CareOregon monoclonal antibody (mAb) for COVID-19 treatment billing FAQ

Billing/reimbursement questions

Q. Is monoclonal antibody administration for COVID-19 treatment a covered benefit for CareOregon Medicare Advantage members?
A. Yes, but payment will be made through the original fee-for-service Medicare program. Send claims to FFS Medicare through your Medicare Administrative Contractor (MAC).

Q. Is monoclonal antibody administration for COVID-19 treatment a covered benefit for CareOregon Medicaid members?
A. Yes, but only for contracted providers. If you are a contracted provider with CareOregon, please bill the CCO. If you are not contracted, please submit claims to DMAP FFS. Please use the appropriate drug and administration codes specified in the Oregon Medicaid COVID-19 Provider Guide.

Q. Will CareOregon reimburse uncontracted providers for mAbs treatment?
A. OHA has implemented an "open-door policy" to ensure access for both FFS and CCO members to receive covered mAb prophylaxis or COVID-19 treatment.

- Providers contracted with the member's CCO should bill the CCO.
- Providers not contracted with the member's CCO should bill OHA directly.

Q. Should we include the drug and administration codes on the claim if we did not purchase the drug off the market or if we received it at no cost to us?
A. No. Please only submit drug codes that were purchased off the market. If you received the drug at no cost to you, please only submit the administration code.

Q. Will CareOregon reimburse for drug products related to mAbs treatment?
A. Yes, but only if the drug product was purchased off the market. If you purchased the drug products off the market, please submit the drug code with NDC information and the administration code on the claim.

Q. What drug product and administration codes should be submitted on the claims?
A. Please refer to the Oregon Medicaid COVID-19 Provider Guide for the most current set of drug product and administration codes eligible for reimbursement.

Q. For mAbs treatment administered in an outpatient visit, will CareOregon require a separate claim like Medicare does for the charges?
A. No. Please do not separate mAbs treatment charges from other services provided during an outpatient visit.

Q. Will CareOregon reimburse mAbs treatment provided during an inpatient stay separate from the inpatient admission? If so, is a separate claim from the stay required?
A. Yes. Please split the services and submit a claim for mAbs treatment administration separate from the inpatient stay. Please use the following claim instruction for the mAbs treatment.

Please split the bill as an outpatient service as follows:

- Type of bill: 131
- Statement covers period ("from" and "to" dates): Use the discharge date of the inpatient claim.

- Condition code: DR (disaster-related)
- Revenue code: 771 (admin)
- Revenue code: 636 (drug)

Q. Will there be any member liability for this treatment?
A. No, Medicaid members have no liability for covered services.

Q. Does ICD-10 U07.1 (COVID-19) need to be the primary diagnosis for mAbs treatment administration?
A. No. There is no requirement for primary diagnosis on these claims. Providers should use their clinical judgment when determining what diagnosis to add to claims and in what order.

Q. Have you established rates for payment of mAbs treatment?
A. Contracted providers will be reimbursed at contracted rates. Please review the Oregon Medicaid COVID-19 Provider Guide for DMAP rates.

Q. Who should I contact if I feel a claim for mAbs treatment was not adjudicated correctly?
A. If, for some reason, a past claim was denied and has not been retro adjudicated correctly, please follow up with Provider Customer Service at 800-224-4840, option 3.

Q. Are we required to include a CR or DR modifier when submitting a claim for mAbs treatment?
A. The CR or DR modifier should be used if the service you are providing is related to the prevention, identification, assessment or treatment of COVID-19 exposure (provider or member). These modifiers should be added after any other modifiers the clinic would have submitted on claims prior to COVID-19.

Q. For institutional claims, should a DR condition code be reported for vaccine claims?
A. Yes. Providers should submit a DR modifier for any visit related to COVID prevention, identification, diagnosis and treatment. If all services are disaster-related, use DR condition codes to indicate that the entire claim is disaster-related. The CR modifier should be used to designate any service line item on a claim that is disaster-related.

Q. Will the COVID-19 modifiers affect claim processing or payment?
A. No. The use of these modifiers will not affect claim payment and processing if the appropriate codes, modifiers and POS are used.