Frequently Asked Questions

The responses below are provided with the most accurate information available as of August 3, 2020. This document will be updated as needed.

How will the testing be billed when only primary insurance is requested?

The costs for testing done during the statewide initiative were paid for by the Texas Division of Emergency Management and will be reimbursed through FEMA. Facilities will not be required to bill for these services. Additional direction will be provided regarding additional testing requirements and the appropriate payment processes to use at that time.

Facility Initiated Testing

For Residents

Medicare: The CARES Act waives cost-sharing (including deductibles, copayments, and coinsurance) for Medicare Part B enrollees for COVID-19 testing-related services. Per CMS guidance, Medicare covers lab administration of testing for residents, including dual eligibles using the following codes:

- G2023, specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
- G2024, specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a Home Health Agency, any specimen source

Medicaid: Medicaid covers COVID-19 testing. Nursing facilities may contract with a provider or lab to conduct testing.

For Staff: The CARES Act mandates that private insurance cover testing costs with no cost sharing or prior authorization for tests that are medically necessary. For both residents and staff who have private insurance, there will

not be a need for secondary insurance information. Claims for staff covered by Medicare or Medicaid may be submitted.

Will providers who self-tested during the mandatory testing period be reimbursed for tests conducted?

Providers can seek reimbursement for testing costs for both residents and staff through the COVID-19 Uninsured Program Portal. This includes funds from both the CARES Act and the Health Resources and Services Administration.

Providers may also apply for relief funds through the CARES Act at the Provider Relief Fund Payment Portal.

How do providers bill for tests performed by a private lab?

For Residents: Both Medicare and Medicaid will reimburse testing costs from Medicare/Medicaid-enrolled provider labs with whom the nursing facilities contract. These labs should submit claims directly to either Medicare or to TMHP for Medicaid claims. During the testing initiative, DSHS contracted with labs to process all the tests. Those labs were paid per test and facilities will not be responsible for those fees.

For Staff: If a staff member goes to a private lab to be tested and has insurance, the insurance plan will cover the costs with no co-pays as required by the CARES Act. If a staff member is uninsured, providers can enroll as a provider participant through the COVID-19 Uninsured Program Portal and request claims reimbursement through the CARES Act.

Claims for staff receiving Medicare or Medicaid may be submitted.

How will self-insured providers be reimbursed?

Per the most recent CMS FAQ, self-insured plans must follow the guidelines in section 6001(c) of the Families First Coronavirus Response Act (FFCRA).

Nursing Facility Testing Reimbursement

Who pays for tests if staff does not have insurance?

The Families First Coronavirus Act of 2020 included $1 billion under the Public Health and Social Services Emergency Fund (PHSSEF) for testing services for the uninsured. Providers can enroll as a provider participant through the COVID-19 Uninsured Program Portal and request claims reimbursement while funding is available. Claims will generally be reimbursed at Medicare rates.

Providers who have conducted COVID-19 testing or provided treatment for uninsured residents or staff with a COVID-19 diagnosis on or after February 4. 2020 can begin the process of filing claims for reimbursement by accessing the portal at coviduninsuredclaim.linkhealth.com.

Additional information can be found here.

Under consolidated billing, is the facility required to pay for testing a skilled resident if the hospital requires a test before a scheduled procedure?

CMS's skilled nursing facility consolidated billing guidelines outline which services are excluded, and thus are separately payable, and laboratory tests are not excluded. Additional CMS guidance can be found here.

Is the cost covered for the two tests 24 hours apart to rule out COVID?

For Residents: Testing under Medicaid and Medicare is covered when it is diagnostic and medically necessary and billed by a covered provider. There are not any coding rules that would prevent the testing code from being billed 24 hours apart.

For Staff: According to CDC guidance, private insurance will not cover return to work testing, unless it is determined as diagnostic and medically necessary. For uninsured staff, provider participants can see reimbursement through the [COVID-19 Uninsured Program Portal.](#)