/2021) No policy or contract delivered or issued for delivery in this State that provides comprehensive coverage for hospital, surgical, or medical care shall impose, and no insured shall be required to pay, copayments, coinsurance, or annual deductibles for an in-network service delivered via telehealth when such service would have been covered under the policy if it had been delivered in person. Insurers shall provide written notification to its in-network providers that they shall not collect any deductible, copayment, or coinsurance in accordance with this subdivision. Information: https://www.dfs.ny.gov/system/files/documents/2021/01/re62_a58_text.pdf

Sixtieth Amendment to 11 NYCRR 52 (5/2/2020) On May 2, the Department of Financial Services in New York promulgated a similar regulation which requires insurers to provide written notification to in-network providers that they shall not collect any deductible, copayment, coinsurance, or annual deductibles for outpatient mental health services rendered to Essential Workers in person or by telehealth. This extensive definition of Essential Worker is included in the regulation and circular. Information: https://www.dfs.ny.gov/system/files/documents/2020/11/reg62_amend60_text.pdf

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New York DFS Circular 14 The New York Department of Financial Services issued the following guidance: Issuers should immediately notify participating providers that they should not charge insureds fees that are beyond the insureds' financial responsibility for covered services, such as fees for PPE, and issuers should instruct participating providers to refund any such fees to insureds. Information: https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2020_14

Oregon

Pertinent information regarding cost-sharing and/or out-of-network services: The state has reached an agreement with several health insurance companies to waive co-payments, co-insurance, and deductibles for their customers who need COVID-19 testing. The agreement means consumers with fully-insured individual and group health plans will not be charged co-payments, co-insurance, or deductibles related to COVID-19 for the following: • COVID-19 laboratory testing administered consistent with guidelines issued by the United States Centers for Disease Control and Prevention. • An in-network provider office visit or a visit to an in-network urgent care center to be tested for COVID-19. • An emergency room visit to be tested for COVID-19. • Immunization for COVID-19, once it becomes available. Information: https://dfr.oregon.gov/insure/health/understand/Pages/coronavirus.aspx

Pennsylvania

Pertinent information regarding cost-sharing and/or out-of-network services: All major health insurers providing comprehensive medical coverage in the commonwealth will cover medically appropriate COVID-19 diagnostic testing and associated treatment for consumers and have committed to waive any cost-sharing for the testing. Pennsylvania's major health insurers, all of whom have committed to take this critical step, are Highmark, UPMC Health Plan, Geisinger, Independence BlueCross, Capital Blue Cross, Aetna, Cigna, UnitedHealthcare, Pennsylvania Health & Wellness, and Oscar. Waiver Announcement: https://www.governor.pa.gov/newsroom/gov-wolf-states-major-health-insurers-arecovering-covid-19-testing-resources-available-related-to-covid-19-and-insurance-coverage/

South Dakota

Pertinent information regarding cost-sharing and/or out-of-network services: In conjunction with H.R. 6201, the Families First Coronavirus ResponseAct, all health carriers must cover COVID-19 testing and the associated office visit, urgent care,or emergency room charge at no cost to insureds. Bulletin: https://dlr.sd.gov/insurance/bulletins/bulletin_20_02_covid_19_health_benefit_plans.pdf

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Vermont

Pertinent information regarding cost-sharing and/or out-of-network services: Because knowledge of whether an individual is infected with COVID-19 is critical to limiting their exposure to others – and thus the spread of the disease – the Department is directing insurers to cover any medically necessary COVID-19 testing performed by the Centers for Disease Control (CDC), the Vermont Department of Health (VDH), or a laboratory approved by CDC or VDH, with no co-payment, coinsurance or deductible requirements for members. This includes in-network provider office or urgent care visits and emergency services visits to test for COVID-19. If in-network providers are unavailable to conduct testing for COVID-10, insurers must cover out-of-network testing on the terms outlined above, consistent with Department Regulation 2009-03. Bulletin: https://dfr.vermont.gov/sites/finreg/files/regbul/dfr-insurance-bulletin-209-covid19-testing.pdf

Washington

Pertinent information regarding cost-sharing and/or out-of-network services: Insurance Commissioner of the state of Washington orders all health carriers as follows: • Cover, prior to application of any deductible and with no cost-sharing, the health care provider visit and FDAauthorized coronavirus disease 2019 (COVID-19) testing for enrollees who meet the CDC criteria for testing, as determined by the enrollee's health care provider. • Allow enrollees to obtain a one-time refill of their covered prescription medications prior to the expiration of the waiting period between refills so that enrollees can maintain an adequate supply of necessary medication. Carriers may take into consideration patient safety risks associated with early refills for certain drug classes, such as opioids, benzodiazepines and stimulants. • Suspend any prior authorization requirements that apply to covered diagnostic testing and treatment of coronavirus disease 2019 (COVID-19). • Ensure compliance with WAC 284-170-200(5), which requires that if a carrier has an insufficient number or type of providers in their network to provide testing and treatment of coronavirus disease 2019 (COVID-19), the carrier must ensure that the enrollee obtains the covered service from a provider or facility within reasonable proximity of the enrollee at no greater cost than if the provider were in-network. Emergency Order: https://www.insurance.wa.gov/sites/default/files/documents/emergency-order-number-20- 01.pdf For additional information, please visit the CDC's website: https://www.cdc.gov/coronavirus/2019-ncov/about/prevention-treatment.html

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oscar

Oscar prior authorization requirements

We review our current policies related to prior authorization on a regular basis and will share any updates as they are made. At this time, our standard prior authorization policies are in place.

We review our current policies related to prior authorization on a regular basis and will share any updates as they are made. At this time, our standard prior authorization policies are in place.

- Oscar will waive prior authorization on all COVID-19 tests, and on items and services furnished to an individual during health care provider office visits, urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product, but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product.

- Effective 8/17/21, Oscar is waiving prior authorization requirements for inpatient transfers in CA to comply with state mandated requirements. This waiver applies to members in CA with individual/family plans (IFP).

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Ohio | Department of Medicaid

Ohio Department of Medicaid
Effective Immediately – COVID 19 Surge-Removing Administrative Barriers

August 27,2021

Ohio is experiencing another surge in COVID-19 cases, hospitalizations, and ICU admissions across the state. In response, the Ohio Department of Medicaid (ODM) is requiring Medicaid managed care organizations (MCOs) and MyCare Ohio plans (MCOPs) [for services where Medicaid is the primary payer] to lift all prior authorizations and/or pre-certifications for all long-term acute care facility (hospital), skilled nursing facility (SNF), and Inpatient Rehabilitation facility (IRF-hospital) admissions. It is imperative that we respond swiftly to remove barriers to care and reduce administrative burden on hospitals, SNFs, and IRFs.

MCOs and MCOPs shall assist providers with discharge planning activities including:

- Ensuring the member is transferred to the appropriate facility and level of care
- Adding services for the member's home care needs
- Expediting referrals to participating providers, and
- Ensuring all plans are in place before the member discharges.

Lifting prior authorization requirements for long-term acute care facility (LTACH), SNF, and IRF (hospital) admissions is **effective August 27, 2021**. Limited authorizations, i.e. three-day authorizations upon notification a SNF admission, are prohibited. MCOs and MCOPs shall continue to determine their members' level of care upon admission.

MCOs and MCOPs will be notified when this mandate ends. For more information about this directive, contact Roxanne Richardson at Roxanne.Richardson@medicaid.ohio.gov.

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Scott & White Health
Reduced Prior Authorization Requirements:
December 18, 2021

Scott and White Health Plan continues the reduced prior authorization requirements set earlier in 2020.

The following will continue through March 31, 2021:

• Increased authorization duration for non-emergency elective surgeries and outpatient diagnostic testing and procedures including physical therapy, occupational therapy and speech therapy for chronic needs. Where not restricted by regulation, the authorization window will be 180 days.
• Authorization requirements are suspended for the durable medical equipment below for fully insured, self-insured and Medicare members who are in an inpatient, rehabilitation, or skilled nursing facility and planning for homegoing:
    - Ventilators and associated equipment (E0457, E0459, E0471, E0472)
    - Oxygen and associated equipment (E0432, E0435, E0439, E0440, E1390, E1391, E1392)
    - Formula (B4153, B4161

• Admission to an in-network skilled nursing facility that is in the member's plan benefit network will require a notification within 4 days of admission, instead of a pre-authorization.
    - Medical necessity is required.
    - Length of stay reviews will apply
• Reminder: Scott and White Health Plan allows direct admissions to SNF from home, from ER, and does not require an overnight stay in a hospital prior to SNF admission.
• Pre-authorization is not required for the start of in-network Home Health Care Services for all lines of business.
    - Notification within 4 days of start of service is required.
    - Medical necessity is required.
• Please refer to swhp.org/coronavirus for up-to-date information from Scott and White Health Plan related to COVID-19.

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Sonder Health Plans

COVID-19 Information for Providers

Part C Requirements

1. Out of Network Services:

Cover Medicare Parts A and B services and supplemental Part C plan benefits furnished at non-contracted facilities subject to § 422.204(b)(3), which requires that facilities that furnish covered A/B benefits have participation agreements with Medicare. This is the text area for this paragraph. To change it, simply click here and start typing.

2. Primary Care Provider Approval:

Waive, in full, requirements for gatekeeper referrals where applicable.

3. Cost Sharing Change:

Provide the same cost-sharing for the enrollee as if the service or benefit had been furnished at a plan-contracted facility.

4. Benefit Change:

Make changes that benefit the enrollee effective immediately without the 30-day notification requirement at § 422.111(d)(3). (Such changes could include reductions in cost-sharing and waiving prior authorizations as described below.)

Part D Requirements

1. Refill-to-soon:

Relax the "refill-too-soon" edits if circumstances are reasonably expected to result in a disruption in access to drugs at the point-of-sale. Health Plans may also allow an affected enrollee to obtain the maximum extended day supply available under their plan, if requested and available.

2. Out of Network:

Consistent with 423.124(a) of the Part D regulations, Health Plans are required to ensure enrollees have adequate access to covered Part D drugs dispensed at out-of-network pharmacies when those enrollees cannot reasonably obtain covered Part D drugs at a network pharmacy. Enrollees remain responsible for any cost sharing under their plan and additional charges (i.e. the out-of-network pharmacy's usual and customary charge), if any, that exceed the plan allowance.

3. Mail or Home Delivery:

In situations when a disaster or emergency makes it difficult for enrollees to get to a retail pharmacy, or enrollees are actually prohibited from going to a retail pharmacy (e.g., in a quarantine situation), Health Plans will relax any plan-imposed policies that may discourage certain methods of delivery, for retail pharmacies that choose to offer these delivery services in these instances. Prior Authorization for Part D Drugs: Health Plans may choose to waive prior requirements at any time that they otherwise would apply to Part B drugs used to treat or prevent COVID-19, if or when such drugs are identified. Any such waiver must be uniformly provided to similarly situated enrollees who are affected by the disaster or emergency.

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Sonder Health Plans

COVID-19 Information for Providers

4. Prior Authorization for Part D Drugs:
Health Plans may choose to waive prior authorization requirements at any time that they otherwise would apply to Part D drugs used to treat or prevent COVID-19, if or when such drugs are identified. Any such waiver must be uniformly provided to similarly situated enrollees who are affected by the disaster or emergency.

5. Drug Shortage
Health Plans will follow the existing drug shortage guidance in Section 50.13 of Chapter 5 of the Part D manual in response to any shortages that result from this emergency.

6. Coverage of Vaccine:
Under current law, if a vaccine becomes available for COVID-19, Medicare will cover the vaccine. Health Plans will be required to cover the vaccine if it is a Part D drug.

Additionally, Sonder Health Plans:
Waives enrollee cost-sharing for COVID-19 laboratory tests, telehealth benefits or other healthcare services to address the outbreak.

Provide enrollees access to Medicare Part B services via telehealth in any geographic area and from a variety of places, including Members' homes.

Waive Plan's prior authorization requirements that otherwise would apply to tests or services related to COVID-19 at any time.

These special requirements are in effect until the end date identified in the Public Health State of Emergency, State Declaration, or other applicable regulatory requirement or order; if no end date is identified by State or Federal orders, Sonder Health Plans will apply a 30 days end date.

For questions regarding services already rendered, claims, contracts, etc., please contact your Provider Relations Representative or send an email to: **providerrelations@sonderhealthplans.com.**

If you require immediate assistance, contact Provider Services team at 1-888-216-5210.

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UnitedHealthcare

UnitedHealthcare Temporary Prior Authorization Program Changes — COVID-19

This announcement is applicable to all in-network hospitals and skilled nursing facilities (SNFs) in **Ohio statewide**.

Due to the persistence of COVID-19 cases in your area, UnitedHealthcare is extending the temporary program suspensions outlined below until Feb. 4, 2022. (They were set to expire on Jan. 21, 2022). This extension and dedicated support resources are being communicated directly to you as one of the impacted hospitals or facilities in Ohio.

The specific adjustments to our program for Ohio apply to UnitedHealthcare Medicare Advantage and Individual and Group Market health plans. These adjustments include:

- **SNF prior authorization:** We're suspending post-acute prior authorization requirements for admission to in-network SNFs
- **Transfer prior authorizations:** We're suspending prior authorization requirements when a member transfers to a new in-network facility
- **COVID-19-related oxygen requests:** As a reminder, for orders **involving COVID-19-related oxygen requests**, oxygen can be delivered without prior authorization and does not need to meet current clinical criteria
- **Discharge and post-care assistance:** If your team needs assistance with discharge planning or finding post-acute care for patients with complex needs, please email **COVID-19dischargeplanning@uhc.com**

After **Feb 4, 2022**, we may conduct selective retrospective reviews for services rendered during this time period. **Admission notification is still required during this time**, in alignment with the current protocol to support you in arranging post-admission care or other support services, if needed. In most cases, notification of inpatient admission is provided to UnitedHealthcare by the hospital or facility through the UnitedHealthcare Provider Portal or an EDI 278N transmission that requires no intervention on the part of your staff.

If you have questions, please contact Gary Grosel, M.D., UnitedHealthcare Market Chief Medical Officer, at **gary_grosel@uhc.com** or **216-263-9533**. For the most up-to-date information surrounding our other efforts related to COVID-19, please visit **UHCprovider.com/COVID19**.

We will continue to monitor guidance issued by regulatory authorities and keep you posted as the COVID-19 crisis continues to evolve. As dedicated workers on the front lines of this pandemic, we deeply appreciate your efforts to fight this virus. Thank you for all you're doing.

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UnitedHealthcare

UnitedHealthcare Temporary Prior Authorization Program Changes — COVID-19

This announcement is applicable to all in-network hospitals and skilled nursing facilities (SNFs) in **Indiana statewide.**

Due to the persistence of COVID-19 cases in your area, UnitedHealthcare is extending the temporary program suspensions outlined below until Feb. 4, 2022. (They were set to expire on Jan. 21, 2022.) This extension and dedicated support resources are being communicated directly to you as one of the impacted hospitals or facilities in Indiana.

The specific adjustments to our program for Indiana apply to UnitedHealthcare Medicare Advantage, Medicaid and Individual and Group Market health plans. These adjustments include:

- **SNF prior authorization**: We're suspending post-acute prior authorization requirements for admission to in-network SNFs
- **Transfer prior authorizations**: We're suspending prior authorization requirements when a member transfers to a new in-network facility
- **COVID-19-related oxygen requests**: As a reminder, for orders involving COVID-19- related oxygen requests, oxygen can be delivered without prior authorization and does not need to meet current clinical criteria
- **Discharge and post-care assistance**: If your team needs assistance with discharge planning or finding post-acute care for patients with complex needs, please email COVID-19dischargeplanning@uhc.com

After Feb. 4, 2022, we may conduct selective retrospective reviews for services rendered during this time period. Admission notification is still required during this time, in alignment with the current protocol to support you in arranging post-admission care or other support services, if needed. In most cases, notification of inpatient admission is provided to Katherine V. Miller President, UnitedHealthcare Networks Anne Boland Docimo, M.D. Chief Medical Officer, UnitedHealthcare UnitedHealthcare by the hospital or facility through the UnitedHealthcare Provider Portal or an EDI 278N transmission that requires no intervention on the part of your staff.

If you have questions, please contact Ty Sullivan, M.D., UnitedHealthcare Market Chief Medical Officer, at jeremy_t_sullivan@uhc.com or 317-405-3861. For the most up-to-date information surrounding our other efforts related to COVID-19, please visit UHCprovider.com/COVID19.

We will continue to monitor guidance issued by regulatory authorities and keep you posted as the COVID-19 crisis continues to evolve. As dedicated workers on the front lines of this pandemic, we deeply appreciate your efforts to fight this virus. Thank you for all you're doing.

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UnitedHealthcare

UnitedHealthcare Temporary Prior Authorization Program Changes — COVID-19

This announcement is applicable to all in-network hospitals and skilled nursing facilities (SNFs) in **Texas statewide.**

UnitedHealthcare is temporarily suspending prior authorization requirements for in-network hospitals and SNFs due to an overwhelming increase in COVID-19-related emergency department visits, admissions and transfers. The suspended requirements and dedicated support resources are being communicated directly to you as one of the impacted hospitals or facilities in Texas.

The specific adjustments to our program for Texas apply to UnitedHealthcare Medicare Advantage, Medicaid, Individual and Group Market and Individual and Family (formerly known as Individual Exchange) health plan members, effective Jan. 14, 2022 until Feb. 11, 2022. These adjustments include:

- **SNF prior authorization**: We're suspending post-acute prior authorization requirements for admission to in-network SNFs
- **Transfer prior authorizations**: We're suspending prior authorization requirements when a member transfers to a new in-network facility
- **COVID-19-related oxygen requests**: As a reminder, for orders involving COVID-19- related oxygen requests, oxygen can be delivered without prior authorization and does not need to meet current clinical criteria
- **Discharge and post-care assistance**: If your team needs assistance with discharge planning or finding post-acute care for patients with complex needs, please email COVID-19dischargeplanning@uhc.com

After Feb. 11, 2022, we may conduct selective retrospective reviews for services rendered during this time period. Admission notification is still required during this time, in Katherine V. Miller President, UnitedHealthcare Networks Anne Boland Docimo, M.D. Chief Medical Officer, UnitedHealthcare alignment with the current protocol to support you in arranging post-admission care or other support services, if needed. In most cases, notification of inpatient admission is provided to UnitedHealthcare by the hospital or facility through the UnitedHealthcare Provider Portal or an EDI 278N transmission that requires no intervention on the part of your staff.

If you have questions, please contact Ty Sullivan, M.D., UnitedHealthcare Market Chief Medical Officer, at jeremy_t_sullivan@uhc.com or 317-405-3861. For the most up-to-date information surrounding our other efforts related to COVID-19, please visit UHCprovider.com/COVID19.

We will continue to monitor guidance issued by regulatory authorities and keep you posted as the COVID-19 crisis continues to evolve. As dedicated workers on the front lines of this pandemic, we deeply appreciate your efforts to fight this virus. Thank you for all you're doing.

CENTENE Corporation wellcare sunshine health

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Florida Only

January 11, 2022

Post-Acute Accommodations for rehab hospitals and Long Term Acute Care hospitals (LTACH): We will relax our requirements related to facility transfers including: a. We will not require discharging acute care facilities to obtain prior authorization for patient transfers to participating post-acute facilities. b. We will not require sending facilities to provide notification of transfer to participating providers. c. However, we will require receiving facilities to notify the health plan of patient admission. And we will accept notification up to five days post-transfer. d. We will continue to conduct medical necessity review e. Because we will not have visibility prior to transfer, we request that hospitals utilize our in network post-acute facilities This waiver currently only covers Medicare and Medicaid lines of business for Sunshine Health and Wellcare. Skilled Nursing Facilities: We will allow post admission notification and authorize up to a 7 day stay before medical necessity continued stay review.

wellcare™

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Texas Only

January 12, 2022

Dear Provider,

Effective immediately for our Medicare Products, WellCare Health Plans has implemented guidelines regarding COVID19 related admissions through January 31, 2022. Guidelines are below for review.

NEWS & UPDATES

To be implemented until 1/31/22

Inpatient Admissions: *We will allow notification of admission up to 5 days post admission date and complete medical necessity reviews when notification is received.*

Post-Acute Accommodations for rehab hospitals and Long Term Acute Care hospitals (LTACH):

We will relax our requirements related to facility transfers including:

a. *We will not require discharging acute care facilities to obtain prior authorization for patient transfers to participating post-acute facilities.*

b. *We will not require sending facilities to provide notification of transfer to participating providers.*

c. *However, we will require receiving facilities to notify the health plan of patient admission. And we will accept notification up to five days post-transfer.*

d. *We will continue to conduct medical necessity review*

e. *Because we will not have visibility prior to transfer, we request that hospitals utilize our in network post-acute facilities*

Skilled Nursing Facilities: *We will allow post admission notification and authorize up to a 7 day stay before medical necessity continued stay review.*

WELLMED

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Texas Only
POST ACUTE CARE NETWORK NEXT SITE OF CARE (NSOC)
Quick Approval Admission Process from the Hospital

Purpose:
- To avoid unnecessary delays in skilled nursing transfer admissions to partnering facilities for the appropriate members.

Members to be considered for this process:
- Members with an IP/Observation status with a skilled nursing request who meet skilled criteria for stay.

Members that **DO NOT MEET CRITERIA:**
- Respite Care
- Members who could safely discharge home with home health, infusion therapy or outpatient therapy orders.
- Members who have no skilled needs (custodial admissions for LTC consideration)

Process Steps:
- The Hospital Care Manager/MD telephones the SNF requesting admission for the patient
- Criteria for admission must be reviewed at that time and a decision made for admission to the SNF must occur during that call