interChange Provider Important Message

Attention: All Providers

Diagnosis Code Requirement for COVID-19 Testing Group Claims

As communicated by PB 2020-42 *CMAP COVID-19 Response – Bulletin 27: New COVID-19 Coverage Group for Uninsured Residents*, effective March 18,2020 the Department of Social Services implemented an optional eligibility category to provide coverage of COVID-19 testing and testing-related services for potential beneficiaries that meeting the definition of "uninsured" as defined by the Families First Coronavirus Response Act (FFCRA).

As subsequently specified by PB 2020-48 *REVISED CMAP COVID-19 Response – Bulletin 32: Services Covered under the Optional Medicaid Coverage Group "COVID-19 Testing Group" for Uninsured Connecticut Residents* this coverage group provides limited benefits for COVID-19 testing, an office visit to determine whether testing is necessary and related services to determine whether testing is necessary, such as a chest x-ray.

Due to the federal requirements for payment of services under this optional group, effective retroactive to March 18, 2020 (or the effective date of the diagnosis code), claims submitted under the COVID-19 Testing Group must include one of the following diagnosis codes in order to process and pay. Any claim submitted under the COVID-19 Testing Group that does not include one of the following diagnosis codes, will be denied.

- U07.1: 2019-nCoV acute respiratory disease* (*U07.1 is effective for claims 4/1/2020 and forward*)
- Z20.828: Contact with and (suspected) exposure to other viral communicable diseases (depending on whether or not there was exposure).
- Z03.818: Encounter for observation for suspected exposure to other biological agents ruled out
- Z11.59: Encounter for screening for other viral diseases

The diagnosis codes listed above can be submitted in any position on the claim and do not need to be listed as the primary diagnosis code. Please note that claims that were previously submitted and reimbursed under the COVID-19 Testing Group that did not include one of the diagnosis codes listed above will be recouped in a future claims cycle. The Department of Social Services will issue a separate IM notifying providers when the recoupment will occur. If the service at issue was related to COVID testing, providers will need to resubmit those claims with one of the appropriate diagnosis codes listed above in order to receive payment. For additional information regarding the COVID-19 Testing Group refer to PB 2020-42 and PB 2020-48.